



DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 147, 153, 154, 155, 156, 157, and 158

[CMS-9930-P]

RIN 0938-AT12

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

Parameters for 2019

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** and risk adjustment data validation programs; cost-sharing parameters and **cost-sharing reductions**; and user fees for Federally-facilitated Exchanges and State-based Exchanges on the Federal platform. It proposes changes that would enhance the role of States as related to **essential health benefits** (EHB) and qualified health plan (QHP) certification; and would provide States with additional flexibility in the operation and establishment of Exchanges, including the Small Business Health Options Program (SHOP) Exchanges. It includes proposed changes to standards related to Exchanges; the required functions of the SHOPS; actuarial value for stand-alone dental plans; the rate review program; the medical loss ratio program; eligibility and enrollment; exemptions; 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 November 27, 2017.

ADDRESSES: In commenting, please refer to file code CMS-9930-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-9930-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-9930-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:

Lindsey Murtagh, (301) 492-4106, Rachel Arguello, (301) 492-4263, or Alper Ozinal, (301) 492-4178, for general information.

Krutika Amin, (301) 492-5153, for matters related to risk adjustment, and Federally-facilitated Exchange and State-based Exchange on the Federal platform user fees.

Adrienne Patterson, (410) 786-0686 or Abigail Walker, (410) 786-1725, for matters related to sequestration and administrative appeals of financial transfers.

Melissa Jaffe, (301) 492-4129 or Adam Shaw, (410) 786-1091, for matters related to risk adjustment data validation.

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

Jenny Chen, (301)-492-5156, for matters related to establishing a State-based Exchange, and State-based Exchanges on the Federal platform.

Emily Ames, (301) 492-4246, for matters related to Navigators and non-Navigator assistance personnel.

Elissa Dines, (301) 492-4388, for matters related to employer-sponsored coverage verification.

Kendra May, (301) 492-4477, for matters related to the requirement to file an income tax return and reconcile APTC and terminations.

Carolyn Kraemer, (301)-492-4197, for matters related to special enrollment periods under part 155.

Amanda Brander, (202) 690-7892, for matters related to exemptions from the shared responsibility payment.

Terence Kane, (301) 492-4449, for matters related to income inconsistencies.

Jacob Schnur, (410) 786-7703, for matters related to direct enrollment.

Laura Eldon, (301) 492-4372, for matters related to the Federally-facilitated SHOP.

Shilpa Gogna, (301) 492-4257, for matters related to SHOP in State-based Exchanges.

Leigha Basini, (301) 492-4380, Rebecca Zimmermann, (301) 492-4396, or Allison Yadsco, (410) 786-1740, for matters related to standardized options, essential health benefits, stand-alone dental plans and other standards for QHP issuers.

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

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

Cam Moultrie Clemmons, (206) 615-2338, for matters related to minimum essential coverage.

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 Web site as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that Web site 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.

Acronyms

Because of the many organizations and terms to which we refer by acronym in this proposed rule, we are listing these acronyms and their corresponding terms in alphabetical order below:

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
Code	Internal Revenue Code of 1986 (26 U.S.C. 1, <u>et seq.</u>)
EDGE	External Data Gathering Environment
EHB	Essential health benefits
FFE	Federally-facilitated Exchange
FF-SHOP	Federally-facilitated Small Business Health Options Program
FPL	Federal poverty level
FR	Federal Register
FTI	Federal tax information
HCC	Hierarchical condition category
HHS	United States Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191)

ICR	Information collection requirements
IRS	Internal Revenue Service
MEC	Minimum essential coverage
MLR	Medical loss ratio
NAIC	National Association of Insurance Commissioners
NHEA	National Health Expenditure Accounts
OIG	Office of the Inspector General
OMB	Office of Management and Budget
PHS Act	Public Health Service Act
PMPM	Per member per month
Patient Protection and Affordable Care Act or PPACA	
	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
PRA	Paperwork Reduction Act of 1995
PTC	Premium tax credit
QIA	Quality improvement activities
QHP	Qualified health plan
RBC	Risk-based capital
RXCs	Prescription drug utilization factors
SADPs	Stand-alone dental plans
SBE	State-based Exchange
SBE-FP	State-based Exchange on the Federal platform

SHOP Small Business Health Options Program
SSA Social Security Administration

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I. **Executive Summary**

American Health Benefit Exchanges, or “Exchanges” (also called “Marketplaces”) are entities established under the Patient Protection and Affordable Care Act (PPACA) through which qualified individuals and qualified employers can purchase health insurance coverage. Many individuals who enroll in qualified health plans (QHPs) through individual market Exchanges are eligible to receive a premium tax credit (PTC) to reduce their costs for health insurance premiums, and receive reductions in required cost-sharing payments to reduce out-of-pocket expenses for healthcare services. The PPACA also established the risk adjustment program, which is intended to mitigate the potential impact of adverse selection and stabilize the price of health insurance in the individual and small group markets, both on and off Exchanges.

Over time, issuer exits and increasing insurance rates have threatened the stability of the individual and small group Exchanges in many geographic areas. In previous rulemaking, we established provisions and parameters to implement many PPACA provisions and programs. In this proposed rule, we propose to amend these provisions and parameters, with a focus on enhancing the role of States in these programs and providing States with additional flexibilities, reducing unnecessary regulatory burden on stakeholders, empowering consumers, and improving affordability.

On January 20, 2017, the President issued an Executive Order which stated that, to the maximum extent permitted by law, the Secretary of HHS and heads of all other executive departments and agencies with authorities and responsibilities under the PPACA should exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the PPACA that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, healthcare

providers, health insurers, patients, recipients of healthcare services, purchasers of health insurance, or makers of medical devices, products, or medications. In this proposed rule, we are proposing, within the limitations of the current statute, to reduce fiscal and regulatory burdens across different program areas, and to support innovative health insurance models.

We propose several changes that would significantly expand the role of States in the administration of the PPACA. We propose to provide States with additional flexibility in the definition of essential health benefits (EHBs) and outline potential future directions for defining EHBs. In addition to granting States more flexibility regulating their markets, we believe this change would permit States to modify EHBs to increase affordability of health insurance in the individual and small group markets. We also propose to explore additional ways to support State-based Exchanges (SBEs) in adopting innovative approaches to operating and sustaining their Exchanges, and to make the State-based Exchanges on the Federal platform (SBE-FP) model a more appealing and viable model for States. We propose that States assume a larger role in the QHP certification process for the Federally-facilitated Exchanges (FEEs). This would confirm States' traditional role in overseeing their health insurance markets, and reduce the issuer burden associated with having to comply with duplicative State and Federal reviews.

This proposed rule also contains several policies that would provide States with greater flexibility. We propose to provide States with significantly more flexibility in how they operate a Small Business Health Options Program (SHOP), permitting them to operate these Exchanges more efficiently, potentially benefitting States, issuers, employers and employees. We propose changes that would allow for a more efficient SHOP, such that employers and employees could enroll in SHOP coverage by working with a QHP issuer or SHOP-registered agent or broker. Additionally, we propose to provide States more flexibility regarding risk adjustment transfers in

their markets. We also propose to make it easier for States to apply for and be granted an adjustment to the individual market medical loss ratio (MLR) standard in their State. We believe this change would provide States with an additional tool to help stabilize and provide relief in their individual markets. Additionally, we seek comment related to the inclusion of Federal and State taxes in MLR and rebate calculation, and we propose other changes to the MLR program to reduce the burden on issuers.

Risk adjustment continues to be a core program for stabilizing the individual and small group markets both on and off Exchanges, and we propose recalibrated parameters for the HHS risk adjustment methodology. We also propose several changes related to the risk adjustment data validation program that are intended to ensure the integrity of the results of risk adjustment, while alleviating issuer burden associated with participating in risk adjustment data validation.

As we do every year in the HHS notice of benefit and payment parameters, we propose updated parameters applicable in the individual and small group markets. We propose the user fee rate for issuers participating on FFEs and SBE-FPs for 2019 to be 3.5 and 3.0 percent of premiums, respectively. We propose to update the premium adjustment percentage for 2019, which is used to set the rate of increase for several parameters detailed in the PPACA, including the maximum annual limitation on cost sharing for 2019, the required contribution percentage used to determine eligibility for certain exemptions under section 5000A of the Code, and the assessable payment amounts under section 4980H(a) and (b) of the Code. We propose to update the maximum annual limitations on cost sharing for the 2019 benefit year for cost-sharing reduction plan variations. We also propose changes to the cost-sharing reduction reconciliation process.

We propose a number of changes related to **rate review** that are intended to provide States with greater flexibility in the rate filing process and reduce regulatory burden. Specifically, we propose to exempt student health insurance coverage from Federal rate review requirements, and to provide States with more flexibility regarding timing of the rate review process established under 45 CFR part 154. We also propose to modify the 10 percent threshold for reasonableness review to a 15 percent default threshold, with States continuing to have the flexibility to establish a different threshold.

Recognizing that Exchanges, including the FFEs, face resource constraints, we also propose changes to the requirements regarding Navigators, and the requirements regarding non-Navigator assistance personnel subject to §155.215, to enable Exchanges to more easily operate these programs with limited resources. Similarly, we also propose to allow an agent, broker or issuer participating in direct enrollment to have its selected third-party entity conduct operational readiness reviews, rather than requiring those reviews to be conducted by entities approved by HHS.

In this proposed rule, we propose relatively minor adjustments to our programs and rules as we do each year. We propose a number of incremental amendments to our policies around coverage, eligibility, enrollment, and affordability exemptions.

We continue to be very interested in exploring ways to improve Exchange program integrity. In this rule, we seek comment on a number of program integrity items, including whether we should consider shortening the length of time the Exchanges are authorized to obtain enrollee tax information, as well as ways to prompt more timely consumer reporting of changes in circumstances during the benefit year that may impact an individual's eligibility for coverage and financial assistance. In addition, we ask for comment on any additional program integrity

improvements that have not been outlined in this rule, but could be beneficial in a future rulemaking.

Finally, we note that we intend to consider proposals in future rulemaking that would help reduce drug costs and promote drug price transparency. We also note that we intend to provide guidance on other aspects of Exchange eligibility in the near future. In particular, we intend to reconsider the appropriate thresholds for changes in income that will trigger a data matching inconsistency, processes for denying eligibility for advance subsidies for individuals who fail to reconcile advance payments of the premium tax credit (APTC) on their Federal income tax return, processes for matching enrollment data with the Medicare and Medicaid programs, and the appropriate manner of recalculating APTC following a midyear change in eligibility, and seek comments on each of these issues as we prepare proposed rules on these topics.

Instituting strong program safeguards to ensure that only individuals who are eligible are enrolled in Exchange coverage, and that they are only receiving the amount of financial assistance they are eligible for, is essential to ensuring that the Exchanges operate as intended, and is also a key priority for the Administration. We have already taken action to strengthen safeguards around Exchange eligibility, most recently through the implementation of the Special Enrollment Verification initiative; however, we continue to be interested in exploring ways to further safeguard Federal tax dollars flowing through Exchanges.

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 “Patient Protection and Affordable Care Act” or “PPACA.”

Subtitles A and C of title I of the PPACA 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 PPACA, 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. These 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 PPACA. Section 1312(c) of the PPACA 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 PPACA.

Section 2702 of the PHS Act, as added by the PPACA, 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.¹

¹ Before enactment of the Patient Protection and Affordable Care Act, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) amended the PHS Act (formerly section 2711) to generally require guaranteed availability of coverage for employers in the small group market.

Section 2703 of the PHS Act, as added by the PPACA, and sections 2712 and 2741 of the PHS Act, as added by HIPAA prior to the enactment of the PPACA, 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 PPACA, 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 PPACA, 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.”² 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.

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

² 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 1302 of the PPACA provides for the establishment of an essential health benefits 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 provided under a typical employer plan, and that they cover at least the following 10 general categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Section 1301(a)(1)(B) of the PPACA directs all issuers of QHPs to cover the EHB package described in section 1302(a) of the PPACA, including coverage of the services described in section 1302(b) of the PPACA, to adhere to the cost-sharing limits described in section 1302(c) of the PPACA and to meet the AV levels established in section 1302(d) of the PPACA. 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 health insurance coverage, irrespective of whether such coverage is offered through an Exchange. In addition, section 2707(b) of the PHS Act directs non-grandfathered group health plans to ensure that cost sharing under the plan does not exceed the limitations described in sections 1302(c)(1) of the PPACA.

Section 1302(d) of the PPACA describes the various levels of coverage based on actuarial value (AV). Consistent with section 1302(d)(2)(A) of the PPACA, AV is calculated based on the provision of EHB to a standard population. Section 1302(d)(3) of the PPACA

directs the Secretary to develop guidelines that allow for de minimis variation in AV calculations.

Section 1311(b)(1)(B) of the PPACA directs that the Small Business Health Options Program assist qualified small employers in facilitating the enrollment of their employees in QHPs offered in the small group market. Sections 1312(f)(1) and (2) of the PPACA define qualified individuals and qualified employers. Under section 1312(f)(2)(B) of the PPACA, beginning in 2017, States have the option to allow issuers to offer QHPs in the large group market through an Exchange.³ Section 1312(a)(2) of the PPACA provides that in a SHOP, a qualified employer may select a level of coverage, and that employees may then, in turn, choose SHOP plans within the level selected by the qualified employer.

Section 1311(c)(1)(B) of the PPACA 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 PPACA requires the Secretary to continue to operate, maintain, and update the Internet portal developed under section 1103 of the PPACA to provide information to consumers and small businesses on affordable health insurance coverage options.

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

Section 1311(c)(6)(C) of the PPACA establishes special enrollment periods and section 1311(c)(6)(D) of the PPACA establishes the monthly enrollment period for Indians, as defined by section 4 of the Indian Health Care Improvement Act.

³ 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 1312(e) of the PPACA 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.

Section 1321(a) of the PPACA 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 PPACA. Section 1321(a)(1) of the PPACA directs the Secretary to issue regulations that set standards for meeting the requirements of title I of the PPACA with respect to, among other things, the establishment and operation of Exchanges.

Sections 1313 and 1321 of the PPACA 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 PPACA 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 PPACA, HHS has the authority under sections 1321(c)(1) and 1311(d)(5)(A) of the PPACA 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 PPACA 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 PPACA provides that nothing in title I of the PPACA should be construed to preempt any State law that does not prevent the application of title I of the PPACA. Section 1311(k) of the PPACA specifies that Exchanges may not establish rules that conflict with or prevent the application of regulations issued by the Secretary.

Section 1343 of the PPACA 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 of the PPACA provides 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. This section also provides for reductions in cost sharing for Indians enrolled in QHPs at any metal level.

Section 5000A of the Code, as added by section 1501(b) of the PPACA, requires all applicable individuals to maintain minimum essential coverage (MEC) for each month or make an individual shared responsibility payment. Section 5000A(f) of the Code defines MEC 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 MEC.

The Protecting Affordable Coverage for Employees Act (Pub. L. 114-60) amended section 1304(b) of the PPACA 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**⁴

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

⁴ By premium stabilization program, we are referring to the risk adjustment, risk corridors and reinsurance programs established by the PPACA.

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).

In the December 2, 2015 **Federal Register** (80 FR 75487), we published a proposed rule outlining the benefit and payment parameters for the 2017 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 2017 Payment Notice). We published the 2017 Payment Notice final rule in the March 8, 2016 **Federal Register** (81 FR 12203).

In the September 6, 2016 **Federal Register** (81 FR 61455), we published a proposed rule outlining the benefit and payment parameters for the 2018 benefit year, and to further promote stable premiums in the individual and small group markets. We proposed updates to the risk adjustment methodology, new policies around the use of external data for recalibration of our risk adjustment models, and amendments to the risk adjustment data validation process (proposed 2018 Payment Notice). We published the 2018 Payment Notice final rule in the December 22, 2016 **Federal Register** (81 FR 94058).

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 and SHOP, 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 additional 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.

In an interim final rule, published in the May 11, 2016 **Federal Register** (81 FR 29146), we made amendments to the parameters of certain special enrollment periods (2016 Interim Final Rule). We finalized these in the 2018 Payment Notice final rule in the December 22, 2016 **Federal Register** (81 FR 94058). In the April 18, 2017 Market Stabilization final rule **Federal Register** (82 FR 18346), we amended standards relating to special enrollment periods and QHP certification.

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

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>.

Final Rule, which was published in the February 25, 2013 **Federal Register** (78 FR 12833) (EHB Rule). In the April 18, 2017 Market Stabilization final rule (82 FR 18346), we expanded the de minimis range applicable to plan metal levels.

5. Minimum Essential Coverage

In the February 1, 2013 **Federal Register** (78 FR 7348), we published a proposed rule that designates other health benefits coverage as MEC and outlines substantive and procedural requirements that other types of coverage must fulfill in order to be recognized as MEC. The provisions were finalized in the July 1, 2013 **Federal Register** (78 FR 39494).

In the November 26, 2014 **Federal Register** (79 FR 70674), we published a proposed rule seeking comments on whether State high risk pools should be permanently designated as MEC or whether the designation should be time-limited. In the February 27, 2015 **Federal Register** (80 FR 10750), we designated State high risk pools established on or before November 26, 2014 as MEC.

6. 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 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). The 2018 Payment Notice final rule in the December 22,

2016 **Federal Register** (81 FR 94058) provided additional guidance on guaranteed availability and guaranteed renewability. In the April 18, 2017 Market Stabilization final rule (82 FR 18346), we released further guidance related to guaranteed availability.

7. 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 30239), the February 27, 2015 **Federal Register** (80 FR 10749), the March 8, 2016 **Federal Register** (81 FR 12203) and the December 22, 2016 **Federal Register** (81 FR 94058).

8. 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). The medical loss ratio program requirements were amended in final rules published in the March 11, 2014 **Federal Register** (79 FR 13743), the May 27, 2014 **Federal Register** (79 FR 30339), the February 27, 2015 **Federal Register** (80 FR 10749), the

March 8, 2016 **Federal Register** (81 FR 12203), and the December 22, 2016 **Federal Register** (81 FR 94183).

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, and the actuarial community to gather public input. We have solicited input from State representatives on numerous topics, particularly essential health benefits, QHP certification and Exchange establishment. 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.

HHS also received several thousand unique comments in response to a request for information, entitled “Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act and Improving Healthcare Choices to Empower Patients”, published in the June 12, 2017 **Federal Register** (82 FR 26885) (Request for Information). Review of these comments is ongoing, and we anticipate continuing to address comments in future rulemaking and guidance.

C. Structure of Proposed Rule

The regulations outlined in this proposed rule would be codified in 45 CFR parts 147, 153, 154, 155, 156, 157, and 158.

The proposed regulations in part 147 would amend the rules regarding fair health insurance premiums and guaranteed availability to reflect proposed changes related to the SHOPs and special enrollment periods.

The proposed regulations in part 153 propose to recalibrate the risk adjustment models consistent with the methodology finalized for the 2018 benefit year with slight modifications to the drug classes included in the 2019 benefit year adult models and the incorporation of blended MarketScan[®] and the most recent enrollee-level External Data Gathering Environment (EDGE) data. The proposed regulations address high-cost risk pooling, where we are proposing to implement the same parameters that applied to the 2018 benefit year to the 2019 benefit year. The proposed regulations in part 153 also include the risk adjustment user fee and modifications to risk adjustment data validation. We also propose State flexibility to the risk adjustment transfers starting for the 2019 benefit year.

The proposed regulations in part 154 propose certain modifications to enhance State flexibility for the rate review program. We propose to exempt student health insurance coverage from Federal rate review requirements. We propose to raise the default threshold for review of reasonableness in the rate review process from 10 percent to 15 percent. We also propose to allow States with Effective Rate Review Programs to set later submission deadlines for rate filings from issuers that offer non-QHPs only. In addition, we propose to change the notification period for States with Effective Rate Review Programs to notify HHS prior to posting rate increases (from 30 days to 5 business days).

The proposed regulations in part 155 include modifications to the functions of an Exchange, and a new approach to operational readiness reviews for direct enrollment partners which would allow agents, brokers, and issuers to select their own third-party entities for

conducting those reviews. We propose modifications to the rules around verification of eligibility. We also propose to increase flexibility in the Navigator program by removing the requirement that each Exchange must have at least two Navigator entities, one of which must be a community and consumer focused non-profit, and to remove the standard requiring physical presence of the Navigator entity in the Exchange service area. We propose to modify the parameters around certain special enrollment periods. We propose to modify the effective date options for enrollee-initiated terminations, and amend the affordability exemption so that it may be based on the lowest cost Exchange plan if there is no bronze level plan sold through the Exchange in that rating area.

The proposed regulations in part 156 include changes to essential health benefits and the QHP certification process. 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 2019. We propose to update the FFE and SBE-FP user fee rates for the 2019 benefit year for all issuers participating on the FFEs or SBE-FPs. The proposed regulations in part 156 would designate as MEC Children's Health Insurance Program (CHIP) buy-in programs that provide identical coverage to the State's CHIP program under title XXI of the Social Security Act. The regulations at part 156 also include proposals related to actuarial value for stand-alone dental plans (SADPs) and the administrative appeals right with respect to the amount of the advance payment of cost-sharing reductions.

The proposed amendments to the regulations in parts 155, 156, and 157 include proposals that would provide SHOPs with additional operational flexibility, and would modify the requirements for issuers, employers, and employees interacting with SHOPs.

The proposed amendments to the regulations in part 158 propose revisions related to reporting quality improvement activity expenses as part of the formula for calculating MLR, and revisions related to State requests for adjustment to the individual market MLR standard.

III. Provisions of the Proposed HHS Notice of Benefit and Payment Parameters for 2019

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

1. Fair health insurance premiums (§147.102)

As discussed elsewhere in this proposed rule, we are proposing substantial changes to the requirements applicable to SHOPs to provide those programs with the flexibility to operate in a leaner fashion, a flexibility that we intend to utilize in the FF-SHOPs. As part of these changes and as discussed in the preamble to §§156.285 and 156.286, we are proposing that, effective on the effective date of the final rule, if finalized as proposed, the requirement in §156.285(a)(4)(ii) regarding premium rating standards in the FF-SHOPs would not apply for plan years beginning on or after January 1, 2018. Therefore, we propose to delete from §147.102(c)(3)(iii)(D) a reference to §156.285(a)(4), and to replace the reference to FF-SHOPs with a reference to SHOPs generally, to reflect that, under the proposed approach for SHOPs, some SHOPs may want to prohibit issuers from offering average enrollee premiums. We seek comment on this proposal and on whether issuers offering coverage through SHOPs should always be required to offer average enrollee premiums, or do so only if required under applicable State law.

2. Guaranteed availability of coverage (§147.104)

As discussed elsewhere in this proposed rule, we are proposing substantial changes to the requirements applicable to SHOPs to provide them with the flexibility to operate in a leaner fashion, a flexibility that we intend to utilize in the FF-SHOPs. Among those changes, we

propose that, effective on the effective date of the final rule, if finalized as proposed, the requirements in §156.285 would apply for plan years starting before January 1, 2018. We also propose a new §156.286, which specifies those requirements contained in §156.285 that, effective on the effective date of the final rule, if finalized as proposed, would continue to apply for plan years starting on or after January 1, 2018. Among those requirements is the requirement in §156.285(e) which permits a QHP offered in the SHOP to apply group participation rules under certain circumstances. This provision is listed in proposed §156.286(e). The marketwide regulations at §147.104(b)(1)(i)(B) currently reference §156.285(e), and we propose to add a reference to §156.286(e), to clarify that, effective on the effective date of the final rule, if finalized as proposed, for plans years that start after January 1, 2018, QHPs offered in the SHOP may restrict the availability of coverage with respect to a group health plan that cannot comply with group participation rules, to an annual enrollment period of November 15 through December 15 of each calendar year.

These regulations also propose to remove the small group coverage effective dates that are found in the SHOP regulations at §155.725 with respect to plan years beginning on or after January 1, 2018, effective on the effective date of the final rule, if finalized as proposed. However, there are currently requirements in §147.104(b)(1)(i)(C) that, by cross-referencing §155.725, apply those same requirements marketwide, and we do not propose to remove that marketwide requirement. We propose changes to §147.104 to reflect these proposed changes. Specifically, we propose to eliminate, from §147.104(b)(1)(i)(C), the cross-reference to §155.725. We propose in place of the cross-reference to explicitly specify in §147.104(b)(1)(i)(C) those same coverage effective dates for coverage in the small group market,

and for the large group market if such coverage is offered through a SHOP, that would be eliminated from the SHOP regulations under our proposal for §155.725.

We propose to remove paragraph §147.104(b)(1)(iii), along with the cross-reference to it in §147.104(b)(1)(ii), as paragraph (b)(1)(iii) applies to plan selections made in 2013, and is therefore no longer necessary.

Section 147.104(b)(2)(i) extends several of the special enrollment periods that apply to issuers on the Exchange, to all issuers in the individual market. Although §147.104(b)(2)(i) is intended to specify which special enrollment periods offered through the Exchange must also be offered by health insurance issuers with respect to coverage offered outside of an Exchange, the paragraph as currently written could be read to apply the exceptions to any coverage offered by a health insurance issuer in the individual market. We recognize the potential for confusion, as coverage offered through an Exchange is offered by “a health insurance issuer in the individual market,” but this coverage is subject to the special enrollment rule at §155.420(d), which is intended to require special enrollment periods for triggers including those listed in the exceptions in paragraph (b)(2)(i). Therefore, for purposes of clarification, we propose to amend that phrase in §147.104(b)(2)(i) to clarify that the exceptions in the paragraph only apply with respect to coverage offered outside of the Exchange in the individual market.

With respect to the subset of special enrollment periods in §155.420 that apply off-Exchange, current regulations at §147.104(b)(2)(ii) state that, in applying §147.104(b)(2), a reference in §155.420 to a “QHP” is deemed to refer to a plan, a reference to “the Exchange” is deemed to refer to the applicable State authority, and a reference to a “qualified individual” is deemed to refer to an individual in the individual market. As discussed in the preamble to §155.420, we are proposing a change to §155.420(a)(5) to exempt qualified individuals from the

prior coverage requirement that applies to certain special enrollment periods if for at least 1 of the 60 days prior to the date of their qualifying event they lived in a service area where there were no QHPs offered through an Exchange. Section 155.420(a)(5) applies to qualifying individuals seeking off-Exchange coverage through an applicable special enrollment period, so we propose that this exception for individuals living in a service area where there were no QHPs offered through an Exchange would also apply.⁷ However, in this instance the reference to “QHP” should not be deemed to refer to a plan for purposes of applying §147.104(b)(2).

Therefore, we propose to amend §147.104(b)(2)(ii) to state that a reference in §155.420 (other than in §155.420(a)(5)) to a “QHP” is deemed to refer to a plan, a reference to “the Exchange” is deemed to refer to the applicable State authority, and a reference to a “qualified individual” is deemed to refer to an individual in the individual market.

We seek comment on these proposals.

Among the special enrollment periods in §155.420 that apply off-Exchange are those specified in §155.420(d)(2)(i), under which a qualified individual gains a dependent or becomes a new dependent through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order. As applied to on-Exchange

⁷ As stated in the preamble to §155.420, the exception to the requirement to have previous coverage is intended to relieve individuals of that requirement when there was no affordable coverage (that is, coverage that could be purchased through an Exchange to which APTC might apply) available in their previous service area. We believe affordability is key to this exception, and therefore, that the scope of the exception should apply equally, regardless of whether the individual is seeking to purchase coverage inside or outside an Exchange during the special enrollment periods for which this exception applies; that is, the exception should apply if there was no such affordable coverage available in the individual’s previous service area (regardless of whether or not any coverage was being actively marketed in that service area outside the Exchange). Also, when an individual seeks to purchase coverage outside an Exchange during such a special enrollment period, we believe it might be unreasonably difficult for an issuer to determine if at least one issuer was actively marketing coverage in the individual’s previous service area outside the Exchange, as opposed to determining if at least one issuer was making coverage available in that service area specifically through an Exchange. We solicit comments on this approach.

coverage under these special enrollment periods, an existing dependent may enroll in or change their QHP enrollment through these special enrollment periods when a qualified individual gains a dependent or becomes a new dependent under the circumstances described in §155.420(d)(2)(i) and the requirement in §155.420(a)(4)(i) that the new dependent must be allowed to enroll in the QHP in which the family is already enrolled is not applicable. Under the HIPAA special enrollment provisions that continue to apply to group health plans and health insurance issuers in connection with group health coverage, there are similar special enrollment periods when a child becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.⁸ The HIPAA regulations specify that, under such circumstances, those special enrollment periods apply only to dependents who become a dependent through marriage, birth, adoption, or placement for adoption (that is, new dependents). We seek comment on whether, in the off-Exchange individual market, the special enrollment periods for when an individual gains a dependent or becomes a new dependent under the circumstances described in §155.420(d)(2)(i) should apply to new and existing dependents (as is the case in the Exchanges when the requirement in §155.420(a)(4)(i) that the new dependent must be allowed to enroll in the QHP in which the family is currently enrolled is not applicable), whether they should apply only to new dependents (consistent with the HIPAA group market regulations), or whether we should adopt some other approach, such as affording the special enrollment periods to some, but not all categories of existing dependents.

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

⁸ See §146.117(b).

1. Sequestration

In accordance with the OMB Report to Congress on the Joint Committee Reductions for Fiscal Year 2018,⁹ both the transitional reinsurance program and permanent risk adjustment program are subject to the fiscal year 2018 sequestration. The Federal government's 2018 fiscal year begins October 1, 2017. Although the 2016 benefit year is the final year of the transitional reinsurance program, HHS will continue to make reinsurance payments in the 2018 fiscal year, as the second contribution collection deadline for the 2016 benefit year is November 15, 2017. Therefore, the reinsurance program will be sequestered at a rate of 6.6 percent for payments made from fiscal year 2018 resources (that is, funds collected during the 2018 fiscal year). The risk adjustment program will also be sequestered at a rate of 6.6 percent for payments made from fiscal year 2018 resources (that is, funds collected during the 2018 fiscal year).

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 the reinsurance and risk adjustment programs, the funds that are sequestered in fiscal year 2018 from the reinsurance and risk adjustment programs will become available for payment to issuers in fiscal year 2019 without further Congressional action. If 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 Risk Adjustment Program

⁹ Available at https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/sequestration_reports/2018_jc_sequestration_report_may2017_potus.pdf.

In subparts D and G of part 153, we established standards for the administration of the risk adjustment program. The risk adjustment program is a permanent program created by section 1343 of the PPACA 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. HHS will be operating risk adjustment in every State beginning for the 2017 benefit year, and did not receive any applications from States to operate risk adjustment for the 2019 benefit year.

HHS continues to evaluate the risk adjustment program, including by reviewing comments received in response to the Request for Information, and intends to propose changes in a manner that promotes transparency, considers stakeholder feedback and provides adequate notice to issuers, while upholding the integrity and accuracy of the program.

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 risk assigned to an individual's age, sex, and diagnoses are added together to produce an individual risk score. Additionally, in the adult models, we added enrollment duration factors beginning for the 2017 benefit year, and prescription drug utilization factors (RXC's) beginning for the 2018 benefit year, in the calculation of enrollees' risk scores. Infant risk scores are determined by inclusion in one of 25 mutually exclusive groups, based on the infant's maturity

and the severity of diagnoses. If applicable, the risk score for adults, children or infants is multiplied by a cost-sharing reductions adjustment.

The enrollment-weighted average risk score of all enrollees in a particular risk adjustment covered plan (also referred to as the plan liability risk score) 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 accords with the Actuarial Standards Board's Actuarial Standards of Practice for risk classification.

b. Proposed updates to the risk adjustment model (§153.320)

For the 2019 benefit year risk adjustment model, HHS will continue to incorporate the methodological improvements finalized in previous rulemaking, such as incorporating preventive services in our simulation of plan liability, using more granular trend rates to better reflect the growth in specialty drug expenditures and drugs generally as compared to medical and surgical expenditures, accounting for partial year enrollment in the adult models, including prescription drug utilization factors in the adult models, adjusting the risk adjustment model and transfers to account for high-cost enrollees, and removing a portion of the premiums in the transfer formula to account for a portion of administrative costs that do not vary with claims. For the 2019 benefit year, we propose to recalibrate the risk adjustment models using the methodology finalized for the 2018 benefit year, with small modifications to the drug classes included in the 2019 benefit year adult models, and incorporation of the 2016 benefit year EDGE data in the 2019 benefit year risk adjustment model recalibration.

We seek comment on these proposals.

i. Recalibration Using EDGE Data

To recalibrate the 2016, 2017 and 2018 benefit year risk adjustment models, we used the three most recent years of Truven MarketScan[®] data. This approach allowed for using the blended, or averaged, coefficients from 3 years of separately solved models, which promotes stability for the risk adjustment coefficients year-to-year, particularly for rare conditions with small sample sizes. We finalized in the 2018 Payment Notice the collection of enrollee-level EDGE data and the recalibration of the risk adjustment model for the 2019 benefit year using 2016 benefit year EDGE data. We believe that blending the coefficients calculated from the 2016 benefit year EDGE enrollee-level data with MarketScan[®] data will provide stability within the risk adjustment program and minimize volatility in changes to risk scores from the 2018 to 2019 benefit years due to differences in the datasets' underlying populations. As such, we propose blending 3 years of data to recalibrate the coefficients used in the risk adjustment model and, for the 2019 benefit year, blending separately solved coefficients from the 2016 benefit year EDGE enrollee-level data and the 2014 and 2015 MarketScan[®] data using the methodology that will be finalized in the 2019 Payment Notice final rule. Given the timing of the 2019 Payment Notice and the significant analysis necessary to develop the 2016 benefit year EDGE recalibration dataset, we are not able to incorporate the 2016 benefit year EDGE data in this proposed rule. Therefore, we use the 2014 and 2015 MarketScan[®] data for the coefficients in this proposed rule. We propose to finalize the 2019 benefit year blended coefficients with the separately solved models from the 2016 benefit year EDGE enrollee-level data with the 2014 and 2015 MarketScan[®] data. This approach is similar to our approach in previous years, in which we

updated the final coefficients using data from the most recently available benefit year.¹⁰ We expect to publish the final risk adjustment model coefficients for the 2019 benefit year in the final rule. However, we seek comment on whether we should publish the final risk adjustment model coefficients in guidance in the spring of 2018, prior to rate setting for the 2019 benefit year, similar to our approach for publishing the 2018 benefit year risk adjustment coefficients, if we need additional time to analyze the 2016 enrollee-level EDGE data. Under either approach, the final risk adjustment model coefficients for the 2019 benefit year would be determined using the methodology that we finalize in the 2019 Payment Notice final rule, and would be published either in the final rule or in guidance prior to the 2019 benefit year rate setting. Additionally, if we find significant demographic or distributional differences in the enrollee-level EDGE data compared to the MarketScan data, we seek comment on whether we should make adjustments to the risk adjustment recalibration model age-sex, HCC and RXC categories for the final 2019 benefit year. In such a case, we would make adjustments to the models to better align them with the enrollee-level EDGE data, to improve the prediction of plan liability. The risk adjustment model coefficients listed in Tables 2, 4, and 5 are blended coefficients using the 2014 and 2015 MarketScan[®] data.

We seek comment on our proposal to determine coefficients based on a blend of 2014 and 2015 MarketScan[®] data and 2016 enrollee-level EDGE data using the methodology that will be finalized in the 2019 Payment Notice final rule in the final rule or through guidance. We also seek comment on the proposed methodology to equally weight the separately solved model coefficients from the 2014 MarketScan[®], 2015 MarketScan[®], and 2016 enrollee-level EDGE

¹⁰ See, for example, 2018 Payment Notice final rule, 81 FR 94058 (December 22, 2016).

data for the final coefficients, instead of using only the 2016 enrollee-level EDGE data to recalibrate the risk adjustment model coefficients for the 2019 benefit year.

ii. **Prescription Drugs**

In the 2018 Payment Notice, we finalized the inclusion of twelve RXCs that interact with diagnoses (hierarchical condition categories (HCCs)), or drug-diagnosis (RXC-HCC) pairs, in the adult risk adjustment models for the 2018 benefit year. Ten of the RXC-HCC pairs have three levels of incremental predicted costs (diagnosis-only, prescription drug-only, and both diagnosis and prescription drug), indicating that they can be used to impute a particular diagnosis. The 2018 benefit year risk adjustment adult models also included two RXC-HCC pairs that are used for severity-only — that is, they predict incremental costs for enrollees with the diagnosis-only, or with both the diagnosis and the prescription drug. For enrollees without the associated diagnoses documented for these severity-only RXC-HCC pairs, the presence of the drug alone would not lead to the imputation of additional plan liability costs attributed to the plan.

For the 2019 benefit year, we propose to remove the two severity-only RXCs (RXC 11: Ammonia Detoxicants, and RXC 12: Diuretics, Loop and Select Potassium-Sparing). Both severity-only RXCs have low average costs per enrollee per year and were constrained to the average cost of the drugs to avoid overcompensating issuers for these RXCs. Constraining these RXCs removed overprescribing or gaming incentives to prescribe a low-cost drug to receive a much larger risk adjustment payment. However, after constraints, the two severity-only RXCs have extremely small coefficients that no longer predict meaningful incremental plan risk associated with a severe health condition. Therefore, we propose eliminating these two RXCs from the model. We believe that the remaining RXCs do not engender significant gaming

concerns due to the cost and side-effects of the drugs if prescribed without cause. As we noted in the 2018 Payment Notice, where the risk of unintended effects on provider prescribing behavior is low, we are continuing to include a small number of prescription drug classes as predictors of risk and plan liability. For the remaining RXCs, there is a high rate of presence of a diagnosis code in the associated HCC in the MarketScan[®] data, indicating a positive predictive value for using these RXCs to impute missing diagnoses. Additionally, as we have previously noted, we intend to monitor prescription drug utilization for unintended effects, and may propose to remove drug classes based on such evidence in future rulemaking. Table 1 contains the proposed list of prescription drug factors for the 2019 benefit year risk adjustment model. We will evaluate the effects of incorporating prescription drugs in the adult models to determine whether to continue, broaden or reduce the impact of this set of factors on the HHS risk adjustment models. Additionally, we note that commenters on the Request for Information support the inclusion of prescription drugs in the risk adjustment methodology.

We seek comment on this proposal.

TABLE 1: Proposed Drug-Diagnosis (RXC-HCC) Pairs for the 2019 Adult Model

RXC	RXC Label	HCC	HCC Label	Proposed RXC Use
RXC 01	Anti-HIV Agents	001	HIV/AIDS	imputation/severity
RXC 02	Anti-Hepatitis C (HCV) Agents	037C, 036, 035, 034	Chronic Hepatitis C, Cirrhosis of Liver, End-Stage Liver Disease, and Liver Transplant Status/Complications	imputation/severity
RXC 03	Antiarrhythmics	142	Specified Heart Arrhythmias	imputation/severity
RXC 04	Phosphate Binders	184, 183, 187, 188	End Stage Renal Disease, Kidney Transplant Status, Chronic Kidney Disease, Stage 5, Chronic Kidney Disease, Severe (Stage 4)	imputation/severity
RXC 05	Inflammatory Bowel Disease Agents	048, 041	Inflammatory Bowel Disease, Intestine Transplant Status/Complications	imputation/severity
RXC 06	Insulin	019, 020, 021, 018	Diabetes with Acute Complications; Diabetes with Chronic Complications; Diabetes without Complication, Pancreas Transplant Status/Complications	imputation/severity
RXC 07	Anti-Diabetic Agents, Except Insulin and Metformin Only	019, 020, 021, 018	Diabetes with Acute Complications, Diabetes with Chronic Complications, Diabetes without Complication, Pancreas Transplant Status/Complications	imputation/severity
RXC 08	Multiple Sclerosis Agents	118	Multiple Sclerosis	imputation/severity
RXC 09	Immune Suppressants and Immunomodulators	056, 057, 048, 041	Rheumatoid Arthritis and Specified Autoimmune Disorders, Systemic Lupus Erythematosus and Other Autoimmune Disorders, Inflammatory Bowel Disease, Intestine Transplant Status/Complications	imputation/severity
RXC 10	Cystic Fibrosis Agents	159, 158	Cystic Fibrosis, Lung Transplant Status/Complications	imputation/severity

iii. High-Cost Risk Pool Adjustment

HHS finalized a high-cost risk pool adjustment in the 2018 Payment Notice to account for the incorporation of risk associated with high-cost enrollees in the risk adjustment model. Specifically, we finalized adjusting the risk adjustment model for high-cost enrollees beginning

for the 2018 benefit year by excluding a percentage of costs above a certain threshold level in the calculation of enrollee-level plan liability risk scores so that risk adjustment factors are calculated without the high-cost risk, because the average risk associated with HCCs and RXCs is better accounted for without the inclusion of the high-cost enrollees. In addition, to account for issuers' risk associated with the high-cost enrollees, issuers will be compensated for a percentage of costs above the threshold. We set the threshold and percentage of costs at a level that would continue to incentivize issuers to control costs while improving the risk prediction of the risk adjustment model. Issuers with high-cost enrollees will receive a payment for the percentage of costs above the threshold in their respective transfers. Using claims data submitted to the EDGE server by issuers of risk adjustment covered plans, HHS will calculate the total amount of paid claims costs for high-cost enrollees based on the threshold and the coinsurance rate. HHS will then calculate a charge as a percentage of the issuers' total premiums in the individual (including catastrophic and non-catastrophic plans and merged market plans), or small group markets, which will be applied to the total transfer amount in that market, maintaining the balance of payments and charges within the risk adjustment program. In the 2018 Payment Notice, we finalized a threshold of \$1 million and a coinsurance rate of 60 percent across all States for the individual (including catastrophic and non-catastrophic plans and merged market plans) and small group markets for the 2018 benefit year.

For the 2019 benefit year, we are proposing to maintain the same parameters that would apply to the 2018 benefit year. Therefore, we propose to maintain a \$1 million threshold and 60 percent coinsurance rate for the high-cost risk pool for the 2019 benefit year risk adjustment program. We believe this threshold and coinsurance rate would result in total payments or charges nationally that are very small as a percentage of premiums for issuers, and will prevent

States and issuers with very high-cost enrollees from bearing a disproportionate amount of unpredictable risk. We seek comment on the proposed parameters of the high-cost risk pool for the 2019 benefit year risk adjustment model.

Comments in response to the Request for Information noted the benefits of incorporating the high-cost risk pool in the risk adjustment methodology. We have also received feedback from stakeholders on the structure of the high-cost risk pool, including that the pool should be multi-tiered, with multiple thresholds and increased coinsurance as the thresholds increase to account for the reduced number of enrollees at higher thresholds where costs to an issuer are catastrophic. We seek comment on alternative methods for reimbursing issuers for exceptionally high-cost enrollees through the high-cost risk pool and improving the calculation of plan liability in the HHS-operated risk adjustment models for future benefit years.

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

The proposed factors resulting from the blended factors from the 2014 and 2015 MarketScan[®] data separately solved models (with the incorporation of the partial year enrollment adjustment and prescription drugs reflected in the adult models only) are shown in the Tables 2, 4, and 5. The adult, child, and infant models have been truncated to account for the high-cost enrollee pool payment parameters (\$1 million threshold, 60 percent coinsurance) finalized in the 2018 Payment Notice. As discussed in the preceding section, we are proposing to keep the 2019 benefit year high-cost enrollee risk pool payment parameters the same as those finalized for the 2018 benefit year.

Table 2 contains factors for each adult model, including the age-sex, HCCs, RXCs and HCC-RXC interaction coefficients. As we have previously noted,¹¹ some interactions of RXCs and HCCs have negative coefficients; however, this does not mean that an enrollee's risk score decreases due to the presence of an RXC, an HCC, or both.

Table 3 contains the HHS HCCs in the severity illness indicator variable. Table 4 contains the factors for each child model. Table 5 contains the factors for each infant model. Tables 6 and 7 contain the HCCs included in the infant model maturity and severity categories, respectively.

TABLE 2: Proposed Adult Risk Adjustment Model Factors for 2019 Benefit Year^A

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
<i>Demographic Factors</i>						
	Age 21-24, Male	0.174	0.138	0.094	0.052	0.050
	Age 25-29, Male	0.151	0.116	0.073	0.030	0.028
	Age 30-34, Male	0.191	0.147	0.093	0.039	0.036
	Age 35-39, Male	0.252	0.198	0.132	0.065	0.062
	Age 40-44, Male	0.321	0.258	0.182	0.104	0.101
	Age 45-49, Male	0.385	0.313	0.227	0.138	0.134
	Age 50-54, Male	0.510	0.428	0.328	0.222	0.217
	Age 55-59, Male	0.577	0.483	0.372	0.253	0.247
	Age 60-64, Male	0.647	0.538	0.411	0.271	0.264
	Age 21-24, Female	0.286	0.232	0.163	0.093	0.090
	Age 25-29, Female	0.323	0.261	0.185	0.104	0.100
	Age 30-34, Female	0.449	0.372	0.281	0.188	0.184
	Age 35-39, Female	0.540	0.454	0.355	0.257	0.253
	Age 40-44, Female	0.598	0.502	0.392	0.281	0.276
	Age 45-49, Female	0.607	0.506	0.390	0.268	0.263
	Age 50-54, Female	0.686	0.581	0.456	0.323	0.317
	Age 55-59, Female	0.674	0.565	0.436	0.294	0.288

¹¹ 2018 Benefit Year Final HHS Risk Adjustment Model Coefficients. April 18, 2017. Available at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/2018-Benefit-Year-Final-HHS-Risk-Adjustment-Model-Coefficients.pdf>.

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
	Age 60-64, Female	0.699	0.579	0.441	0.285	0.277
<i>Diagnosis Factors</i>						
HCC001	HIV/AIDS	0.520	0.434	0.349	0.275	0.271
HCC002	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	8.152	7.980	7.865	7.920	7.924
HCC003	Central Nervous System Infections, Except Viral Meningitis	5.518	5.438	5.379	5.405	5.407
HCC004	Viral or Unspecified Meningitis	4.063	3.867	3.741	3.677	3.676
HCC006	Opportunistic Infections	5.606	5.522	5.468	5.439	5.438
HCC008	Metastatic Cancer	21.369	20.985	20.694	20.753	20.756
HCC009	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	12.190	11.902	11.689	11.686	11.687
HCC010	Non-Hodgkin's Lymphomas and Other Cancers and Tumors	5.316	5.119	4.971	4.910	4.907
HCC011	Colorectal, Breast (Age < 50), Kidney, and Other Cancers	4.295	4.100	3.948	3.888	3.885
HCC012	Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors	2.528	2.386	2.275	2.212	2.209
HCC013	Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors	1.195	1.076	0.976	0.869	0.864
HCC018	Pancreas Transplant Status/Complications	4.522	4.340	4.216	4.238	4.239
HCC019	Diabetes with Acute Complications	0.624	0.555	0.490	0.416	0.412
HCC020	Diabetes with Chronic Complications	0.624	0.555	0.490	0.416	0.412

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
HCC021	Diabetes without Complication	0.624	0.555	0.490	0.416	0.412
HCC023	Protein-Calorie Malnutrition	11.390	11.380	11.365	11.434	11.438
HCC026	Mucopolysaccharidosis	2.122	2.025	1.949	1.887	1.884
HCC027	Lipidoses and Glycogenosis	2.122	2.025	1.949	1.887	1.884
HCC029	Amyloidosis, Porphyrin, and Other Metabolic Disorders	2.122	2.025	1.949	1.887	1.884
HCC030	Adrenal, Pituitary, and Other Significant Endocrine Disorders	2.122	2.025	1.949	1.887	1.884
HCC034	Liver Transplant Status/Complications	10.018	9.924	9.866	9.856	9.856
HCC035	End-Stage Liver Disease	5.862	5.675	5.548	5.558	5.559
HCC036	Cirrhosis of Liver	2.158	2.040	1.962	1.918	1.916
HCC037_1	Chronic Viral Hepatitis C	0.430	0.327	0.283	0.259	0.258
HCC037_2	Chronic Hepatitis, Other/Unspecified	0.430	0.327	0.283	0.259	0.258
HCC038	Acute Liver Failure/Disease, Including Neonatal Hepatitis	4.242	4.105	4.008	3.986	3.985
HCC041	Intestine Transplant Status/Complications	29.207	29.126	29.062	29.112	29.112
HCC042	Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis	9.688	9.465	9.302	9.321	9.323
HCC045	Intestinal Obstruction	5.465	5.238	5.087	5.089	5.090
HCC046	Chronic Pancreatitis	4.522	4.340	4.216	4.238	4.239
HCC047	Acute Pancreatitis/Other Pancreatic Disorders and Intestinal Malabsorption	2.204	2.054	1.947	1.882	1.880
HCC048	Inflammatory Bowel Disease	2.094	1.926	1.795	1.702	1.698
HCC054	Necrotizing Fasciitis	5.492	5.329	5.207	5.219	5.220

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
HCC055	Bone/Joint/Muscle Infections/Necrosis	5.492	5.329	5.207	5.219	5.220
HCC056	Rheumatoid Arthritis and Specified Autoimmune Disorders	3.393	3.217	3.077	3.031	3.029
HCC057	Systemic Lupus Erythematosus and Other Autoimmune Disorders	1.032	0.923	0.831	0.726	0.720
HCC061	Osteogenesis Imperfecta and Other Osteodystrophies	2.586	2.421	2.290	2.217	2.213
HCC062	Congenital/Developmental Skeletal and Connective Tissue Disorders	2.586	2.421	2.290	2.217	2.213
HCC063	Cleft Lip/Cleft Palate	1.108	0.963	0.856	0.777	0.773
HCC066	Hemophilia	43.857	43.613	43.412	43.412	43.412
HCC067	Myelodysplastic Syndromes and Myelofibrosis	11.329	11.211	11.123	11.130	11.132
HCC068	Aplastic Anemia	11.329	11.211	11.123	11.130	11.132
HCC069	Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn	7.452	7.322	7.217	7.188	7.187
HCC070	Sickle Cell Anemia (Hb-SS)	7.452	7.322	7.217	7.188	7.187
HCC071	Thalassemia Major	7.452	7.322	7.217	7.188	7.187
HCC073	Combined and Other Severe Immunodeficiencies	5.031	4.913	4.827	4.827	4.827
HCC074	Disorders of the Immune Mechanism	5.031	4.913	4.827	4.827	4.827
HCC075	Coagulation Defects and Other Specified Hematological Disorders	2.419	2.339	2.274	2.237	2.235
HCC081	Drug Psychosis	3.864	3.647	3.486	3.379	3.373
HCC082	Drug Dependence	3.864	3.647	3.486	3.379	3.373
HCC087	Schizophrenia	3.093	2.866	2.702	2.629	2.626
HCC088	Major Depressive and Bipolar Disorders	1.545	1.407	1.297	1.191	1.186

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
HCC089	Reactive and Unspecified Psychosis, Delusional Disorders	1.545	1.407	1.297	1.191	1.186
HCC090	Personality Disorders	1.055	0.948	0.846	0.736	0.731
HCC094	Anorexia/Bulimia Nervosa	2.381	2.241	2.130	2.064	2.061
HCC096	Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes	2.057	1.952	1.870	1.810	1.807
HCC097	Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes	0.845	0.758	0.679	0.599	0.595
HCC102	Autistic Disorder	1.055	0.948	0.846	0.736	0.731
HCC103	Pervasive Developmental Disorders, Except Autistic Disorder	1.055	0.948	0.846	0.736	0.731
HCC106	Traumatic Complete Lesion Cervical Spinal Cord	9.063	8.932	8.834	8.822	8.821
HCC107	Quadriplegia	9.063	8.932	8.834	8.822	8.821
HCC108	Traumatic Complete Lesion Dorsal Spinal Cord	7.368	7.239	7.144	7.121	7.120
HCC109	Paraplegia	7.368	7.239	7.144	7.121	7.120
HCC110	Spinal Cord Disorders/Injuries	5.019	4.833	4.698	4.663	4.662
HCC111	Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease	2.107	1.911	1.772	1.707	1.705
HCC112	Quadriplegic Cerebral Palsy	0.433	0.289	0.181	0.108	0.107
HCC113	Cerebral Palsy, Except Quadriplegic	0.364	0.264	0.181	0.108	0.107

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
HCC114	Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies	0.016	0.000	0.000	0.000	0.000
HCC115	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	5.116	4.991	4.900	4.882	4.881
HCC117	Muscular Dystrophy	2.109	1.970	1.873	1.783	1.778
HCC118	Multiple Sclerosis	8.046	7.788	7.595	7.579	7.578
HCC119	Parkinson's, Huntington's, and Spinocerebellar Disease, and Other Neurodegenerative Disorders	2.109	1.970	1.873	1.783	1.778
HCC120	Seizure Disorders and Convulsions	1.423	1.288	1.183	1.100	1.096
HCC121	Hydrocephalus	4.823	4.717	4.628	4.597	4.596
HCC122	Non-Traumatic Coma, and Brain Compression/Anoxic Damage	8.085	7.965	7.866	7.861	7.860
HCC125	Respirator Dependence/Tracheostomy Status	27.074	27.045	27.016	27.096	27.100
HCC126	Respiratory Arrest	8.400	8.265	8.168	8.241	8.245
HCC127	Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes	8.400	8.265	8.168	8.241	8.245
HCC128	Heart Assistive Device/Artificial Heart	27.593	27.404	27.268	27.331	27.336
HCC129	Heart Transplant	27.593	27.404	27.268	27.331	27.336
HCC130	Congestive Heart Failure	2.847	2.758	2.693	2.686	2.686
HCC131	Acute Myocardial Infarction	8.501	8.214	8.005	8.114	8.120

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
HCC132	Unstable Angina and Other Acute Ischemic Heart Disease	4.515	4.281	4.129	4.132	4.133
HCC135	Heart Infection/Inflammation, Except Rheumatic	5.135	5.022	4.938	4.908	4.907
HCC142	Specified Heart Arrhythmias	2.365	2.241	2.148	2.080	2.077
HCC145	Intracranial Hemorrhage	7.686	7.448	7.279	7.270	7.270
HCC146	Ischemic or Unspecified Stroke	2.324	2.176	2.085	2.079	2.079
HCC149	Cerebral Aneurysm and Arteriovenous Malformation	3.171	3.011	2.895	2.840	2.837
HCC150	Hemiplegia/ Hemiparesis	4.396	4.314	4.257	4.306	4.309
HCC151	Monoplegia, Other Paralytic Syndromes	2.634	2.522	2.444	2.414	2.413
HCC153	Atherosclerosis of the Extremities with Ulceration or Gangrene	9.113	9.051	9.004	9.096	9.101
HCC154	Vascular Disease with Complications	6.411	6.255	6.143	6.133	6.133
HCC156	Pulmonary Embolism and Deep Vein Thrombosis	3.132	2.995	2.895	2.850	2.848
HCC158	Lung Transplant Status/Complications	25.523	25.380	25.270	25.354	25.358
HCC159	Cystic Fibrosis	11.222	10.969	10.767	10.781	10.782
HCC160	Chronic Obstructive Pulmonary Disease, Including Bronchiectasis	0.859	0.766	0.683	0.595	0.591
HCC161	Asthma	0.859	0.766	0.683	0.595	0.591
HCC162	Fibrosis of Lung and Other Lung Disorders	1.724	1.629	1.562	1.510	1.507
HCC163	Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	5.920	5.866	5.827	5.835	5.836
HCC183	Kidney Transplant Status	7.636	7.438	7.304	7.276	7.276

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
HCC184	End Stage Renal Disease	31.427	31.237	31.086	31.232	31.238
HCC187	Chronic Kidney Disease, Stage 5	1.369	1.313	1.276	1.285	1.286
HCC188	Chronic Kidney Disease, Stage 4	1.369	1.313	1.276	1.285	1.286
HCC203	Ectopic and Molar Pregnancy, Except with Renal Failure, Shock, or Embolism	1.219	1.074	0.947	0.745	0.733
HCC204	Miscarriage with Complications	1.219	1.074	0.947	0.745	0.733
HCC205	Miscarriage with No or Minor Complications	1.219	1.074	0.947	0.745	0.733
HCC207	Completed Pregnancy With Major Complications	3.243	2.827	2.608	2.399	2.398
HCC208	Completed Pregnancy With Complications	3.243	2.827	2.608	2.399	2.398
HCC209	Completed Pregnancy with No or Minor Complications	3.243	2.827	2.608	2.399	2.398
HCC217	Chronic Ulcer of Skin, Except Pressure	1.958	1.865	1.801	1.788	1.788
HCC226	Hip Fractures and Pathological Vertebral or Humerus Fractures	8.626	8.433	8.291	8.324	8.326
HCC227	Pathological Fractures, Except of Vertebrae, Hip, or Humerus	2.240	2.124	2.033	1.957	1.954
HCC251	Stem Cell, Including Bone Marrow, Transplant Status/Complications	23.527	23.526	23.520	23.544	23.544
HCC253	Artificial Openings for Feeding or Elimination	8.149	8.067	8.005	8.041	8.043
HCC254	Amputation Status, Lower Limb/Amputation Complications	3.928	3.819	3.740	3.770	3.772
	<i>Interaction Factors</i>					

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
SEVERE x HCC006	Severe illness x Opportunistic Infections	8.221	8.406	8.532	8.658	8.663
SEVERE x HCC008	Severe illness x Metastatic Cancer	8.221	8.406	8.532	8.658	8.663
SEVERE x HCC009	Severe illness x Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	8.221	8.406	8.532	8.658	8.663
SEVERE x HCC010	Severe illness x Non-Hodgkin's Lymphomas and Other Cancers and Tumors	8.221	8.406	8.532	8.658	8.663
SEVERE x HCC115	Severe illness x Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	8.221	8.406	8.532	8.658	8.663
SEVERE x HCC135	Severe illness x Heart Infection/Inflammation, Except Rheumatic	8.221	8.406	8.532	8.658	8.663
SEVERE x HCC145	Severe illness x Intracranial Hemorrhage	8.221	8.406	8.532	8.658	8.663
SEVERE x G06	Severe illness x HCC group G06 (G06 is HCC Group 6 which includes the following HCCs in the blood disease category: 67, 68)	8.221	8.406	8.532	8.658	8.663

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
SEVERE x G08	Severe illness x HCC group G08 (G08 is HCC Group 8 which includes the following HCCs in the blood disease category: 73, 74)	8.221	8.406	8.532	8.658	8.663
SEVERE x HCC035	Severe illness x End-Stage Liver Disease	1.816	1.916	1.979	2.088	2.092
SEVERE x HCC038	Severe illness x Acute Liver Failure/Disease, Including Neonatal Hepatitis	1.816	1.916	1.979	2.088	2.092
SEVERE x HCC153	Severe illness x Atherosclerosis of the Extremities with Ulceration or Gangrene	1.816	1.916	1.979	2.088	2.092
SEVERE x HCC154	Severe illness x Vascular Disease with Complications	1.816	1.916	1.979	2.088	2.092
SEVERE x HCC163	Severe illness x Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	1.816	1.916	1.979	2.088	2.092
SEVERE x HCC253	Severe illness x Artificial Openings for Feeding or Elimination	1.816	1.916	1.979	2.088	2.092
SEVERE x G03	Severe illness x HCC group G03 (G03 is HCC Group 3 which includes the following HCCs in the musculoskeletal disease category: 54, 55)	1.816	1.916	1.979	2.088	2.092
<i>Enrollment Duration Factors</i>						
	One month of enrollment	0.491	0.431	0.385	0.363	0.363
	Two months of enrollment	0.439	0.384	0.337	0.317	0.316
	Three months of enrollment	0.356	0.308	0.264	0.245	0.244

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
	Four months of enrollment	0.302	0.261	0.222	0.204	0.204
	Five months of enrollment	0.263	0.229	0.195	0.179	0.178
	Six months of enrollment	0.220	0.193	0.164	0.148	0.147
	Seven months of enrollment	0.217	0.191	0.164	0.148	0.147
	Eight months of enrollment	0.160	0.141	0.121	0.109	0.109
	Nine months of enrollment	0.121	0.107	0.095	0.088	0.088
	Ten months of enrollment	0.106	0.098	0.090	0.086	0.086
	Eleven months of enrollment	0.097	0.091	0.085	0.083	0.083
<i>Prescription Drug Factors</i>						
RXC 01	Anti-HIV Agents	7.903	7.394	7.016	6.869	6.863
RXC 02	Anti-Hepatitis C (HCV) Agents	42.192	41.724	41.357	41.522	41.530
RXC 03	Antiarrhythmics	0.115	0.115	0.115	0.115	0.115
RXC 04	Phosphate Binders	0.640	0.640	0.640	0.640	0.640
RXC 05	Inflammatory Bowel Disease Agents	1.926	1.751	1.620	1.446	1.437
RXC 06	Insulin	1.520	1.384	1.235	1.059	1.049
RXC 07	Anti-Diabetic Agents, Except Insulin and Metformin Only	0.499	0.437	0.369	0.282	0.277
RXC 08	Multiple Sclerosis Agents	20.967	20.276	19.754	19.796	19.801
RXC 09	Immune Suppressants and Immunomodulators	12.856	12.303	11.895	11.956	11.959
RXC 10	Cystic Fibrosis Agents	10.619	10.340	10.149	10.250	10.255
RXC 01 x HCC001	Additional effect for enrollees with RXC 01 (Anti-HIV Agents) and HCC 001 (HIV/AIDS)	2.849	2.926	2.995	3.292	3.306

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
RXC 02 x HCC037 _1, 036, 035, 034	Additional effect for enrollees with RXC 02 (Anti-Hepatitis C (HCV) Agents) and (HCC 037_1 (Chronic Viral Hepatitis C) or 036 (Cirrhosis of Liver) or 035 (End-Stage Liver Disease) or 034 (Liver Transplant Status/Complications))	3.993	4.162	4.267	4.300	4.301
RXC 03 x HCC142	Additional effect for enrollees with RxC 03 (Antiarrhythmics) and HCC 142 (Specified Heart Arrhythmias)	0.000	0.000	0.000	0.000	0.000
RXC 04 x HCC184, 183, 187, 188	Additional effect for enrollees with RxC 04 (Phosphate Binders) and (HCC 184 (End Stage Renal Disease) or 183 (Kidney Transplant Status) or 187 (Chronic Kidney Disease, Stage 5) or 188 (Chronic Kidney Disease, Severe Stage 4))	0.000	0.000	0.000	0.000	0.000
RXC 05 x HCC048, 041	Additional effect for enrollees with RxC 05 (Inflammatory Bowel Disease Agents) and (HCC 048 (Inflammatory Bowel Disease) or 041 (Intestine Transplant Status/Complications))	-1.002	-0.915	-0.829	-0.721	-0.715

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
RXC 06 x HCC018, 019, 020, 021	Additional effect for enrollees with RxC 06 (Insulin) and (HCC 018 (Pancreas Transplant Status/Complications) or 019 (Diabetes with Acute Complications) or 020 (Diabetes with Chronic Complications) or 021 (Diabetes without Complication))	0.444	0.410	0.463	0.550	0.555
RXC 07 x HCC018, 019, 020, 021	Additional effect for enrollees with RxC 07 (Anti-Diabetic Agents, Except Insulin and Metformin Only) and (HCC 018 (Pancreas Transplant Status/Complications) or 019 (Diabetes with Acute Complications) or 020 (Diabetes with Chronic Complications) or 021 (Diabetes without Complication))	-0.174	-0.161	-0.129	-0.129	-0.130
RXC 08 x HCC118	Additional effect for enrollees with RxC 08 (Multiple Sclerosis Agents) and HCC 118 (Multiple Sclerosis)	-4.718	-4.268	-3.935	-3.822	-3.819

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
RXC 09 x HCC056 or 057 and 048 or 041	Additional effect for enrollees with Rx C 09 (Immune Suppressants and Immunomodulators) and (HCC 048 (Inflammatory Bowel Disease) or 041 (Intestine Transplant Status/Complications)) and (HCC 056 (Rheumatoid Arthritis and Specified Autoimmune Disorders) or 057 (Systemic Lupus Erythematosus and Other Autoimmune Disorders))	-0.505	-0.528	-0.536	-0.574	-0.576
RXC 09 x HCC056	Additional effect for enrollees with Rx C 09 (Immune Suppressants and Immunomodulators) and HCC 056 (Rheumatoid Arthritis and Specified Autoimmune Disorders)	-2.712	-2.470	-2.285	-2.173	-2.168
RXC 09 x HCC057	Additional effect for enrollees with Rx C 09 (Immune Suppressants and Immunomodulators) and HCC 057 (Systemic Lupus Erythematosus and Other Autoimmune Disorders)	-0.434	-0.272	-0.144	0.012	0.020

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
RXC 09 x HCC048, 041	Additional effect for enrollees with Rx C 09 (Immune Suppressants and Immunomodulators) and (HCC 048 (Inflammatory Bowel Disease) or 041 (Intestine Transplant Status/Complications))	1.311	1.573	1.744	1.909	1.917
RXC 10 x HCC159, 158	Additional effect for enrollees with Rx C 10 (Cystic Fibrosis Agents) and (HCC 159 (Cystic Fibrosis) or 158 (Lung Transplant Status/Complications))	29.675	29.853	29.949	29.967	29.967

^A The proposed risk adjustment model factors for the 2019 benefit year include blended coefficients based on separately solved 2014 and 2015 MarketScan® data. We are proposing to finalize the 2019 benefit year risk adjustment model factors based on blended factors from separately solved models using the 2014 and 2015 MarketScan® data, and the 2016 benefit year enrollee-level EDGE data.

TABLE 3: 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 4: Proposed Child Risk Adjustment Model Factors for 2019 Benefit Year

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
<i>Demographic Factors</i>					
Age 2-4, Male	0.194	0.139	0.077	0.023	0.020
Age 5-9, Male	0.130	0.091	0.043	0.004	0.002
Age 10-14, Male	0.199	0.156	0.099	0.056	0.054
Age 15-20, Male	0.268	0.218	0.156	0.102	0.100
Age 2-4, Female	0.147	0.100	0.047	0.007	0.005
Age 5-9, Female	0.104	0.069	0.029	0.002	0.001

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Age 10-14, Female	0.189	0.147	0.095	0.057	0.055
Age 15-20, Female	0.298	0.239	0.167	0.100	0.097
<i>Diagnosis Factors</i>					
HIV/AIDS	5.744	5.340	5.034	4.949	4.944
Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	13.174	13.022	12.922	12.938	12.940
Central Nervous System Infections, Except Viral Meningitis	7.345	7.194	7.085	7.094	7.095
Viral or Unspecified Meningitis	3.062	2.879	2.757	2.629	2.625
Opportunistic Infections	16.688	16.642	16.604	16.594	16.593
Metastatic Cancer	30.079	29.879	29.711	29.715	29.715
Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	9.654	9.442	9.264	9.190	9.186
Non-Hodgkin's Lymphomas and Other Cancers and Tumors	8.104	7.883	7.707	7.615	7.611
Colorectal, Breast (Age < 50), Kidney, and Other Cancers	2.866	2.706	2.572	2.460	2.454
Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors	2.866	2.706	2.572	2.460	2.454
Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors	1.218	1.090	0.977	0.858	0.852
Pancreas Transplant Status/Complications	21.519	21.274	21.082	21.114	21.116
Diabetes with Acute Complications	2.422	2.129	1.939	1.683	1.672
Diabetes with Chronic Complications	2.422	2.129	1.939	1.683	1.672
Diabetes without Complication	2.422	2.129	1.939	1.683	1.672
Protein-Calorie Malnutrition	11.421	11.335	11.264	11.302	11.304

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Mucopolysaccharidosis	8.584	8.361	8.176	8.141	8.139
Lipidoses and Glycogenosis	8.584	8.361	8.176	8.141	8.139
Congenital Metabolic Disorders, Not Elsewhere Classified	8.584	8.361	8.176	8.141	8.139
Amyloidosis, Porphyria, and Other Metabolic Disorders	8.584	8.361	8.176	8.141	8.139
Adrenal, Pituitary, and Other Significant Endocrine Disorders	8.584	8.361	8.176	8.141	8.139
Liver Transplant Status/Complications	21.519	21.274	21.082	21.114	21.116
End-Stage Liver Disease	11.016	10.865	10.767	10.761	10.761
Cirrhosis of Liver	6.158	6.041	5.950	5.916	5.914
Chronic Viral Hepatitis C	6.888	6.742	6.621	6.604	6.604
Chronic Hepatitis, Other/Unspecified	1.679	1.571	1.470	1.385	1.381
Acute Liver Failure/Disease, Including Neonatal Hepatitis	10.719	10.579	10.476	10.479	10.480
Intestine Transplant Status/Complications	21.519	21.274	21.082	21.114	21.116
Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis	10.481	10.202	9.989	9.995	9.996
Intestinal Obstruction	3.953	3.763	3.613	3.521	3.518
Chronic Pancreatitis	10.876	10.686	10.549	10.567	10.569
Acute Pancreatitis/Other Pancreatic Disorders and Intestinal Malabsorption	2.107	1.992	1.891	1.793	1.788
Inflammatory Bowel Disease	6.687	6.344	6.085	5.986	5.981
Necrotizing Fasciitis	3.868	3.678	3.524	3.459	3.456
Bone/Joint/Muscle Infections/Necrosis	3.868	3.678	3.524	3.459	3.456
Rheumatoid Arthritis and Specified Autoimmune Disorders	4.271	4.056	3.872	3.782	3.778
Systemic Lupus Erythematosus and Other Autoimmune Disorders	1.227	1.111	0.999	0.872	0.867

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Osteogenesis Imperfecta and Other Osteodystrophies	1.364	1.258	1.162	1.079	1.075
Congenital/Developmental Skeletal and Connective Tissue Disorders	1.364	1.258	1.162	1.079	1.075
Cleft Lip/Cleft Palate	1.407	1.241	1.107	0.982	0.977
Hemophilia	55.787	55.354	55.012	54.989	54.988
Myelodysplastic Syndromes and Myelofibrosis	12.015	11.906	11.825	11.801	11.800
Aplastic Anemia	12.015	11.906	11.825	11.801	11.800
Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn	6.603	6.387	6.217	6.130	6.126
Sickle Cell Anemia (Hb-SS)	6.603	6.387	6.217	6.130	6.126
Thalassemia Major	6.603	6.387	6.217	6.130	6.126
Combined and Other Severe Immunodeficiencies	6.007	5.869	5.759	5.696	5.693
Disorders of the Immune Mechanism	6.007	5.869	5.759	5.696	5.693
Coagulation Defects and Other Specified Hematological Disorders	4.186	4.074	3.976	3.905	3.902
Drug Psychosis	5.541	5.318	5.157	5.092	5.090
Drug Dependence	5.541	5.318	5.157	5.092	5.090
Schizophrenia	4.669	4.332	4.086	3.973	3.968
Major Depressive and Bipolar Disorders	1.809	1.621	1.462	1.283	1.275
Reactive and Unspecified Psychosis, Delusional Disorders	1.681	1.507	1.356	1.179	1.171
Personality Disorders	0.678	0.582	0.476	0.338	0.332
Anorexia/Bulimia Nervosa	2.792	2.619	2.478	2.413	2.409
Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes	2.339	2.176	2.067	2.032	2.031
Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes	1.838	1.693	1.582	1.491	1.487

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Autistic Disorder	1.513	1.364	1.228	1.070	1.063
Pervasive Developmental Disorders, Except Autistic Disorder	0.737	0.640	0.528	0.382	0.375
Traumatic Complete Lesion Cervical Spinal Cord	12.154	12.087	12.058	12.138	12.142
Quadriplegia	12.154	12.087	12.058	12.138	12.142
Traumatic Complete Lesion Dorsal Spinal Cord	10.641	10.489	10.347	10.348	10.348
Paraplegia	10.641	10.489	10.347	10.348	10.348
Spinal Cord Disorders/Injuries	3.473	3.289	3.147	3.055	3.051
Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease	7.137	6.947	6.796	6.711	6.706
Quadriplegic Cerebral Palsy	3.125	2.921	2.787	2.797	2.797
Cerebral Palsy, Except Quadriplegic	0.730	0.588	0.484	0.395	0.391
Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies	1.219	1.108	1.019	0.949	0.946
Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	8.961	8.809	8.687	8.653	8.652
Muscular Dystrophy	2.675	2.515	2.397	2.310	2.307
Multiple Sclerosis	9.417	9.117	8.880	8.847	8.846
Parkinson`s, Huntington`s, and Spinocerebellar Disease, and Other Neurodegenerative Disorders	2.675	2.515	2.397	2.310	2.307
Seizure Disorders and Convulsions	1.887	1.743	1.611	1.470	1.463
Hydrocephalus	3.800	3.697	3.620	3.605	3.605

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Non-Traumatic Coma, and Brain Compression/Anoxic Damage	5.359	5.248	5.156	5.116	5.114
Respirator Dependence/Tracheostomy Status	31.233	31.127	31.052	31.184	31.190
Respiratory Arrest	9.997	9.799	9.667	9.653	9.653
Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes	9.997	9.799	9.667	9.653	9.653
Heart Assistive Device/Artificial Heart	21.519	21.274	21.082	21.114	21.116
Heart Transplant	21.519	21.274	21.082	21.114	21.116
Congestive Heart Failure	5.652	5.562	5.482	5.438	5.435
Acute Myocardial Infarction	4.541	4.481	4.446	4.422	4.421
Unstable Angina and Other Acute Ischemic Heart Disease	4.541	4.481	4.446	4.422	4.421
Heart Infection/Inflammation, Except Rheumatic	11.390	11.285	11.206	11.181	11.179
Hypoplastic Left Heart Syndrome and Other Severe Congenital Heart Disorders	5.172	5.012	4.857	4.735	4.729
Major Congenital Heart/Circulatory Disorders	1.451	1.360	1.244	1.128	1.122
Atrial and Ventricular Septal Defects, Patent Ductus Arteriosus, and Other Congenital Heart/Circulatory Disorders	0.894	0.810	0.707	0.612	0.609
Specified Heart Arrhythmias	3.536	3.385	3.253	3.178	3.175
Intracranial Hemorrhage	12.297	12.087	11.936	11.925	11.925
Ischemic or Unspecified Stroke	6.626	6.537	6.482	6.494	6.494

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Cerebral Aneurysm and Arteriovenous Malformation	3.425	3.247	3.122	3.047	3.043
Hemiplegia/Hemiparesis	3.713	3.626	3.568	3.555	3.555
Monoplegia, Other Paralytic Syndromes	2.871	2.748	2.664	2.635	2.635
Atherosclerosis of the Extremities with Ulceration or Gangrene	10.177	9.954	9.794	9.715	9.712
Vascular Disease with Complications	15.267	15.144	15.047	15.063	15.063
Pulmonary Embolism and Deep Vein Thrombosis	12.509	12.400	12.319	12.358	12.360
Lung Transplant Status/Complications	21.519	21.274	21.082	21.114	21.116
Cystic Fibrosis	21.519	21.274	21.082	21.114	21.116
Chronic Obstructive Pulmonary Disease, Including Bronchiectasis	0.364	0.303	0.220	0.128	0.123
Asthma	0.364	0.303	0.220	0.128	0.123
Fibrosis of Lung and Other Lung Disorders	3.740	3.635	3.537	3.471	3.469
Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	8.744	8.694	8.652	8.688	8.690
Kidney Transplant Status	13.420	13.163	12.976	12.979	12.978
End Stage Renal Disease	33.178	33.107	33.050	33.146	33.150
Chronic Kidney Disease, Stage 5	1.895	1.768	1.660	1.557	1.555
Chronic Kidney Disease, Severe (Stage 4)	1.895	1.768	1.660	1.557	1.555
Ectopic and Molar Pregnancy, Except with Renal Failure, Shock, or Embolism	1.049	0.899	0.765	0.553	0.542
Miscarriage with Complications	1.049	0.899	0.765	0.553	0.542
Miscarriage with No or Minor Complications	1.049	0.899	0.765	0.553	0.542
Completed Pregnancy With Major Complications	2.784	2.404	2.197	1.961	1.958
Completed Pregnancy With Complications	2.784	2.404	2.197	1.961	1.958

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Completed Pregnancy with No or Minor Complications	2.784	2.404	2.197	1.961	1.958
Chronic Ulcer of Skin, Except Pressure	2.025	1.939	1.854	1.785	1.781
Hip Fractures and Pathological Vertebral or Humerus Fractures	5.331	5.100	4.905	4.806	4.802
Pathological Fractures, Except of Vertebrae, Hip, or Humerus	1.417	1.296	1.168	1.028	1.019
Stem Cell, Including Bone Marrow, Transplant Status/Complications	21.519	21.274	21.082	21.114	21.116
Artificial Openings for Feeding or Elimination	11.532	11.432	11.368	11.481	11.487
Amputation Status, Lower Limb/Amputation Complications	7.235	7.007	6.844	6.738	6.734

TABLE 5: Proposed Infant Risk Adjustment Model Factors for 2019 Benefit Year

Group	Platinum	Gold	Silver	Bronze	Catastrophic
Extremely Immature * Severity Level 5 (Highest)	268.917	267.690	266.660	266.665	266.666
Extremely Immature * Severity Level 4	164.057	162.851	161.848	161.805	161.804
Extremely Immature * Severity Level 3	34.929	34.068	33.319	33.095	33.090
Extremely Immature * Severity Level 2	34.929	34.068	33.319	33.095	33.090
Extremely Immature * Severity Level 1 (Lowest)	34.929	34.068	33.319	33.095	33.090
Immature *Severity Level 5 (Highest)	163.691	162.498	161.499	161.501	161.503
Immature *Severity Level 4	72.779	71.594	70.608	70.581	70.582
Immature *Severity Level 3	33.416	32.404	31.556	31.393	31.387
Immature *Severity Level 2	24.515	23.529	22.711	22.500	22.490

Group	Platinum	Gold	Silver	Bronze	Catastrophic
Immature *Severity Level 1 (Lowest)	24.515	23.529	22.711	22.500	22.490
Premature/Multiples *Severity Level 5 (Highest)	118.666	117.511	116.565	116.511	116.512
Premature/Multiples *Severity Level 4	26.998	25.884	24.983	24.819	24.815
Premature/Multiples *Severity Level 3	13.865	13.000	12.294	11.914	11.898
Premature/Multiples *Severity Level 2	7.702	7.015	6.435	5.861	5.832
Premature/Multiples *Severity Level 1 (Lowest)	5.180	4.663	4.139	3.538	3.508
Term *Severity Level 5 (Highest)	94.243	93.167	92.263	92.087	92.080
Term *Severity Level 4	14.247	13.396	12.715	12.261	12.242
Term *Severity Level 3	5.672	5.124	4.602	3.974	3.940
Term *Severity Level 2	3.403	2.987	2.524	1.843	1.808
Term *Severity Level 1 (Lowest)	1.530	1.305	0.896	0.365	0.345
Age1 *Severity Level 5 (Highest)	49.506	48.891	48.377	48.287	48.283
Age1 *Severity Level 4	8.229	7.779	7.399	7.151	7.141
Age1 *Severity Level 3	2.945	2.674	2.388	2.123	2.112
Age1 *Severity Level 2	1.913	1.697	1.446	1.161	1.147
Age1 *Severity Level 1 (Lowest)	0.513	0.420	0.276	0.179	0.175
Age 0 Male	0.575	0.533	0.515	0.461	0.456
Age 1 Male	0.115	0.100	0.088	0.060	0.059

TABLE 6: 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 7: HHS HCCs Included in Infant Model Severity Categories

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 Category	HCC
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 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 Category	HCC
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 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 Category	HCC
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 healthcare services by enrollees receiving cost-sharing reductions (**induced demand**) in all States where HHS operates risk adjustment. The proposed cost-sharing reductions adjustment factors for the 2019 benefit year risk adjustment are unchanged from those finalized in the 2018 Payment Notice, and are set forth in Table 8. These adjustments would be effective for 2016, 2017, 2018, and 2019 risk adjustment, and would be multiplied against the sum of the demographic, diagnosis, and interaction factors, and enrollment and prescription drug utilization factors (for the adult model). We anticipate adjusting these factors in the annual HHS notice of benefit and payment parameters for the 2020 benefit year as enrollee-level data from the individual market will be available in time for proposal in that rulemaking.

We seek comment on this approach.

TABLE 8: Cost-Sharing Reductions 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 statistic 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 ratios are in the range of published estimates

for concurrent risk adjustment models.¹² Because we are proposing to blend the coefficients from separately solved models based on MarketScan® 2014 and 2015 data in the proposed rule, we are publishing the R-squared statistic for each model and benefit year separately to verify their statistical validity. The R-squared statistic for each model is shown in Table 9.

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

Risk Adjustment Model	R-Squared Statistic	
	2014	2015
Platinum Adult	0.4221	0.4212
Platinum Child	0.293	0.3314
Platinum Infant	0.3284	0.3329
Gold Adult	0.4179	0.4164
Gold Child	0.2883	0.3269
Gold Infant	0.3264	0.3309
Silver Adult	0.4143	0.4123
Silver Child	0.2841	0.3227
Silver Infant	0.325	0.3295
Bronze Adult	0.4117	0.4095
Bronze Child	0.2805	0.3188
Bronze Infant	0.3247	0.3292
Catastrophic Adult	0.4115	0.4094
Catastrophic Child	0.2803	0.3186
Catastrophic Infant	0.3247	0.3292

- f. Overview of the payment transfer formula (§153.320)
- i. Accounting for high-cost risk pool in the transfer formula

We previously 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 concepts into a risk adjustment payment transfer formula. Risk adjustment transfers (total payments and charges including outlier pooling) will be calculated after issuers

¹² Winkelman, Ross and Syed Mehmud. “A Comparative Analysis of Claims-Based Tools for Health Risk Assessment.” Society of Actuaries. April 2007.

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. The total payment or charge is thus calculated to balance the State market risk pool in question. In addition to the total charge collected and payment made for the State market risk pool, in the 2018 Payment Notice, we added to the risk adjustment methodology additional transfers that would reflect the payments and charges assessed with respect to the costs of high-risk enrollees. To account for costs associated with high-risk enrollees, we added transfer terms (a payment term and a charge term) that would be calculated separately from the State transfer formula. Thus, the non-high cost pooling portion of plan risk would continue to be calculated as the member month weighted average of individual enrollee risk scores. Beginning for the 2018 benefit year, we added one term that reflects 60 percent of costs above \$1 million, the threshold for our payments for these high-risk enrollees, and another term that reflects a percentage of PMPM premium adjustment to the transfer formula for the high-cost enrollee pool to maintain the balance of payment and charges within the risk adjustment program. For the 2019 benefit year we propose to maintain this adjustment to the risk adjustment transfers with the threshold of \$1 million and a coinsurance rate of 60 percent, as finalized for the 2018 benefit year.

- ii. Administrative cost reduction to Statewide average premium

Additionally, we propose to continue the policy finalized in the 2018 Payment Notice to reduce the Statewide average premium in the risk adjustment transfer formula by 14 percent to account for the proportion of administrative costs that do not vary with claims for the 2019 benefit year and future benefit years until changed in rulemaking. As a note, we define unadjusted Statewide average premiums as the sum of average premium per member month of plan (P_i) multiplied by plan i 's share of Statewide enrollment in the market in the risk pool (s_i). For the 2019 benefit year, the Statewide average premium, which will be used for the transfer formula finalized beginning for the 2018 benefit year, will be calculated based on the formula below:

$$\bar{P}_S = \left(\sum_i (s_i \cdot P_i) \right) * 0.86$$

Where:

s_i = plan i 's share of Statewide enrollment in the market in the risk pool;

P_i = average premium per member month of plan i .

iii. State Flexibility

The HHS risk adjustment payment transfer formula generally transfers amounts from issuers with lower than average actuarial risk to those with higher than average actuarial risk. Such risk adjustment transfers are widely used in health insurance markets and recognized as critical in mitigating the effects of adverse selection, ensuring financial viability of plans that enroll a higher proportion of high-risk enrollees, and thus, fostering competitive health insurance markets. The HHS risk adjustment program transfers are scaled with the Statewide average premium in the applicable State market. In the 2018 Payment Notice, we noted that compared to other scaling factors, such as, plans' own premiums, our analyses found Statewide average premium proves to be a more accurate means of scaling the transfers for differences in relative

actuarial risk, particularly in the context of a budget-neutral system. We also finalized in the 2018 Payment Notice an administrative cost adjustment to the statewide average premium to remove a portion of administrative costs that did not vary based on claims differences from the Statewide average premium and base the transfers on the portion of the premiums that vary with claims.¹³ Nevertheless, we acknowledge that, for some States that deviate significantly from the national dataset used, a further adjustment to the Statewide average premium may more precisely account for differences between the plan premium estimate reflecting adverse selection and the plan premium estimate not reflecting selection in the respective State market risk pools.

In the 2016 Interim Final Rule,¹⁴ HHS recognized some State regulators' desire to reduce the magnitude of risk adjustment charge amounts for some issuers. We acknowledged that States are the primary regulators of their insurance markets, and as such, we encouraged States to examine whether any local approaches under State legal authority are warranted to help ease the transition to new health insurance markets.

In the small group market, employers select the plans offered to their employees and often pay a significant portion of employees' premiums to encourage enrollment. Depending on the participation rules and market dynamics within a particular State, risk selection can be significantly less in a State's small group market compared to its individual market. The HHS methodology calculates relative risk scores between issuers in a State market, and in the case of the small group market, the differences between risk scores for issuers within State markets are generally smaller, leading to a smaller magnitude of risk adjustment transfers in the small group

¹³ 81 FR 94099, 94100. (December 22, 2016). Available at <https://www.gpo.gov/fdsys/pkg/FR-2016-12-22/pdf/2016-30433.pdf>.

¹⁴ 91 FR 29146, 29152. (May 11, 2016). Available at <https://www.gpo.gov/fdsys/pkg/FR-2016-05-11/pdf/2016-11017.pdf>.

market as compared to the individual market. However, certain States have opined that the HHS risk adjustment methodology, which is calibrated on a national dataset, may in some circumstances, overcompensate for risk differences in the small group market for their particular State. In such cases, the States have the statutory authority to operate their own State risk adjustment program under a Federally-certified alternate risk adjustment methodology as they deem fit. We believe that allowing certain State-by-State adjustments to the HHS risk adjustment program can account for such State-specific differences in risk without the necessity for States to undertake operation of their own risk adjustment program. Therefore, in the case of small group markets, where States can demonstrate that the actuarial risk differences due to adverse selection are mitigated by the small group market dynamics described above, to tailor the risk adjustment methodology to particularities of reduced risk selection in a State's small group market, we are proposing to permit States' primary insurance regulators to request a percentage adjustment in the calculation of the risk adjustment transfer amounts in the small group market in their State, beginning for the 2019 benefit year.

Under this proposal, beginning in the 2019 benefit year and beyond, HHS would require any State that intends to request this flexibility to submit its proposal for an adjustment to the Statewide average premium in the small group market within 30 calendar days after publication of the proposed HHS notice of benefit and payment parameters for the applicable benefit year in order to permit issuers to incorporate any such adjustment into their proposed rates. For example, for the 2019 benefit year risk adjustment transfers, which will be calculated in the 2020 calendar year, State proposals would be submitted to HHS no later than 30 days after publication of this proposed HHS notice of benefit and payment parameters for the 2019 benefit year, similar to the public comment deadline for the proposed rule. In order to promote transparency and solicit

feedback from consumers and stakeholders on the proposed adjustment to the HHS risk adjustment transfer formula, HHS would publish the requested State adjustments for public comment in guidance while it begins its initial review of the State proposal. HHS would then make final determinations of approval of State requests by March 1 of the benefit year prior to the applicable benefit year, in time for issuers' initial rate setting deadline. That is, for the 2019 benefit year, HHS would make final determinations of approval by March 1, 2018. The proposed timing of the State adjustment request submission, publication of HHS guidance, the public notice and comment period and HHS request approval process will permit plans to incorporate approved adjustments in their rates for the applicable benefit year.

HHS would consider requests from State regulators to reduce the calculation of the Statewide average premium used in the HHS risk adjustment transfer formula by up to 50 percent for the applicable benefit year. As noted above, Statewide average premium is defined as unadjusted Statewide average premium reduced by 14 percent, to account for a portion of administrative costs, or as 86 percent of unadjusted Statewide average premium. Transfers in the small group market could be reduced by up to an additional 43 percent (or 50 percent of the transfer amounts, after the 14 percent reduction for a portion of administrative costs to the Statewide average premium). We believe this adjustment would proportionally reduce the magnitude of risk adjustment transfers in the small group market. We seek comment on all aspects of this proposal, including the permissible extent of the adjustment, the timing of the submission, any evidence the State should be required to provide, and what procedural requirements should be in place.

We also seek comment on whether we should establish a similar process through which States could request an adjustment to the calculation of Statewide average premiums for risk

adjustment in the individual market similarly to the proposed small group market adjustment. Although adverse selection in the individual market is not mitigated by group enrollment or minimum participation requirements that require a minimum percentage of employees to enroll in coverage as is the selection in the small group market, a State may believe the HHS risk adjustment methodology, which is calibrated on a national dataset, disproportionately accounts for relative actuarial risk differences in its individual market risk pool. We seek comment on whether, if a State can demonstrate such a difference in calculated relative actuarial risk, we should reduce States' administrative burden in operating its own risk adjustment program by allowing some flexibility in the HHS risk adjustment methodology to the extent permissible under the statute. Therefore, we seek comment on whether the adjustment described above for the small group market should also apply to the individual market, what individual market features would justify such an adjustment, and what additional submissions a State should provide in order to justify such a departure for that market. For example, to accommodate a State with particular State rating practices that serve to mitigate risk selection, we might require a statistical or actuarial study demonstrating the extent to which transfer amounts calculated pursuant to the HHS risk adjustment methodology finalized for the applicable benefit year would overstate differentials in uncompensated predicted risk in the individual market.

As noted above, a State that wishes to make an adjustment for the magnitude of these transfers in the individual and small group markets may take temporary, reasonable measures under State authority to mitigate effects under their own authority.

We seek comment on these proposals.

iv. The payment transfer formula

Except as proposed above, the payment transfer formula would be unchanged from what was finalized in the 2014 Payment Notice (78 FR 15430 through 15434). We believe it 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 = Statewide 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 adjustment charge or receives a risk adjustment 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 (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.

This existing formula would be multiplied by the number of member months to determine the total payment or charge assessed with respect to plan average risk scores for a plan's geographic rating area for the market within the State, and this payment or charge will be added to the transfer terms described above to account for the costs of high-risk enrollees.

g. Risk adjustment data validation requirements when HHS operates risk adjustment (§153.630)

HHS will conduct risk adjustment data validation under §153.630 in any State where HHS is operating risk adjustment on a State's behalf.¹⁵ The purpose of risk adjustment data validation is to ensure issuers are providing accurate high-quality information to HHS, which is crucial for the proper functioning of the risk adjustment program. Risk adjustment data validation consists of an initial validation audit and a second validation audit. Under §153.630, each issuer of a risk adjustment covered plan must engage an independent initial validation audit entity. The issuer provides demographic, enrollment, and medical record documentation for a sample of enrollees selected by HHS to its initial validation auditor for data validation. Set forth below are proposed amendments and clarifications to the risk adjustment data validation program in light of experience and feedback from issuers during the first pilot year.

i. Payment adjustments for error rates

¹⁵ Starting with the 2017 benefit year, no State has elected to operate a risk adjustment program. Therefore, HHS operates risk adjustment in all States.

Under §153.350(c), HHS may adjust risk adjustment payments and charges to all issuers of risk adjustment covered plans based on adjustments to the average actuarial risk of a risk adjustment plan due to errors discovered during risk adjustment data validation. We believe that some variation and error should be expected in the compilation of data for risk scores, because providers' documentation of enrollee health status varies across provider types and groups. Our experiences with the Medicare Advantage risk adjustment data validation program and the HHS risk adjustment data validation pilot for the 2015 benefit year reinforce this belief.

We propose evaluating material statistical deviation in error rates in applying error rates to risk scores beginning with the 2017 benefit year risk adjustment data validation. We are considering adjusting an issuer's risk score only when the issuer's error rate materially deviates from a statistically meaningful value, such as the central tendency (a mean or typical value) of errors, nationally. HHS could also evaluate error rates within each HCC, or groups of HCCs, and then only apply error rates to outlier issuers' risk scores within each HCC or group of HCCs. When an error rate materially deviates from the central tendency, we propose to apply the difference between the mean error rate or the confidence interval around the population's central tendency and the calculated error rate instead of the full error rate. If all error rates in a State risk pool do not materially deviate from the national central tendency of error rates, we propose to not apply any adjustments to issuers' risk scores for that benefit year in the respective State risk pool.

We believe the implementation of any of the alternative evaluations and subsequent adjustments we propose here would reduce issuer burden, streamline the risk adjustment data validation process, improve issuers' ability to predict risk adjustment transfers, and promote

confidence and stability in the budget-neutral payment transfer methodology while ensuring the integrity and quality of data provided by issuers.

We seek comment on this proposal and alternatives to evaluating material deviation in error rates for applying error rates to risk scores beginning with the 2017 benefit year risk adjustment data validation.

ii. Payment adjustments for issuers that have exited the market

In the 2015 Payment Notice, we established that HHS will use a prospective approach to adjust risk scores and payment transfers based on the results of risk adjustment data validation. Specifically, HHS will apply the error rate calculated through the risk adjustment data validation process for the applicable benefit year to plan risk scores in the subsequent benefit year, and then make risk adjustment payment transfers based on adjusted plan average risk scores in that subsequent benefit year. However, in some cases, an issuer of a risk adjustment covered plan may have exited a State market during or at the end of the benefit year being audited and therefore would not have risk scores or payment transfers in the subsequent benefit year to which HHS could make adjustments.

As previously noted, the purpose of data validation for risk adjustment is to promote confidence in the budget-neutral payment transfer methodology by ensuring the integrity and quality of data provided from issuers. HHS believes that the prospect of not receiving payment adjustments based on the results of risk adjustment data validation results could undermine these goals by eliminating the incentive for an exiting issuer to carefully and accurately submit risk adjustment data for its final benefit year in the market. Not only could this type of inaccuracy result in overpayments to the exiting issuer, it could also cause the other issuers in the market to be over or undercompensated for the actual risk of their enrollee populations. Therefore, we

propose that HHS would use the error rate derived from the risk adjustment data validation process to adjust the payment transfer for the issuer's final benefit year in the State market, which would be concurrent with the benefit year being audited, for issuers that exit a State market during or at the end of the benefit year being audited. Because risk adjustment transfers for a given benefit year are calculated and paid before the risk adjustment data validation process for that benefit year is completed, this approach would require HHS to make a retroactive adjustment to the issuer's payment transfer for its final benefit year and reallocate the adjusted transfer amount to the other issuers in the State market in that year.

HHS believes that the proposed retroactive adjustment to an exited issuer's payment transfer would help ensure that an issuer with inaccurate data does not benefit from this error and that other issuers in the State market are not harmed by it. However, we acknowledge that this approach could reduce issuers' confidence in the finality of risk adjustment transfers for any given benefit year because of the potential for retroactive adjustments for an issuer that has exited the market. In addition, the calculation of payment transfers could become increasingly complex for 2018 benefit year risk adjustment transfers and beyond, because HHS could be adjusting payment transfers based on the results of data validation, even if transfers were already adjusted retroactively for an exited issuer's data validation adjustment (for example, 2018 benefit year risk adjustment transfers would be adjusted for 2017 benefit year risk adjustment data validation, and would also be adjusted for 2018 risk adjustment benefit year data validation if an issuer exits the market at the end of the 2018 benefit year). However, we believe the payment adjustment proposal for error rates that is discussed above could result in some exiting issuers not being adjusted at all, alleviating some of the complexity associated with retroactively adjusting transfers. We seek comment on this proposal to make retroactive adjustments to

payment transfers for issuers that have exited the market based on the results of risk adjustment data validation for the most recent benefit year in which they participated in risk adjustment.

iii. 500 Billable Member Months

Numerous small issuers have expressed concern regarding the regulatory burden and cost associated with complying with the risk adjustment data validation program. HHS has previously considered these concerns and provided relief where possible. For example, in the 2017 Payment Notice, we included a lower, separate default risk adjustment charge for small issuers with 500 billable member months or fewer beginning with the 2016 benefit year in light of the high operational burden associated with compliance for these issuers.

We propose that, beginning with 2017 benefit year risk adjustment data validation, issuers with 500 billable member months or fewer that elect to establish and submit data to an EDGE server would not be subject to the requirement to hire an initial validation auditor or submit initial validation audit results. Issuers at or below the 500 billable member months threshold would have their risk score adjusted by a default error rate equal to the lower of either the national average negative error rate, or the average negative error rate within a State, as set forth in the 2018 Payment Notice. We believe exempting issuers with 500 billable member months or fewer from the requirement to hire an initial validation auditor is appropriate because issuers of this size would have a disproportionately high operational burden for compliance with risk adjustment data validation. We note that, beginning with 2018 benefit year risk adjustment data validation, these issuers would not be subject to random sampling under the materiality threshold discussed below, and would continue to not be subject to the requirement to hire an initial validation auditor or submit initial validation audit results, but would have their risk scores adjusted by a default error rate annually. We note that if the proposal discussed above to

implement a central tendency approach to payment adjustments is finalized, then it is possible no adjustment would occur for issuers below this threshold. We seek comment on the proposed exemption from risk adjustment data validation, including the 500 billable member months threshold.

iv. Materiality threshold for risk adjustment data validation

In the 2018 Payment Notice, HHS implemented a materiality threshold for risk adjustment data validation to ease the burden of annual audit requirements for smaller issuers of risk adjustment covered plans. Specifically, we stated that issuers with total annual premiums at or below \$15 million (calculated based on the premiums of the benefit year being validated) will not be subject to annual initial validation audit requirements, beginning with the 2017 benefit year, but will still be subject to an initial validation audit approximately every 3 years. HHS based the timeline for enforcement of the materiality threshold on the expectation that we would begin making payment adjustments based on the results of 2016 benefit year risk adjustment data validation, effectively requiring all issuers of risk adjustment covered plans to participate in the first benefit year for which risk adjustment payments are adjusted. However, in light of our subsequent decision to convert the 2016 benefit year to another pilot year,¹⁶ we propose to postpone application of the materiality threshold to the 2018 benefit year. Therefore, all issuers of risk adjustment covered plans would be required to conduct an initial validation audit for the 2017 benefit year risk adjustment data validation, other than issuers with 500 billable member months or fewer as discussed above. Beginning with the 2018 benefit year, issuers below the \$15

¹⁶ “HHS-Operated Risk Adjustment Data Validation (HHS-RADV) – 2016 Benefit Year Implementation and Enforcement.” May 3, 2017. Available at https://www.regtap.info/uploads/library/HRADV_PilotGuidance_5CR_050317.pdf.

million premium threshold would not be required to conduct an initial validation audit every year. Under this proposal, HHS would still conduct random and targeted sampling under which issuers below the materiality threshold would be subject to an initial validation audit approximately every 3 years, beginning with 2018 benefit year risk adjustment data validation. In addition, issuers below the \$15 million threshold that are not selected for the random and targeted sampling would have their risk adjustment transfers adjusted by a default error rate equal to the lower of the average negative error rate nationally, or the average negative error rate within a State. We note that if the proposal to implement a central tendency approach to payment adjustments discussed above is finalized, then it is possible no adjustment would occur for issuers below this threshold. We seek comment on this proposal.

v. Data validation sampling methodology

Section 153.350(a) requires that a statistically valid sample of enrollees from each issuer of risk adjustment covered plans be validated. In the 2015 Payment Notice, HHS finalized its methodology for selecting the sample of enrollees for the initial validation audit for each issuer of a risk adjustment covered plan. We established a sample size per issuer for each State in which the issuer offers risk adjustment covered plans and clarified that the sample would include 200 enrollees per issuer for each risk pool in which the issuer participates, not 200 enrollees per plan. However, HHS will not calculate a risk score, or apply risk adjustment payment transfers except for high-cost risk pool transfers beginning with the 2018 benefit year, on behalf of a State in a market and risk pool when there is only one issuer in the market and risk pool. That issuer may participate in another market in the State where it is not the sole issuer and, as such, would still participate in risk adjustment and risk adjustment data validation for the applicable benefit year. In this circumstance, data from the risk pools in which the issuer was the sole issuer would

not be part of a State market risk pool payment transfer, and would not be subject to the same quality controls as data used to calculate risk scores and payment transfers; consequently, the data could not be validated with the same confidence that data used for payment can be validated. Therefore, HHS would not require the issuer to validate data for its plans in a risk pool that was not risk adjusted against another issuer in the State risk pool in the applicable benefit year. We propose to change the sampling methodology so that, beginning with the 2017 benefit year data validation, the initial data validation audit sample will only include enrollees from State risk pools in which there was more than one issuer and where HHS conducted risk adjustment on behalf of the State for the benefit year being validated.¹⁷ We seek comment on this proposal.

vi. Mental and behavioral health records

Under §153.630(b)(6), the issuer of a risk adjustment covered plan must provide the initial validation auditor and second validation auditor with all relevant source enrollment documentation, all claims and encounter data, and medical record documentation from providers of services to each enrollee in the applicable sample without unreasonable delay and in a manner that reasonably assures confidentiality and security in transmission. Issuers have advised HHS that certain States' medical privacy laws may limit providers' ability to furnish mental and behavioral health records for risk adjustment data validation purposes. We believe that section 1343 of the PPACA and associated regulations require issuers of risk adjustment covered plans to furnish any records needed for purposes of the risk adjustment program, including mental and

¹⁷ For the 2018 and future benefit years, HHS would not require the sole issuer in the State market to include high-cost risk pool enrollees in its sample for data validation, as these payments will be subject to a separate audit process.

behavioral health records. We believe that the HIPAA Privacy Rule at 45 CFR 164.512(a) generally permits disclosures of protected health information that are required by law within the meaning of 45 CFR 164.103. Nevertheless, we recognize that some State and Federal privacy laws impose requirements for mental and behavioral health information that are different from, and potentially more restrictive than, the HIPAA regulations. However, without the necessary mental and behavioral health information, the diagnosis code for an applicable enrollee cannot be validated and, therefore, it would be rejected during risk adjustment data validation.

To address these potential issues, we propose to amend §153.630(b)(6) to provide that, if a provider is prohibited from furnishing a full mental or behavioral health record by State or Federal privacy laws, the provider instead may furnish a mental or behavioral health assessment that providers routinely prepare, for validation of a mental or behavioral health diagnosis. Although HHS needs the full content of the mental or behavioral health record to ensure full validation of the accuracy of diagnosis codes, we believe that we can still perform some risk adjustment data validation based on the information contained in mental or behavioral health assessments in those instances in which State or Federal law prohibits submission of the full record. For risk adjustment data validation purposes, we would expect a mental or behavioral health assessment to be signed by a qualified provider who is licensed by the State to diagnose mental illness and, to the extent permissible under governing privacy and confidentiality laws, to contain: (i) the enrollee's name; (ii) gender; (iii) date of birth; (iv) current status of all mental or behavioral health diagnoses; and (v) dates of service. We note that "psychotherapy notes," a subset of mental and behavioral health information that receives special protections under the

HIPAA Privacy Rule, are not required for the purposes of risk adjustment data validation.¹⁸ We also note that some State and Federal privacy laws require that providers obtain patient consent before disclosing mental or behavioral health records, and that these consent requirements may apply to mental or behavioral health assessments. We clarify that we do not view a State or Federal law requiring patient consent as inconsistent with the risk adjustment data validation requirements to furnish a mental or behavioral health record or assessment. Additionally, we note that certain substance use disorder patient records are subject to the Federal confidentiality law at 42 U.S.C. 290dd-2 and the regulations promulgated thereunder in 42 CFR part 2 and to similar State laws, and generally require consent prior to disclosure. We believe that this proposal is consistent with the foregoing Federal and State confidentiality rules, and that the substance use disorder confidentiality requirements should govern when applicable. Therefore, issuers or providers may be required to obtain written patient consent in order to comply with this proposal.

The proposal described above allows issuers an additional avenue to achieve compliance by permitting abbreviated mental or behavioral health assessments for risk adjustment data validation in the event that a provider is subject to State or Federal privacy laws that prohibit the provider from providing a complete mental or behavioral health record to HHS. To submit a mental or behavioral health assessment instead of the full mental or behavioral health record, a provider would be required to attest that relevant State or Federal privacy laws prohibit him or

¹⁸ “Psychotherapy notes” are notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session, or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record. Psychotherapy notes do not include medication prescription and monitoring, counseling session start and stop times, modalities and frequency of treatment, test results, and summaries of diagnoses, functional status, treatment plan, symptoms, prognosis, and progress to date. See 45 CFR 164.501.

her from providing the entire mental or behavioral health record. HHS also believes that the proposal supports the integrity of the risk adjustment data validation program by ensuring that an initial validation auditor obtains data that will enable proper validation of mental or behavioral health HCCs, which are susceptible to discretionary coding. Furthermore, we believe the use of mental or behavioral health assessments would reduce burden on providers by permitting them to utilize records they routinely prepare and likely already have, which would avoid the need to prepare special summaries solely for the purpose of risk adjustment data validation. We seek comment as to the prevalence and typical contents of mental or behavioral health assessments under current practice, as well as other aspects of this proposal.

vii. Inter-rater reliability rates

Under §153.630(b)(8), the initial validation auditor must measure and report to the issuer and HHS, in a manner and timeframe specified by HHS, its inter-rater reliability rates among its reviewers. An initial validation auditor must achieve a consistency measure of at least 95 percent for his or her review outcomes, except for the initial benefit years of risk adjustment data validation, for which the initial validation auditor may meet an inter-rater reliability standard of 85 percent. Consistent with our decision to make the 2016 benefit year another pilot year as referenced above, we propose to amend §153.630(b)(8) to add the 2016 benefit year as an initial year of risk adjustment data validation for which the initial validation auditor may meet the lower inter-rater reliability standard of 85 percent.

viii. Civil money penalties

An effective risk adjustment data validation program is essential to the proper functioning of HHS-operated risk adjustment. In order to enforce risk adjustment data validation standards when operating risk adjustment data validation on behalf of a State, we are proposing to clarify

and amend the bases upon which HHS may impose CMPs for violations of risk adjustment data validation requirements.

To give HHS additional flexibility for ensuring compliance with the risk adjustment data validation requirements and in light of our experience in the first pilot year of the risk adjustment data validation program, HHS is proposing to amend §153.630(b)(9) to give HHS the authority to impose a CMP on an issuer of a risk adjustment covered plan in the event of misconduct or substantial non-compliance with the risk adjustment data validation standards and requirements. Specifically, we propose to amend §153.630(b)(9) to state that, if an issuer of a risk adjustment covered plan (1) fails to engage an initial validation auditor; (2) fails to submit the results of an initial validation audit to HHS; (3) engages in misconduct or substantial non-compliance with the risk adjustment data validation standards and requirements applicable to issuers of risk adjustment covered plans; or (4) intentionally or recklessly misrepresents or falsifies information that it furnishes to HHS, HHS may impose CMPs in accordance with the procedures set forth in §156.805(b) through (e). We note that §153.630(b)(9) already addresses the possible imposition of CMPs for (1) and (2) above, and provides a cross-reference to §156.805, which contains the bases and procedures for imposing CMPs for (3) and (4) above. Section 153.630(b)(9) provides the authority to assess CMPs on all issuers of risk adjustment covered plans, not just issuers on an FFE as does §156.805.¹⁹ Through this proposal, we are clarifying that the authority to impose CMPs for (3) and (4) applies to all issuers of risk adjustment covered plans, not just those issuers

¹⁹ Pursuant to §153.20, risk adjustment covered plan means, for the purpose of the risk adjustment program, any health insurance coverage offered in the individual or small group market with the exception of grandfathered health plans, group health insurance coverage described in 45 CFR 146.145(c), individual health insurance coverage described in 45 CFR 148.220, and any plan determined not to be a risk adjustment covered plan in the applicable Federally certified risk adjustment methodology.

on an FFE. We note that the CMP authority would be in addition to HHS's ability to adjust an issuer's transfers under §153.350(c).

As previously noted in the Second 2013 Program Integrity Rule, and in the 2015 Payment Notice, we propose that HHS's possible application of CMPs would continue to take into account the totality of the issuer's circumstances, including such factors as an issuer's previous record of non-compliance (if any), the frequency and level of the violation, and any aggravating or mitigating circumstances. Additionally, we would continue to impose any CMPs so that the level of the enforcement action is proportional to the level of the violation. While we reserve the right to impose penalties up to the maximum amounts set forth in §156.805(c), as a general principle, we intend to work collaboratively with issuers to address any problems in conducting the risk adjustment data validation process.

We believe this additional CMP authority will improve program integrity and fairness by permitting HHS the authority to assess CMPs on issuers that engage in misconduct in risk adjustment data validation. Although §153.630(e) permits HHS to adjust payments and charges for issuers that do not comply with audit requirements and standards, this provision only makes the markets whole in the event of a violation of the risk adjustment data validation standards or misconduct. We do not believe this provision provides a sufficient deterrent effect to ensure program integrity of the risk adjustment data validation program. Additionally, we believe this additional authority is necessary in light of the policies finalized in the 2018 Payment Notice, specifically, the concerns HHS highlighted around gaming and the inclusion of prescription drug data in the risk adjustment model. We seek comment on this proposal.

ix. Adjustment of risk adjustment transfers due to submission of incorrect data

On September 2, 2015, HHS released the *Adjustment of Risk Adjustment Transfers Due to Submission of Incorrect Data* guidance,²⁰ setting forth the process by which HHS would address instances of materially incorrect EDGE server data submissions. We propose to include risk adjustment data validation as a method of discovering materially incorrect EDGE server data submissions and making adjustments pursuant to §153.630(e), as described in our September 2, 2015 guidance. We propose that demographic or enrollment errors discovered during risk adjustment data validation would be the basis for an adjustment to the applicable benefit year transfer amount, rather than the subsequent benefit year risk score. The elements being validated are related to the transfer formula. As such, we believe they are substantially similar to a discrepancy in the transfer process, which is addressed in the current benefit year as part of the process for handling discrepancies in data under §153.710, as opposed to a discrepancy in underlying enrollee diagnoses contributing to risk scores, which is addressed through subsequent year risk score adjustments as part of risk adjustment data validation.

As we noted in the September 2, 2015 guidance, an overstatement or understatement of premium data may affect issuers differently, because it will lead to an increase or decrease in the absolute value of the magnitude of the transfers (and will affect the calculation of the geographic rating area factors). Therefore, an issuer's submission of incorrect EDGE server premium data may have the effect of increasing or decreasing the magnitude of risk adjustment transfers to other issuers in the market, depending on the direction of the premium error, holding constant the other elements of the payment transfer formula. In cases where there is a material impact on risk adjustment transfers for that particular market as a result of incorrect EDGE server premium

²⁰ Available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/RA-Adjustment-Guidance-9-2-15.pdf>.

data, HHS would calculate the dollar value of differences in risk adjustment transfers, and, where the difference is detrimental to one or more issuers in the market, adjust the other issuers' risk adjustment transfer amount by that calculation, and increase the risk adjustment charge (or decrease the risk adjustment payment) to the issuer that made the data error, in order to balance the market.²¹ We believe this approach allows HHS to operate the risk adjustment program efficiently, while ensuring that issuers do not profit from their data submission errors or harm their competitors in the relevant market. We seek comment on this proposal.

h. Risk adjustment user fee for 2019 benefit year (§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 its behalf. In 2019, HHS anticipates operating a risk adjustment program in every State. 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 must remit a user fee to HHS equal to the product of its monthly billable member enrollment in the plan and the per member 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 established Federal policy regarding user fees, and specified 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 mitigates the financial instability associated with

²¹ Calculation of the dollar value will include adjustment to the statewide premium average and, to the extent possible, adjustment to the geographic cost factor.

potential adverse risk selection. The risk adjustment program also contributes to consumer confidence in the health insurance industry by helping to stabilize premiums across the individual and small group markets.

In the 2018 Payment Notice, we calculated the Federal administrative expenses of operating the risk adjustment program for the 2018 benefit year to result in a risk adjustment user fee rate of \$1.68 per billable member per year or \$0.14 PMPM, based on our estimated contract costs for risk adjustment operations and estimates of billable member months for individuals enrolled in a risk adjustment covered plan. For the 2019 benefit year, we propose to use the same methodology to estimate our administrative expenses to operate the program. These contract costs 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 divided HHS's projected total costs for administering the risk adjustment programs on behalf of States by the expected number of billable member months in risk adjustment covered plans in HHS-operated risk adjustment States for the benefit year.

We estimate that the total cost for HHS to operate the risk adjustment program on behalf of States for 2019 will be approximately \$38 million, and the risk adjustment user fee would be \$1.68 per billable member per year, or \$0.14 PMPM. The risk adjustment user fee contract costs for the 2019 benefit year are lower than the 2018 benefit year contract costs due to lower risk adjustment data validation and stakeholder training costs as issuers are becoming more familiar with our programs. We expect billable member months to decline slightly compared to the 2016 benefit year, whereas we expected billable member months to increase over this time period when setting the risk adjustment user fee rate for the 2018 benefit year. Therefore, the calculated

2019 benefit year risk adjustment user fee is lower than the rate for the 2018 benefit year prior to rounding, but after rounding to the nearest cent, is the same as that for the 2018 benefit year. We seek comment on the proposed risk adjustment user fee for the 2019 benefit year.

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

1. Applicability (§154.103)

Since July 18, 2011, issuers have been required to submit **rate filing justifications** for rate increases for non-grandfathered plans in the individual and small group markets.²² This requirement was established, in part, to carry out the Secretary’s responsibility, in conjunction with 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. Student health insurance coverage is considered by HHS to be a type of individual market coverage and is generally subject to the PHS Act individual market requirements including rate review.²³ However, student health insurance coverage is not subject to single risk pool requirements.²⁴ Because student health insurance coverage is only available through colleges and universities, it is also exempt from the guaranteed availability and guaranteed renewability requirements enacted under HIPAA. For purposes of the guaranteed availability and guaranteed renewability requirements enacted under the PPACA, a health insurance issuer that offers student health insurance coverage is not required to accept individuals who are not students or dependents of

²² See Rate Increase Disclosure and Review; Final Rule, 76 FR 29964, 29966 (May 23, 2011).

²³ See Student Health Insurance Coverage Final Rule 77 FR 16453 (March 21, 2012).

²⁴ A health insurance issuer that offers student health insurance coverage may establish one or more separate risk pools for an 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 45 CFR 146.121). However, student health insurance rates must reflect the claims experience of individuals who comprise the risk pool, and any adjustments to rates within a risk pool must be actuarially justified. See 45 CFR 147.145(b)(3).

students, and is not required to renew or continue in force coverage for individuals who are no longer students or dependents of students. Student health insurance coverage also need not be issued on a calendar year basis.²⁵

We propose to modify §154.103(b) to exempt from rate review student health insurance coverage, effective for plan or policy years beginning on or after January 1, 2019. Grandfathered health plan coverage as defined in 45 CFR 147.140 and excepted benefits as described in section 2791(c) of the PHS Act are already exempted from rate review under the existing regulation at §154.103(b).

The Federal rate review requirements currently apply to student health insurance coverage because it is considered individual market coverage.²⁶ Issuers of student health insurance plans are required to use the Rate Review Justification module of the Health Insurance Oversight System (HIOS) to submit the required rate filing information. However, student health insurance coverage is written and sold more like large group coverage, which was exempted from rate review as part of the implementing regulations in part 154 because States traditionally focused their efforts on the review of rates in the small group and individual markets. Additionally, purchasers in the large group market were viewed as being more sophisticated, with greater leverage, and therefore better able to avoid the imposition of large rate increases.²⁷ Similarly, institutions of higher education that offer student health insurance coverage are seen as well informed, with significant purchasing power, and student health insurance coverage is

²⁵ 45 CFR 147.145(b)(1).

²⁶ 45 CFR 147.145.

²⁷ See preamble discussion in the proposed rule, “Rate Increase Disclosure and Review” 75 FR 81004, 81009 (December 23, 2010).

generally rated and administered differently from other forms of individual health insurance coverage.²⁸

States have allowed rating practices for student health insurance coverage to be more in line with large group pricing, in which experience rating and other factors can be used to determine rates. Because student health insurance coverage is typically experience rated, and is typically only available to students and their dependents with an open enrollment period coinciding with the start of the academic year, it is exempt from single risk pool rating requirements and not guaranteed to be available or renewable to individuals who are not students or dependents of students in an institution of higher education. In addition, States have generally given student health insurance coverage more plan design flexibility compared to individual market plans to better meet student needs and utilization of on-campus providers. Because of these factors, some States have requested student health insurance coverage be exempt from the rate review requirements in part 154 of title 45. The proposed change would reduce the regulatory burden on States and issuers of student health insurance plans. This proposal is consistent with our general approach of providing tailored flexibility with respect to the PHS Act individual market reforms for student health insurance coverage. Eliminating the burdens associated with the Federal rate review requirements may incentivize issuers to offer more student health insurance plans, increasing competition among issuers to the benefit of institutions of higher education and their students.

We note that States would continue to have the flexibility to review rate increases or other aspects of student health insurance coverage. Under this proposal, in States that do not

²⁸ See preamble discussion in the final rule, “Health Insurance Market Rules; Rate Review” 78 FR 13406, 13424 (February 27, 2013).

have an Effective Rate Review Program, we would monitor the compliance of student health insurance coverage with applicable market rating reforms based on complaints and as part of targeted market conduct examinations. In States where we are enforcing market reforms, we would continue to review form filings for student health insurance coverage for compliance with applicable PHS Act individual market requirements, but would not review rate increases for reasonableness under part 154 of title 45.

We solicit comment on this proposal.

2. **Rate Increases Subject to Review (§154.200)**

Section 2794(a)(1) of the PHS Act requires the Secretary, in conjunction with States, to establish a process for the annual review of unreasonable premium increases for health insurance coverage. Section 2794(a)(2) of the PHS Act requires health insurance issuers to submit to the Secretary and relevant State a justification for an unreasonable premium increase prior to implementation. States may establish a more robust review process, and many have chosen to do so.

Section 154.200(a)(1) currently provides that a rate increase for single risk pool coverage beginning on or after January 1, 2017 is subject to a reasonableness review if: (1) the average increase, including premium rating factors described in 45 CFR 147.102, for all enrollees, weighted by premium volume for any plan within the product, meets or exceeds 10 percent; or (2) the increase exceeds a State-specific threshold approved by the Secretary. We propose to amend this provision to establish a 15 percent default threshold for reasonableness review, in

recognition of significant rate increases in the past number of years, rather than the current 10 percent default threshold, and seek comment on the appropriate default threshold.²⁹

A reasonableness review looks at the assumptions used in determining the rate increase to make sure those assumptions are supported by evidence. The reasonableness review also checks that the increase will not result in a projected Federal MLR below the minimum standard in the applicable market and will not unfairly discriminate between insureds with similar risk categories.

Regardless of the threshold set for reasonableness review, all issuers must submit a Uniform Rate Review Template (URRT) (Part I of the Rate Filing Justification) for all single risk pool plan submissions. Issuers offering a QHP or any single risk pool submission containing a rate increase of any size must also submit an actuarial memorandum (Part III of the Rate Filing Justification). Issuers with rate filings that do not meet the threshold for a reasonableness review are exempt from the requirement to submit Part II of the Rate Filing Justification (Consumer Justification Narrative) for those rate filings. No changes are being proposed to these requirements.

We note that the threshold set by CMS constitutes a minimum standard. Some States currently employ stricter rate review standards and may continue to do so. Section 154.200(a)(2) currently requires States to submit a proposal to the Secretary for approval of any State-specific threshold. We propose to amend §154.200(a)(2) to require submission of a proposal only if the

²⁹ The 10 percent threshold was established in the “Rate Increase Disclosure and Review” Final rule (76 FR 29963, May 23, 2011) based upon three indices. These indices are: (1) the medical component of the Consumer Price Index (CPI); (2) the National Health Expenditure data (NHE); and (3) the Standard and Poor’s Healthcare Economic Commercial Index. The threshold was finalized at 10 percent based on the analysis of the trend in health care costs and rate increases provided in the preamble to the proposed rule.

State-specific threshold is higher than the Federal default threshold. We are proposing this change to reduce burdens and promote State flexibility. We also propose to amend this provision to clarify that a State seeking approval for a higher threshold than the Federal default must base its request on factors impacting rate increases in the State to the extent that the data relating to such factors are available by August of the preceding year.

CMS released guidance entitled, “State-Specific Threshold Proposals, Guidance for States” on March 27, 2012,³⁰ and outlined the process to be followed by States wishing to propose a State-specific threshold to be effective from September 1, 2012 through August 31, 2013. We will issue future guidance on the process for submission and review of State requests to propose a State-specific threshold above what is set by CMS, to be effective for rate filings submitted on or after January 1, 2019.

We also propose to delete paragraph (b) in its entirety. That paragraph currently requires that the Secretary publish a notice each year indicating which threshold applies to each State. CMS currently posts information regarding State-specific threshold requests on its Web site³¹ and would continue to do so for States that request a State-specific threshold above what is set by CMS, beginning with rate filings submitted on or after January 1, 2019. If this proposal is finalized, CMS would not post information on States where the Federal default or a stricter State-specific threshold applies. Under the proposed approach, we would rely on States to communicate information about stricter thresholds, as well as any other State-specific requirements.

³⁰ <https://www.cms.gov/CCIIO/Resources/Files/Downloads/dwnlds/rjssptguidance.pdf>.

³¹ <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/sst.html>.

We propose to redesignate paragraph (c) as paragraph (b) and revise that paragraph to delete the language related to rates filed for coverage beginning before January 1, 2017, currently captured in paragraph (c)(1) as this provision is no longer necessary.³² We propose to redesignate paragraph (d) as paragraph (c). Finally, we propose conforming changes to change the cross references in §154.200 to align with the changes described above.

We seek comment on these proposals.

3. **Submission of Rate Filing Justification (§154.215)**

Section 154.215(h)(2) includes a reference to 45 CFR 5.65, which defined trade secret, confidential commercial or financial information under HHS regulations implementing the Freedom of Information Act, 5 U.S.C. 552. HHS revised 45 CFR part 5 in a final rule issued on October 28, 2016, effective on November 28, 2016 (81 FR 74930). We propose to make a technical correction to §154.215(h)(2) to refer to 45 CFR 5.31(d) because 45 CFR 5.65 no longer exists and §5.31(d) now lists the reasons a record may be withheld.

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

Section 154.220(b) provides that 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 by the earlier of (1) the date by which the State requires submission of a rate filing; or (2) the date specified in guidance by the Secretary. As discussed in the 2016 Payment Notice,³³ we have interpreted that section to require submission of all rate filings, for both QHPs

³² This standard (that is, the average increase for all enrollees weighted by premium volume meets or exceeds the applicable threshold), however, continues to apply to rates filed for coverage beginning before January 1, 2017, including with respect to compliance reviews and enforcement actions.

³³ 80 FR 10782.

and non-QHPs, at a uniform time. We have issued rate filing timeline guidance on an annual basis establishing the respective dates for each benefit year and reiterating that requirement.³⁴

Several State regulators have indicated that requiring all submissions at one time poses an undue regulatory burden. They have stated that they prefer to set a later date for submission of rate filings from issuers that only offer non-QHPs to enable regulators to complete the review of QHP rate filings first and review non-QHP rate filings later. Therefore, starting with plan year 2019, we propose to interpret §154.220(b) to allow a State with an Effective Rate Review Program to set different submission deadlines for rate filings from issuers that only offer non-QHPs. This change would reduce burden while empowering States to pick the timeframe that works best for their markets, and also accounts for market differences between States. This is also in line with a comment we received in response to the Request for Information requesting that States be allowed to set rate filing dates. Under this proposal, an issuer that offers both QHPs and non-QHPs in a market in a given State would be required to submit its rate filing in accordance with the deadlines established for QHPs pursuant to §154.220(b) to support regulatory review of compliance with the single risk pool requirement.

CMS would need to coordinate with all States in order to continue collecting preliminary rate filing information and final rate determinations in order to comply with the statutory requirement under section 2794(b)(2)(A) of the PHS Act to monitor premium increases of health insurance coverage offered inside and outside of the Exchanges. This coordination will also be important to support compliance under section 1311(e)(2) of the PPACA for the FFEs to take

³⁴ See, for example, Bulletin: Revised Timing of Submission and Posting of Rate Filing Justifications for the 2017 Filing Year for Single Risk Pool Coverage; Revised Timing of Submission for Qualified Health Plan Certification Application (April 13, 2017), available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Revised-2017-filing-timeline-bulletin-4-13-17.pdf>.

into consideration State recommendations provided under section 2794(b)(1) of the PHS Act when certifying QHPs, as well as information on any excess premium growth outside of Exchanges as compared to inside the Exchanges. We solicit comment on this proposal.

5. Determinations of Effective Rate Review Programs (§154.301)

a. State posting of rate increases

We propose to modify §154.301(b)(2), which requires a State with an Effective Rate Review Program to notify us in writing, no later than 30 days prior to the date it intends to make any proposed or final rate filing information public if the State will be posting prior to the date specified by the Secretary. We propose to reduce the advance notification required from 30 days to 5 business days. The 30-day notification period was intended to give us sufficient notice in advance of State rate increase announcements. However, in many instances a State does not know the posting date 30 days in advance, so it was difficult to meet this requirement. Shortening the advance notice period to 5 business days would better reflect existing State practices. Under this proposal, if a State opts to post submissions on a rolling basis, as specified in the proposed change below, then the State would need to provide this notification to us only for the first submission for a given plan year that is publicly posted.

b. Posting of rate increases.

Section 154.301(b)(3) currently provides that a State with an Effective Rate Review Program must ensure that information regarding rate increases is made available to the public at a uniform time for all proposed and final rate increases, as applicable, in the relevant market segment and without regard to whether coverage is offered on or off of an Exchange. That provision was codified in order to set a level playing field, to prevent issuers that submit rate filings later from having an advantage over their competitors that submitted rate filings earlier.

Upon further analysis and input from stakeholders, including a comment we received in response to the Request for Information, we propose to eliminate the requirement for uniform posting by deleting paragraph (b)(3). This would permit States that have an Effective Rate Review Program to post proposed and final rate filing information on a rolling basis. We believe that providing this flexibility better accords with State laws and historical practices. Prior to the introduction of the Federal rate review program, many States received and posted rate filing information on a rolling basis. Some State laws conflict with the Federal uniform posting requirement and require posting of rate filing information upon receipt. In addition, several States faced challenges due to information systems that were unable to suppress rate filing information until a later date.

Under this proposal, States with Effective Rate Review Programs would continue to be required to provide access from their respective Web sites to at least the same information from the rate filing that we make available on our Web site (or provide our web address for such information). Further, such States must have a mechanism for receiving public comments on proposed rate increases subject to review and must post the required rate filing information by the applicable deadlines established under §154.301(b)(1).

We would need to coordinate with States to continue collecting preliminary rate filing information and final rate determinations to comply with the statutory requirement under section 2794(b)(2)(A) of the PHS Act to monitor premium increases of health insurance coverage offered inside and outside of the Exchanges. This coordination would also be important to support compliance under section 1311(e)(2) of the PPACA for the FFEs to take into consideration State recommendations provided under section 2794(b)(1) of the PHS Act when certifying QHPs, as well as information on any excess premium growth outside of Exchanges as

compared to inside the Exchanges. We would continue to post proposed and final rate changes at <http://ratereview.HealthCare.gov> at a uniform time, consistent with current practices and §154.215(h).

We solicit comment on these proposals for posting of rate increases.

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

1. **Standardized Options (§155.20)**

In the 2017 Payment Notice, HHS introduced standardized options (also now referred to as Simple Choice plans). A standardized option is a QHP offered for sale through an individual market Exchange that either has a standardized cost-sharing structure specified by HHS in rulemaking or has a standardized cost-sharing structure specified by HHS in rulemaking that is modified only to the extent necessary to align with the high deductible health plan (HDHP) requirements under section 223 of the Code or the applicable annual limitation on cost sharing and HHS actuarial value requirements. For the 2017 and 2018 benefit years, HHS specified standardized options in rulemaking, encouraged issuers to offer such plans and provided differential display of these plans on HealthCare.gov.

We seek to encourage free market principles in the individual market, and to maximize innovation by issuers in designing and offering a wide range of plans to consumers. We have heard concerns that providing differential display for these plans may limit enrollment in coverage with plan designs that do not match the standardized options, removing incentives for issuers to offer coverage with innovative plan designs. We believe that encouraging innovation is especially important now, given the stresses faced by the individual market. Therefore, we are proposing not to specify any standardized options for the 2019 benefit year, and not to provide

differential display for standardized options on HealthCare.gov. If this proposal is finalized, agents, brokers and issuers that assist consumers with QHP selection and enrollment as described in §155.220(c)(3) and §156.265(b), respectively, would also not be required to provide differential display for standardized options on those third-party Web sites.

We seek comment on this proposal.

2. General Standards Related to the Establishment of an Exchange

a. Flexibility for State-based Exchanges and State-based Exchanges on the Federal platform (§155.106 and §155.200)

While the PPACA allowed each State to operate its own SBE, currently, 11 States and the District of Columbia operate their own Exchanges, five States utilize the SBE-FP model, and FFEs operate in the remaining 34 States. We seek to support innovation by States operating SBEs by providing opportunities for increased program flexibilities to help support the retention and financial self-sustainability of States participating in the SBE model. In particular, we seek comment on how HHS can best support SBE efforts to utilize commercial platform services, including what type of technical support would be useful and what, if any, specific regulatory changes would facilitate the use of these services.

We also propose to explore strategies to make the SBE-FP model more appealing and viable to States with FFEs, as well as to support retention of existing SBE-FPs. As codified in the 2017 Payment Notice, the SBE-FP model allows States to establish the legal status of their Exchanges as SBEs while leveraging the economies of scale available through the Federal eligibility and enrollment platform and information technology infrastructure. The SBE-FP model offers States opportunities to retain more control over their Exchanges than if an FFE operated in the State, as it allows them to control plan management and consumer assistance

activities, without the additional responsibility of building the infrastructure required to operate an IT eligibility and enrollment platform. Accordingly, we seek to explore options for streamlining current requirements and leveraging private sector and Federal platform technologies and advances to increase opportunities for those States interested in remaining or becoming SBE-FPs.

As discussed in prior rulemaking, due to operational limitations, HHS is unable at this time to offer a “menu” of Federal services from which an SBE-FP may select some, but not other, services on the Federal platform. However, we have stated in previous rules that we would explore the availability of new capabilities of the Federal platform to customize particular functionalities. We intend to continue to explore additional areas where current authority, technology, and operational capacities would permit HHS to provide additional options in operational functions to SBE-FPs and provide SBE-FPs with a greater role in decision-making. Those areas include allowing SBE-FPs greater access to enrollment data and operational statistics to enable States to more effectively design their local outreach and education strategies, providing SBE-FPs access to personally identifiable consumer data to assist the FFE with conducting resource-intensive consumer assistance activities such as data matching issues or special enrollment period verifications, and exploring branding opportunities for SBE-FPs to make their role more visible, including potential State-specific landing pages on HealthCare.gov. We seek comment on these options, as well as other activities that SBE-FPs could undertake that would strengthen and enhance the SBE-FP model.

b. Election to operate an Exchange after 2014 (§155.106)

Section 155.106 describes the process for a State electing to operate an SBE, for a State terminating its SBE and transitioning to an FFE, and for a State seeking to operate an SBE-FP.

This section applies to both individual market and SHOP Exchanges. Currently, under §155.106(c), as finalized in the 2017 Payment Notice, States can elect to operate an individual market SBE-FP, an SBE-FP for SHOP, or both. If a State operates an SBE-FP for SHOP, the SBE-FP utilizes the Federal platform for enrollment, eligibility, and premium aggregation services.

As discussed more fully in section III.D.7 of this proposed rule, we are proposing changes to required SHOP functionality, effective on the effective date of the final rule, if finalized as proposed, for plan years beginning on or after January 1, 2018, under which qualified employers and employees could enroll in SHOP plans by working with a QHP issuer or SHOP-registered agent or broker. If these proposals are finalized as proposed, many Federal platform services currently available to a State operating an SBE-FP would no longer exist, including employee eligibility, enrollment, and premium aggregation services. Therefore, States operating an SBE-FP for SHOP would no longer be able to utilize the Federal platform for those functions.

If the proposed changes reducing SHOP requirements for SHOP functionality are finalized as proposed, we propose to amend §155.106(c) to remove the option for States to seek approval to operate an SBE-FP for SHOP after the effective date of the final rule. Nonetheless, States that are currently operating an SBE-FP for SHOP, which include Kentucky and Nevada, could maintain their existing SBE-FPs for SHOP, using the Federal platform functionality that would remain if the proposals regarding SHOP functionality are finalized as proposed and subject to the applicable requirements in §155.200(f)(4), which we also have proposed to amend to align with the proposed changes to SHOP functionality requirements. Issuers in these SBE-FPs for SHOP would continue to be subject to §156.350, which we have also proposed to amend

to align with the proposed changes to SHOP functionality requirements. For those issuers that offer SHOP QHPs in SBE-FPs for SHOP beginning on or after January 1, 2018, the expected burden (as well as expected reduction in burden) should be similar to that of issuers in the FF-SHOPs.

We seek comment on all aspects of this proposal.

c. **Additional required benefits (§155.170)**

Section 1311(d)(3)(B) of the PPACA permits a State, at its option, to require QHPs to cover benefits in addition to the EHB, 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 previous rulemaking, we directed States to identify additional State-required benefits that are subject to defrayal and provided direction on how States must calculate the cost of those benefits.³⁵

At §156.111 of this proposed rule, we make a number of proposals related to State changes to EHB-benchmark plans beginning for the 2019 plan year. In light of those proposals, we are affirming that we are not proposing any changes to the policies governing State-required benefits at §155.170. Under any of the proposed methods for a State to select a new EHB-benchmark plan, benefits mandated by State action prior to or on December 31, 2011 could be considered EHB according to the continuing policy described above and would not require State defrayal. However, State-required benefits mandated by State action taking place after December

³⁵ See the EHB Rule, available at <https://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf>. Also see the 2016 Payment Notice Final Rule, available at <https://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf> and the 2017 Payment Notice Final Rule, available at <https://www.gpo.gov/fdsys/pkg/FR-2016-03-08/pdf/2016-04439.pdf>.

31, 2011, other than for purposes of compliance with Federal requirements, would continue to be considered in addition to EHB under this continuing policy even if embedded in the State's newly selected EHB-benchmark plan under the proposals at §156.111, and their costs would accordingly be required to be defrayed by the State. Therefore, whether a State mandate could be considered EHB is dependent on when the State enacted the mandate.

As discussed more in the preamble for §156.111, we propose that §155.170 would continue to apply in the same manner as it currently applies to §156.110 and that the proposed §156.111, which offers States the flexibility to select a new EHB-benchmark plan, would not remove the obligations required under the proposed §156.111(a)(3) with regard to maximum allowed generosity for a State's EHB-benchmark plan. For further discussion of how the State mandate policy at §155.170 would apply to EHB under the proposals at §156.111 supplying States with options to select a new EHB-benchmark plan for plan years beginning in 2019 and later, see the preamble to §156.111.

We solicit comments regarding State mandates and our proposal to apply §155.170 in the same manner as it currently applies to §156.110 to the options proposed at §156.111, which would allow States to select new EHB-benchmark plans. Specifically, we are interested in comments on different applications of the State mandate policy to the proposed policy for EHB-benchmark plan selections at §156.111 that would increase State flexibility, while also being cost effective for States, consumers, and the Federal government, such as allowing States the flexibility to update benefits mandated by State action prior to or on December 31, 2011, that are considered EHB if the State can prove that the update to the State mandate is budget neutral.

3. General Functions of an Exchange
 - a. Functions of an Exchange (§155.200)

The 2017 Payment Notice finalized requirements at §155.200(f)(2) for SBE-FPs to establish and oversee certain requirements for their QHPs and QHP issuers that are no less strict than the requirements that apply to QHPs and QHP issuers on an FFE. Due to the operational complexities in implementing these requirements from both the State and Federal perspective, and to promote the goal of returning regulatory authority over the insurance markets to States, we propose to eliminate requirements for SBE-FPs to enforce FFE standards for network adequacy at §155.200(f)(2)(ii) and essential community providers at §155.200(f)(2)(iii). Instead, we propose that the SBE-FPs, like other SBEs, would have the flexibility to determine how to implement the network adequacy and essential community provider standards with which issuers offering QHPs through the SBE-FP must comply. We believe SBE-FPs are best positioned to determine these standards for the QHP certification process in their States, and that the removal of the requirement that SBE-FPs establish and oversee requirements for their issuers that are no less strict than the manner in which these regulatory requirements are applied to FFE issuers would streamline certain aspects of the QHP certification process, and return traditional insurance market regulatory authority to the States. Additionally, HHS is proposing elsewhere in this proposed rule that, for 2019 plan years and later, the FFEs would rely on State reviews of network adequacy standards where the States have been determined to have an adequate review process. Accordingly, we believe similar deference should be granted to States with SBE-FPs. We believe these changes would further empower SBE-FPs to use their QHP certification authority to encourage issuers to stay in the Exchange, enter the Exchange for the first time, or expand into additional service areas.

We also are proposing to remove the requirement at §155.200(f)(2)(iv) that QHP issuers in SBE-FPs comply with the Federal meaningful difference standard to reflect the proposal to remove §156.298 described elsewhere in this rule.

Section 155.200(f)(4) describes requirements for States that operate an SBE-FP for SHOP. As discussed above, although we are proposing that States can no longer elect to operate SBE-FPs for SHOP after the effective date of the final rule, if finalized as proposed, Kentucky and Nevada are already approved to operate SBE-FPs for SHOP, and thus the requirements in §155.200(f)(4) could remain relevant for those SBE-FPs for SHOP. We therefore propose to amend §155.200(f)(4) to reflect the proposed amendments (described in section III.D.7 of this proposed rule) under which the functionality of the FF-SHOPs' platform would be reduced for plan years beginning on or after January 1, 2018. Specifically, we propose to amend the introductory text to §155.200(f)(4) to describe the requirement applicable, effective on the effective date of the final rule, if finalized as proposed, for plan years beginning on January 1, 2018 and beyond, and to make the requirements in paragraphs (f)(4)(i) through (vii), effective on the effective date of the final rule, if finalized as proposed, applicable for only plan years beginning prior to January 1, 2018.

Specifically we propose that the requirements in (f)(4)(i) and (iv), which require SBE-FPs for SHOP to align their premium payment and employer contribution calculation methodologies with those used by the Federal platform, would not apply for plan years beginning on or after January 1, 2018, effective on the effective date of the final rule, if finalized as proposed. Because under our proposed amendments to §155.705 and proposed introduction of §155.706, for plan years beginning on or after January 1, 2018, the Federal platform for SHOP would no longer calculate premium rates or employer contributions, and would no longer

aggregate premium payments (as of the effective date of the final rule, if finalized as proposed), there would be no further need for such alignment for plan years beginning on or after January 1, 2018.

Because under our proposed approach the Federal platform would continue to include plan display with premium amounts, we do not propose changes to the requirement that States operating an SBE-FP must require its QHP issuers to make any changes to rates in accordance with the timeline applicable in a Federally-facilitated SHOP under current §155.705(b)(6)(i)(A), which regulation is mirrored in our proposed introduction of §155.706(b)(6)(i)(A). However, we propose to specify that this requirement applies in the introductory text to (f)(4), to reflect the proposed change to make the requirements in (f)(4)(i) through (vii) applicable for only plan years beginning prior to January 1, 2018, effective on the effective date of the final rule, if finalized as proposed.

Additionally, because under our proposed approach, for plan years beginning on or after January 1, 2018, the Federal platform would, effective on the effective date of the final rule, if finalized as proposed, no longer calculate whether a qualified employer has met the applicable minimum participation rate, there would no longer be any need for States operating an SBE-FP for SHOP to align their minimum participation rate requirements and calculation methodologies with those applicable in the FF-SHOPs for plan years beginning on or after January 1, 2018. We therefore propose that this requirement would only apply for plan years beginning prior to January 1, 2018, effective on the effective date of the final rule, if finalized as proposed.

To align with our proposed amendments at §155.725 and proposed new section §155.726, under which the FF-SHOPs, effective on the effective date of the final rule, if finalized as proposed, for plan years beginning on or after January 1, 2018, would no longer

establish annual employee open enrollment periods, or establish effective dates of coverage for an initial group enrollment or group renewal, we also propose that the requirements in §155.200(f)(4)(v) and (vi) would only apply for plan years beginning prior to January 1, 2018, effective on the effective date of the final rule, if finalized as proposed. Finally, to align with our proposed amendments at §155.735, under which the FF-SHOP, effective on the effective date of the final rule, if finalized as proposed, for plan years beginning on or after January 1, 2018, would no longer determine the timing, form, and manner in which coverage or enrollment in a SHOP QHP may be terminated, we propose that the requirement in §155.200(f)(4)(vii) would only apply for plan years beginning prior to January 1, 2018, effective on the effective date of the final rule, if finalized as proposed.

We seek comment on these proposals.

b. **Navigator program standards (§155.210)**

Each Exchange is required under section 1311(d)(4)(K) and 1311(i) of the PPACA to establish a Navigator program under which it awards grants to entities that, among other things: conduct public education activities to raise awareness of the availability of QHPs, distribute fair and impartial information concerning enrollment in QHPs and the availability of premium tax credits and CSRs, and facilitate enrollment in QHPs. Under section 1311(i)(2)(B) of the PPACA, these entities may include trade, industry, and professional associations; commercial fishing industry organizations; ranching and farming organizations; community and consumer-focused nonprofit groups; chambers of commerce; unions; resource partners of the Small Business Administration; other licensed insurance agents and brokers; and other entities that meet the statutory requirements at section 1311(i)(3), (4), and (5) of the PPACA.

Currently, §155.210(c)(2) specifies that each Exchange must include among its Navigator grantees both a community and consumer-focused nonprofit group and at least one other entity that is from one of the other categories listed at §155.210(c)(2), including other public or private entities or individuals that meet the requirements of §155.210. Section 155.210(c)(2)(viii) specifies that these other entities may include Indian tribes, tribal organizations, urban Indian organizations, and State or local human service agencies.

To maximize the flexibility and efficiency of the Navigator program, we propose to amend §155.210(c)(2) to remove the requirements that each Exchange must have at least two Navigator entities and that one of these entities must be a community and consumer-focused nonprofit group. We believe removing these requirements would provide Exchanges with improved flexibility to award funding to the number and type of entities that would be most effective for the specific Exchanges. Eliminating the requirement to have at least two Navigator entities would allow each Exchange to optimally use the funding amounts available, which may include selecting a single, high performing grantee in an Exchange.

The requirement that one Navigator grantee in each Exchange must be a community and consumer-focused nonprofit group may unnecessarily limit an Exchange's ability to award grants to the strongest applicants. Additionally, if we finalize our proposal to permit an Exchange to have only one Navigator grantee but retain the requirement regarding community and consumer-focused nonprofit groups, this requirement could effectively exclude any other type of statutorily eligible entities from becoming Navigators. Eliminating this requirement would provide Exchanges with the flexibility to target grants to the highest scoring and performing entities, regardless of organization type.

Removing these requirements at §155.210(c)(2) would also promote Exchange flexibility and autonomy to structure Navigator programs tailored to each Exchange. An Exchange could award a grant to a single Navigator entity from any of the permitted types. Alternatively, Exchanges could elect to continue awarding two or more grants, as they have been doing thus far, and include a community and consumer-focused nonprofit group among those grantees.

Section 155.210(e)(7) requires each Navigator entity to maintain a physical presence in the Exchange service area, so that face-to-face assistance can be provided to applicants and enrollees. We propose to remove this requirement to provide more flexibility to each Exchange to structure its Navigator program to best serve the Exchange service area. Under section 1311(i)(2)(A) of the PPACA and §155.210(c)(1)(ii), entities seeking to become Navigator grantees must demonstrate to the Exchange that they have existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be eligible for enrollment in a QHP. Consistent with those provisions, Navigator grant applicants in the FFEs are scored on their ability to make this demonstration. Based on HHS's experience with Navigator programs in FFEs and other public programs, we believe entities with a physical presence and strong relationships in their FFE service areas tend to deliver the most effective outreach and enrollment results. However, we believe that each Exchange is best suited to determining the weight to give a physical presence in the Exchange service area when selecting Navigator entities, as long as the Exchange's Navigator grantee selection process is consistent with section 1311(i)(2)(A) of PPACA and §155.210(c)(1)(ii).

These proposals are intended to maximize flexibility for each Exchange in awarding Navigator grants. We seek comment on statutorily acceptable alternative types of entities that

could serve as Navigators and possible new ways in which Navigators could carry out their duties.

For reasons similar to those motivating our proposed changes to §155.210(e)(7), as well as to promote consistency across programs, we propose to remove the corresponding requirement at §155.215(h) that requires maintenance of a physical presence in the Exchange service area by all non-Navigator entities subject to §155.215.

In addition to the requirement to maintain a physical presence in the Exchange service area, §§155.210(e)(7) and 155.215(h) currently provide that, in an FFE, no individual or entity is ineligible to operate as a Navigator or non-Navigator assistance personnel solely because its principal place of business is outside of the Exchange service area. We note that there is also a corresponding provision applicable to certified application counselors and certified application counselor organizations at §155.225(b)(3). We are not proposing changes to these provisions. We codified these provisions due to concerns about non-Federal requirements that these types of assisters maintain their principal place of business in the State (79 FR 30273-30274), and we continue to have these concerns.

We solicit comments on all aspects of these proposals.

c. 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 (§155.215)

For a discussion of the provisions of this proposed rule related to standards applicable to non-Navigator Assistance Personnel subject to §155.215, please see the preamble to §155.210.

d. Standards for third-party entities to perform audits of agents, brokers, and issuers

participating in direct enrollment (§155.221)

In the 2018 Payment Notice, we implemented an approach for an HHS-approved third party to conduct onboarding operational readiness reviews and audits authorized by §155.220(c)(5), specific to use of the direct enrollment pathway by agents and brokers registered with the FFEs. HHS proposes new standards in this rule to replace the standards set forth in the 2018 Payment Notice for §155.221. HHS also proposes to expand the applicability of this section to require issuers, in addition to agents and brokers, participating in direct enrollment to engage third-party entities to conduct the required operational readiness reviews. We propose a conforming edit to §156.1230(b)(2) to reflect this proposal.

HHS is proposing to implement an approach wherein agents, brokers, and issuers that participate in direct enrollment and use their own Internet Web site for QHP selection or to complete the Exchange eligibility application would select their own third-party entities for conducting audits, rather than requiring HHS to initially review and approve these entities. HHS anticipates this approach would reduce the regulatory burden on agents, brokers, and issuers by allowing the opportunity to choose an auditor or use an existing auditor. In addition, HHS anticipates that agents, brokers, and issuers already conduct audits for compliance with HHS requirements, and implementing this program would reduce duplicative HHS oversight. This approach would also reduce the burden on third-party entity reviewers, as the entities would no longer need to apply for HHS-approval to perform operational readiness reviews. HHS believes this approach would expand the available number of qualified third-party entities to perform the audits, thereby enabling more agents, brokers and issuers to demonstrate operational readiness to participate in direct enrollment. We believe this would expand consumer access to direct enrollment pathways for enrolling in Exchange coverage. The proposed approach would also

reduce the burdens on HHS by no longer requiring the establishment of a Federal application, approval and appeals process for these entities to conduct operational readiness reviews. HHS anticipates this approach would allow more flexibility for private entities to respond to potential changes and HHS requirements as HHS considers future enhancements to the direct enrollment pathway. Under this proposal, agents, brokers and issuers must select an auditor who meets the requirements described in the proposed amendments to §155.221(b), such as privacy and security experience, to perform a review to demonstrate operational readiness as required under §155.220(c)(3)(i)(K) and §156.1230(b)(2).

We propose to replace §155.221(a) with a new paragraph to require agents, brokers, and issuers to select a third-party entity that meets the proposed standard outlined in the new §155.221(b), described below, to perform these operational readiness reviews, instead of restricting the availability to third-party entities that have been pre-approved by HHS. Specifically, §155.221(a) would require that the agent, broker, or issuer engage a third-party entity that meets the standards outlined in the new §155.221(b) to conduct an annual operational readiness review prior to participating in direct enrollment. Consistent with §155.220(c)(3)(i)(K) and §156.1230(b)(2), the operational readiness review would be performed using the third parties' own audit processes and methods subject to HHS-defined specifications and requirements. The third-party entity's review would verify compliance by the agent, broker, or issuer with the applicable requirements in §§155.220, 155.260, 156.265, and 156.1230, and would need to be completed prior to the use of the agent, broker or issuer Internet Web site for submission of an Exchange application or completion of QHP selection. HHS would publish technical guidance outlining the review standards and other operational details, as well as provide other resources to assist the third-party entities in conducting the reviews at a later date.

The new proposed paragraph (a) also provides that the third-party entity would be a downstream or delegated entity of the agent, broker or issuer that participates or wishes to participate in direct enrollment. Therefore, these third-party entities would be subject to HHS oversight as delegated or downstream entities of an agent, broker, or issuer, and the agent, broker, or issuer would remain responsible for compliance with all applicable direct enrollment requirements.

HHS proposes revising §155.221(b) to modify the standards that third-party entities must satisfy to perform the reviews to demonstrate operational readiness under §155.220(c)(3)(i)(K) and §156.1230(b)(2). HHS proposes replacing the introductory language at §155.221(b) with new language to align with the new proposed approach where the agent, broker, or issuer selects the third-party entity to perform the audit under paragraph (a) and remove the requirement for approval of these entities by HHS. New §155.221(b)(1) would remove the requirement that an entity must submit its application to HHS; instead we propose to require the entity to have experience conducting audits or similar services, including specific experience with relevant privacy and security standards due to the operational requirements of the current direct enrollment processes and any potential future enhancements. This would include demonstrated experience with current National Institute of Standards and Technology (NIST) SP 800-53 or the HIPAA Security Rule standards, and the review of compliance with those standards. Auditors must also be capable of performing penetration testing on all interfaces that collect personally identified information or connect with HHS. We propose modifying §155.221(b)(2) to include issuers participating in direct enrollment and to expand the scope of the audit to also include review of compliance with other applicable program requirements (for example, Web site design, or consumer disclosures). We propose to modify §155.221(b)(3) to require the auditor to collect, store, and share with HHS all data related to its audits of agents, brokers, and issuers under

paragraph (a) in a manner, format, and frequency specified by HHS until 10 years from the date of creation. The proposed amendments to paragraph (b)(3) also require the auditor to comply with the privacy and security standards HHS adopts for agents, brokers, and issuers as required in accordance with §155.260.

Further, HHS proposes adding new paragraph (b)(4) to implement a conflict of interest standard that requires disclosure of financial relationships between a third-party entity conducting a direct enrollment operational readiness review and the agent, broker, or issuer. We also propose to add §155.221(b)(5) to require compliance by the third-party entity with all applicable Federal and State requirements, and to add §155.221(b)(6) to require the third-party entity to ensure, on an annual basis, that appropriate staff successfully complete operational readiness review training as established by HHS prior to conducting audits under paragraph (a) of this section. The training would provide information about compliance, direct enrollment technical requirements, applicable privacy and security standards, and reporting requirements.

Under proposed §155.221(b)(7), a third-party entity would be required to permit access by the Secretary and the Office of the Inspector General (OIG), or their designees, in connection with their right to evaluate through audit, inspection, or other means, to the third-party entity's books, contracts, computers, or other electronic systems, relating to the third-party entity's audits of agents, broker's, or issuer's obligations in accordance with Federal standards under paragraph (a) of this section until 10 years from the date of creation. This is intended to align with the existing obligation on QHP issuer downstream and delegated entity requirements under §156.340(b) to cooperate with HHS and OIG audits, investigations, or other reviews. Proposed new paragraph (b)(8) would require compliance with other minimum business criteria specified in guidance by HHS.

To provide agents, brokers, and issuers with flexibility, HHS proposes replacing §155.221(c) with a new paragraph to permit an agent, broker, or issuer participating in direct enrollment to engage multiple third-party entities to perform the audits under paragraph (a) and to clarify that each such third-party entity will need to separately comply with the standards proposed under paragraph (b).

HHS proposes deleting paragraphs §155.221(d) (regarding a list of HHS-approved entities) and (e) (regarding an appeals process for entities that were not approved) to conform to the other proposed changes in this section.

We solicit comments on these proposals, and general feedback on the direct enrollment process to inform the development of future direct enrollment operational and oversight standards, including improvements to the pathway to further expand access to coverage.

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

a. Eligibility standards (§155.305)

Section §155.305(f)(4)(i) prohibits an Exchange from determining a consumer is eligible for APTC if APTC payments were made on behalf of the tax filer for the consumer's household (or either spouse, if the tax filer is married) for a previous year for which tax data would be utilized for verification of household income and family size, and the tax filer or his or her spouse did not comply with the requirement to file an income tax return and reconcile APTC received for that year. Under the current regulation at paragraph (f)(4)(ii), Exchanges cannot discontinue APTC due to the failure to file and reconcile associated APTC unless direct notification is first sent to the tax filer that his or her eligibility will be discontinued as a result of

the tax filer's failure to comply with the requirement specified under paragraph (f)(4)(i) of §155.305.

We propose to amend §155.305(f)(4) by removing the direct notification requirement in paragraph (f)(4)(ii) and revising the remaining paragraph (f)(4) to move the content in paragraph (f)(4)(i) into paragraph (f)(4).

Upon further examination, we have determined that notification practices in place prior to adoption of the direct notification requirement provide sufficient clarity for consumers prior to action being taken to discontinue APTC. Specifically, these practices were to discontinue APTC by notifying the household contact that his or her eligibility will be discontinued as a result of the tax filer's failure to comply with the filing and reconciliation requirement.

In past years, the FFEs have sent notifications to the household contact based on notification preference—electronically or at the address specified when he or she submitted the application. Because of the restrictions on disclosing Federal tax information (FTI), these notices cited three possible reasons why a consumer may be at risk for losing APTC, one of which is failure to file and reconcile. In our experience operating the FFEs and the Federal eligibility and enrollment platform, the household contact may often be the same person as the tax filer on whose behalf APTC is paid; accordingly, since FFE notices have been sent to the household contact, we believe the notifications have been addressed, in many cases, to the person who is the tax filer for the household. In cases where the household contact has not been the tax filer, because the notification has been clear that it concerns eligibility for APTC, we expect that the household contact likely has shared the notice with the tax filer on whose behalf APTC was paid. As evidence that tax filers generally have received notification directly regarding their receipt of APTC and information that they have not satisfied the requirement to file and reconcile, this

notification method has successfully resulted in tax filers for approximately 60 percent of households receiving the notification taking appropriate action to file a tax return and reconcile associated APTC. However, because tax filers for approximately 40 percent of households receiving the notification did not take appropriate action, HHS believes it is important for program integrity purposes that Exchanges discontinue APTC for tax filers who failed to file a tax return and reconcile after the notice was provided. If the Exchange discontinues APTC in connection with the requirement under paragraph §155.305(f)(4), the enrollee would have the right to appeal the discontinuation of APTC and maintain APTC during the appeal. Therefore, we propose to remove the direct notification requirement in §155.305(f)(4)(ii).

We also believe this change could reduce burden on Exchanges. Absent this proposed change, in order to discontinue APTC for consumers who failed to file a tax return and reconcile their income taxes, Exchanges would be required to establish a mechanism through which to notify tax filers without making an unauthorized disclosure of protected FTI. Doing so could be financially and operationally burdensome and out of proportion to the limited need for FTI handling in Exchange notice generation functionality.

As discussed above, we believe that removing the direct notification requirement will reduce the burden on Exchanges, while tax filers and households that have been identified as not meeting the requirement to file and reconcile will continue to receive adequate notice under the approach that Exchanges using the federal eligibility and enrollment platform have taken in past years. However, improving the clarity and overall effectiveness of this notification process is a priority, and we continue to explore ways to make the process even more robust and consumer-friendly, without unduly burdening the Exchanges. We may issue additional information about

our notification process in the future as an aid to SBEs seeking to implement a more robust process.

We seek comment on this proposal.

- b. Verification process related to eligibility for insurance affordability programs (§155.320)
- i. Income inconsistencies

Section §155.320(c)(3)(iii) sets forth the verification process for increases in household income. Generally, if income data from our electronic data sources indicate a tax filer's attested projected annual income is more than the income amount represented by income data returned by the IRS and the SSA and current income data sources, §155.320(c)(3)(iii) requires the Exchange to accept the attestation without further verification. Currently, Exchanges generally are not permitted to create inconsistencies for consumers when the consumer's attested income is greater than the amount represented by income data returned by IRS and the SSA and current income data sources.

We propose to revise §155.320(c)(3)(iii) to specify that the Exchange will also generate annual income inconsistencies in certain circumstances when a tax filer's attested projected annual income is greater than the income amount represented by income data returned by IRS and the SSA and current income data sources. Current regulations generally require the Exchange to accept a consumer's attestation to projected annual household income when the attestation reflects a higher income than what is indicated in data from the IRS and Social Security Administration. This approach continues to make sense from a program integrity perspective when both the attestation and data from trusted data sources are over 100 percent Federal poverty level (FPL), since an attestation that is higher than data from trusted data sources

in that situation would reflect a lower APTC than would be provided if the information from trusted data were used instead.

However, where electronic data sources reflect income under 100 percent FPL and a consumer attests to income between 100 percent FPL and 400 percent FPL, where the attested income exceeds the income reflected in trusted data sources by more than some reasonable threshold, we believe it would be reasonable to request additional documentation, since the consumer's attested income could make him or her eligible for APTC that would not be available using income data from electronic data sources. This proposal also would help limit tax filers' potential liability at tax reconciliation to repay excess APTC. Accordingly, we propose to add new paragraphs (c)(3)(iii)(D) and (E), and to modify paragraphs (c)(3)(vi)(C), (D), (F), and (G), to specify that the Exchange will follow the procedures in §155.315(f)(1) through (4) to create an annual income data matching issue for consumers if: (1) the consumer attested to projected annual income between 100 percent and 400 percent of the FPL; (2) the Exchange has data from IRS and SSA that indicates income is below 100 percent FPL; (3) the Exchange has not assessed or determined the consumer to have income within the Medicaid or CHIP eligibility standard; and (4) the consumer's attested projected annual income exceeds the income reflected in the data available from electronic data sources by a reasonable threshold established by the Exchange and approved by HHS. We propose that a reasonable threshold must not be less than 10 percent, and can also include a threshold dollar amount. In accordance with the existing process in §155.315(f)(1) through (4), if the applicant fails to provide documentation verifying their income attestation, the Exchange would redetermine the applicant's eligibility for APTC and CSRs based on available IRS and SSA data, which under this proposal would typically result in discontinuing APTC and CSR as required in paragraph (c)(3)(vi)(G). The adjustment and

notification process would work like other inconsistency adjustments laid out in paragraph (c)(3)(vi)(F).

We propose to allow the Exchange to set the threshold for setting a data matching issue similar to §155.320(c)(3)(vi). We propose that a reasonable threshold should take into account that consumers with incomes near 100 percent FPL have a smaller margin for error in dollar terms. Therefore, a reasonable threshold might also include a fixed dollar amount in addition to a percentage threshold. We seek comment on this proposal.

In paragraph (c)(3)(vi)(D) we propose to make changes to provide consistency with changes finalized in the 2017 Payment Notice regarding the threshold for the generation of annual income data matching issues for decreases in annual household income. This proposed change would specify that the 10 percent threshold standard no longer applies to cases when a tax filer's attested projected income is less than all data sources, or when no electronic data sources are available. Instead, an Exchange would use the reasonable threshold established in accordance with §155.320(c)(3)(vi).

We note, however, our interest in providing further guidance on the appropriate thresholds for the generation of data matching issues generally. It is our intent to reconsider and provide further guidance on these thresholds in the near future, and in anticipation of that effort we seek comment on the appropriate thresholds to use at various income levels and in various circumstances. In particular, we welcome data and evidence on this issue.

We intend to address this issue as part of broader rulemaking and guidance on a number of related program integrity issues, including further examination of our processes for denying eligibility for subsidies for individuals who have failed to reconcile APTC on their Federal income tax return, Exchange processes for matching enrollment data with Medicare and

Medicaid in order to remove duplicate enrollments, and our rules around recalculation of eligibility for APTC following a midyear change in eligibility. In anticipation of these actions, we seek comment generally on these and other program integrity topics.

ii. Verification of eligibility for employer sponsored coverage.

An employee, or a member of the employee's family, who is eligible to enroll in qualifying coverage in an eligible employer-sponsored plan is not eligible for a premium tax credit unless the plan's coverage for the employee is either unaffordable, as defined in section 36B(c)(2)(C)(i)(II) of the Code, or does not provide minimum value, as defined in section 36B(c)(2)(C)(ii) of the Code. An employee (or member of the employee's family) also is not eligible if he or she actually enrolls in the employer-sponsored plan, even if the plan is not affordable or fails to provide minimum value.

When an individual submits a request for an eligibility determination for insurance affordability programs, including as part of the eligibility verification process for APTC and CSRs, §155.320(d) requires the Exchange to verify whether the applicant reasonably expects to be 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. Paragraph (d)(2) of §155.320 describes the data sources an Exchange must use to perform verification. Paragraph (d)(2)(i) requires an Exchange to obtain data from any electronic data sources that are available to the Exchange and which have been approved by HHS based on evidence showing that such data sources are sufficiently current, accurate, and minimize administrative burden. Paragraph (d)(2)(ii) requires that the Exchange also obtain available data based on Federal employment through HHS, and paragraph (d)(2)(iii) requires the Exchange to obtain available

data from the SHOP that corresponds to the State in which the Exchange is operating. Under §155.320(d)(4), if an Exchange is unable to fulfill the requirement to connect to the data sources set forth in (d)(2), the Exchange is required to conduct sampling as described under paragraph (d)(4)(i), or—for benefit years 2016 and 2017—it may conduct an HHS-approved alternative process instead of sampling, as provided under paragraph (d)(4)(ii).

We propose to amend §155.320(d)(4) to allow an Exchange to conduct an HHS-approved alternative process instead of sampling, as provided under paragraph (d)(4)(ii), for benefit years through 2019. When we introduced this option for benefit years 2016 and 2017, we received comments that encouraged us to make this option permanent. However, at the time we stated that we believed the alternative process should be used as an interim measure to gather information about the verification process as Exchanges improve their long-term verification programs.³⁶ We also stated that we believed the temporary option would provide Exchanges with needed flexibility as verification processes are refined and employer databases compiled, to improve long-term verification programs. While Exchanges have since gained greater access to data and explored approaches to sampling, challenges remain. To reduce regulatory burdens on Exchanges while they address remaining hurdles to developing a long-term approach to verification, we believe the option to use an alternative process instead of sampling should be extended through plan year 2019.

After the option to use an alternate process for benefit years 2016 or 2017 was finalized, HHS investigated the feasibility of connecting to a comprehensive database of information on employer-sponsored coverage that could be used by all Exchanges to fulfill verification

³⁶ 81 FR 12203, 12269 (March 8, 2016).

requirements under §155.320(d)(2)(i). Such a database would be most useful and cost-effective if it contained information on employer-sponsored coverage from as many non-Federal and non-SHOP employers as possible. We found that a comprehensive database does not currently exist and building such a database would be a resource-intensive endeavor. In addition, employers are not required to provide information to Exchanges or HHS regarding the coverage they offer, potentially limiting the completeness of such a database.

Because of the current challenges associated with building an HHS-approved database that is sufficiently complete and accurate to satisfy requirements under paragraph (d)(2)(i), we anticipate many Exchanges will fulfill verification requirements using an alternate process, as described under paragraph (d)(4). And, in recognition of the challenges that Exchanges may encounter with conducting sampling, as explained below, we propose to extend the option for Exchanges to conduct an alternative process to sampling through benefit year 2019. Our hope is that Exchanges can continue to compile databases sufficient to meet verification requirements under paragraph (d)(2) and to continue to refine their approaches to sampling to meet verification requirements under paragraph (d)(4)(i).

In accordance with the requirement at paragraph (d)(4) to pursue an alternate process, the FFE conducted a pilot study that incorporated many components of sampling. The pilot was intended to assess sampling's value protecting the integrity of the attestation process regarding applicant access to and enrollment in employer-sponsored coverage. As part of this sampling pilot, employers for a small sample of enrollees receiving APTC through the FFE were contacted by telephone, based on the employer contact information applicants provided on their Exchange applications, and asked whether specified employees were also enrolled in a qualifying

employer-sponsored plan or were offered qualifying coverage in an employer-sponsored plan. The FFE collected information by contacting employers' human resources personnel.

Sampling may be a lower cost option for SBEs compared to FFEs. For example, the FFE operates Exchanges for 38 States, and the volume of employers that the FFE encompasses may inherently present challenges in relying on sampling results that States may not face. Some states may collect and have access to data from employers that makes verifying consumers' attestations more efficient and reliable, or may have existing channels through which they can communicate with in-State employers. Therefore, we are maintaining the option to use sampling as an alternate method of verification under paragraph (d)(4) to allow SBEs maximum flexibility. We expect that the proposed change to paragraph (d)(4) to allow Exchanges to continue to use an HHS-approved alternative process to sampling through plan year 2019 will provide Exchanges with important flexibility to conduct the most efficient, reliable alternate method of verification as Exchanges refine their approaches to conducting sampling over time, and until data sources exist that provide an effective way to verify consumers' enrollment in or access to qualifying employer-sponsored coverage. If SBEs use an alternative process to sampling to conduct verification under paragraph (d)(4)(ii), the process must be approved by HHS. To be approved by HHS, we expect an Exchange to develop an alternate process that provides insight into whether employees provide accurate information or the Exchange effectively verifies information about enrollment in and eligibility for qualifying coverage in an eligible employer-sponsored plan.³⁷ This requires Exchanges to conduct reliable and sufficient verification, while giving them the flexibility to find the most efficient ways of doing so for their Exchange.

³⁷ 81 FR 94058, 94125 (December 22, 2016).

We note that to the extent an Exchange believes an alternate process to verification through data sources other than those described under paragraph (d)(2) may result in a more efficient or comprehensive verification procedure, the Exchange may also, in accordance with §§155.315(h) and 155.320(a)(2), request HHS approval for use of an alternate process for verifying enrollment in and access to employer sponsored coverage. We note that HHS received support for providing flexibility for the use of alternate data sources by Exchanges in comments to the Request for Information. For example, we received comments indicating that, for some Exchanges, due to the limited number of Federal employees in their State, connecting to the database containing data on Federal employment provides little utility in Exchange verification of applicants' eligibility for employer-sponsored coverage. One commenter encouraged HHS to consider removing the regulatory requirement to connect to this database for purposes of employer-sponsored coverage verification. We have also received feedback from some Exchanges noting challenges and limitations connecting to a SHOP database. These Exchanges noted that, given the limited enrollment in SHOP in many States and that many States do not have a SHOP database to which to connect, requiring verification through SHOP imposes a technical and financial challenge for States that may not be the most efficient and cost-effective way to perform verification.

We seek comment on these proposals. Additionally, we seek information and suggestions from State-based Exchanges and other stakeholders on ways to improve verification of whether an applicant reasonably expects to be 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.

c. Eligibility redetermination during a benefit year (§155.330)

We seek comment on ways to better encourage enrollees to report changes in circumstance during the benefit year that may have an impact on their eligibility for Exchange coverage or for advance payment of the premium tax credit or cost sharing reductions. The FFEs currently conduct proactive outreach to enrollees through a variety of means, including emails, phone calls, and paper mail to encourage them to return to the Exchange to update their information throughout the benefit year and during key Exchange operational efforts, such as open enrollment. The FFEs also periodically provide general information and reminders to enrollees. However, many individual changes in circumstance, such as an individual's changes in household income or size, remain unknown by the Exchanges until reported by the enrollee and, such changes may have a significant impact on the enrollee's eligibility for QHP coverage through the Exchange and for financial assistance.

Therefore, we are interested in hearing from stakeholders about ways to increase enrollee reporting of individual changes in circumstance within 30 days of the change in order to ensure compliance with §155.330(b). Increasing such reporting would benefit enrollees by ensuring that they continue to be enrolled given their current eligibility for financial assistance and would improve program integrity.

d. Annual eligibility redetermination (§155.335)

We are considering the possibility of amending the length of time that individuals may authorize the Exchanges to obtain the updated tax return information for enrollees as described in §155.335(k)(2). Currently, the Exchanges may obtain updated tax return information for a period of no more than five years based on a single authorization.

We seek comment on whether five years is an appropriate amount of time for this type of an authorization to last or whether a shorter time period should be considered. In particular, we

are contemplating whether shortening this authorization period would improve Exchange program integrity by helping to ensure that the enrollee's application at the time of re-enrollment accurately reflects his or her data collection preferences, that all sources of income that may impact his or her eligibility for APTC and cost sharing reductions are listed on the application, and that individuals update their applications on a more regular basis to reflect other changes in circumstances that affect eligibility (such as changes in employment or marital status).

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

a. Special enrollment periods (§155.420)

i. Plan options under select special enrollment periods

For many special enrollment periods, a dependent of an Exchange enrollee may newly enroll in Exchange coverage or switch Exchange plans when the dependent or another qualified individual on the Exchange application qualifies for a special enrollment period. Even though dependents may access special enrollment periods based on different qualifying events, when they qualify for a special enrollment period to newly enroll in Exchange coverage, regardless of whether it is a special enrollment period due to gaining or becoming a dependent or due to a loss of minimum essential coverage, we believe they should be treated alike. Section 155.420(a)(4) defines the coverage changes Exchange enrollees may make when they or their dependents qualify for special enrollment periods. We are proposing to modify how paragraph (a)(4)(iii) treats dependents to align more closely with paragraph (a)(4)(i) which addresses when an existing enrollee gains a new dependent. To do this, we propose to modify paragraph (a)(4)(iii) to establish a distinction between how the rule treats existing enrollees who qualify for one of the relevant special enrollment periods themselves or when existing Exchange enrollees themselves and their dependent(s) qualify for one of the relevant special enrollment periods; and when only

new dependents qualify for one of the relevant special enrollment periods and are enrolling in coverage with an existing Exchange enrollee. We propose to establish this distinction by separating these situations into new paragraphs (a)(4)(iii)(A) and (a)(4)(iii)(B). We believe the latter situation is akin to when an enrollee adds a new dependent to their coverage, even though in this situation the dependent is qualifying for a different special enrollment period.

Proposed new paragraph (a)(4)(iii)(A) would address the coverage options available to current enrollees and dependents who qualify for a special enrollment period. As is current policy under paragraph (a)(4)(iii), paragraph (a)(4)(iii)(A) would continue to allow enrollees and their dependents who qualify for the special enrollment periods specified in paragraphs (d), other than those described in paragraphs (d)(2)(i), (d)(4), (d)(6)(i) or (ii) for becoming newly eligible for CSRs, (d)(8), (d)(9), and (d)(10) of this section, to use their special enrollment period to change to another QHP within the same level of coverage or one metal level higher or lower, if no such QHP is available, as outlined in §156.140(b) of this subchapter.

Proposed new paragraph (a)(4)(iii)(B) would address the coverage options available when only a dependent who is not currently enrolled in Exchange coverage qualifies for a special enrollment period. We are proposing to revise the policy for these qualified individuals to align with paragraph (a)(4)(i) of this section. We propose that, if a new dependent qualifies for one of the special enrollment periods specified in paragraphs (d)(1), (d)(3), (d)(6)(iii), (d)(6)(iv), (d)(7), (d)(11), and (d)(13) of this section and an enrollee would like to add the dependent to his or her QHP at that time, the Exchange must allow the enrollee to add the dependent to his or her current QHP; or, if the plan's business rules do not allow the dependent to enroll, the Exchange must allow the enrollee and dependent to change to another QHP within the same level of coverage; or, if no such QHP is available, allow them to switch to a QHP one metal level lower or higher,

as outlined in §156.140(b) of this subchapter. Alternatively, the enrollee may enroll the dependent in a separate QHP at any metal level.

We believe that these modifications are needed in order to align the flexibilities available to enrollees and dependents when a dependent is newly enrolling in Exchange coverage during the benefit year due to qualifying for a special enrollment period. With this proposed change, regardless of the special enrollment period for which a dependent qualifies, an enrollee may either add the dependent to his or her existing QHP, as long as they continue to qualify for it, or enroll the new dependent in a separate QHP at any metal level.

In the event that both the enrollee and the new dependent qualify for special enrollment periods referenced in proposed paragraphs (a)(4)(iii)(A) and (a)(4)(iii)(B), respectively, and the enrollee wants to add this new dependent to his or her QHP, the Exchange would allow both the enrollee and dependent to switch to a new QHP at the same metal level, if available, as described in proposed paragraph (a)(4)(iii)(A).

In addition, we propose to exclude the special enrollment period in paragraph (d)(12) for material plan or benefit display errors from paragraph (a)(4)(iii). This is because we understand that certain material plan or benefit display errors may impact an enrollees' decision to enroll in a level of coverage, in addition to his or her decision to enroll in a specific QHP. Therefore, we believe that, if an enrollee qualifies for the special enrollment period because of a material plan or benefit display error, he or she should be allowed to switch to a different QHP at any metal level that better meets his or her needs.

We seek comment on these proposals.

- ii. Exception to prior coverage requirement for qualified individuals who have lived in service areas where no QHP is offered through an Exchange

In response to concerns from stakeholders that certain special enrollment periods intended to help qualified individuals maintain continuous coverage for themselves and their families were being used to newly enroll in coverage mid-year, HHS recently added a prior coverage requirement to the special enrollment period for gaining access to new QHPs as a result of a permanent move, described in §155.420(d)(7), and the special enrollment period for gaining or becoming a dependent through marriage, described in §155.420(d)(2)(i). Section 155.420(a)(5) specifies how a qualified individual can satisfy the prior coverage requirement. Qualified individuals can either demonstrate that they had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of the qualifying event; lived in a foreign country or in a United States territory for 1 or more days during the 60 days preceding the date of the qualifying event; or are an Indian, as defined by section 4 of the Indian Health Care Improvement Act. This prior coverage requirement encourages individuals to maintain coverage throughout the year.

However, we recognize that individuals living in a service area, as defined by §155.1055, where no Exchange QHPs are offered, may not be able to obtain affordable coverage. We believe that individuals in this situation should not later be prevented from enrolling in coverage through a special enrollment period that requires prior coverage, when they were previously unable to enroll in Exchange coverage because it was unavailable or inaccessible. Therefore, we propose to amend paragraph (a)(5) to exempt qualified individuals from the prior coverage requirement if, for at least 1 of the 60 days prior to the date of their qualifying event, they lived in a service area where there were no QHPs offered through an Exchange. Absent this change, qualified individuals who have lived for part of the benefit year in a location where no QHPs were offered through an Exchange, and therefore may have been unable to enroll in minimum

essential coverage, would be prevented from subsequently qualifying for a special enrollment period due to a permanent move or marriage.

Additionally, we note that the proposed amendment to paragraph (a)(5) would apply, along with the rest of the paragraph, to the individual market outside of the Exchange through the cross-reference to §155.420(d) in §147.104(b)(2). In this context, health insurance issuers offering coverage outside an Exchange would not be able to require qualified individuals to demonstrate prior coverage if they lived for at least 1 of the 60 days prior to their qualifying event in a service area where there were no QHPs offered through an Exchange.

We invite comment on this proposal.

iii. Effective date options for special enrollment periods relating to gaining or becoming a dependent

Paragraph (b)(2)(i) of §155.420 requires Exchanges to provide qualified individuals who qualify for a special enrollment period due to gaining or becoming a dependent through birth, adoption, placement for adoption, or placement in foster care with a retroactive coverage effective date back to the date of the qualifying event, and provides Exchanges with the option to allow these consumers to elect an effective date of the first of the month following the date of the event or following regular coverage effective dates, in accordance with paragraph (b)(1) of this section. Paragraph (b)(2)(v) addresses coverage effective date options for special enrollment periods related to gaining or becoming a dependent due to a child support or other court order as described in paragraph (d)(2)(i); it requires Exchanges to ensure that coverage takes effect on the date of the court order and permits the Exchange to allow qualified individuals to elect an effective date based on paragraph (b)(1), but it does not provide qualified individuals with an option to begin their coverage the first of the month following the date of the event.

We propose to remove paragraph (b)(2)(v) of this section and to revise paragraph (b)(2)(i) to include the special enrollment period for a court order to align the coverage effective dates for all special enrollment periods based on gaining or becoming a dependent, with the exception of gaining or becoming a dependent through marriage. Aligning coverage effective date options ensures that Exchanges provide qualified individuals in similar situations with the same flexibility with regard to coverage effective dates. We then propose to redesignate current paragraph (b)(2)(vi) as paragraph (b)(2)(v).

In addition, we propose to modify paragraph (b)(2)(i) so that, in addition to requiring an Exchange to ensure that coverage is effective retroactive to the date of the qualifying event, it may permit the qualified individual or enrollee to elect a coverage effective date of the first of the month following plan selection, rather than the first of the month following the qualifying event, as currently written, or following regular coverage effective dates, in accordance with paragraph (b)(1) of this section.

This amendment would streamline Exchange operations and align this coverage effective date option with the accelerated prospective coverage effective date rule as it applies to other special enrollment periods, including the special enrollment period for gaining or becoming a dependent through marriage, as described in (b)(2)(ii) of this section. Thus, at the Exchange's option, qualified individuals who qualify for a special enrollment period due to gaining or becoming a dependent through birth, adoption, placement for adoption, placement in foster care, or through a child support or other court order, would be able to elect from the same coverage effective date options, including: the date of qualifying event, the first day of the month following plan selection, or regular coverage effective dates in accordance with paragraph (b)(1).

These amendments would standardize the coverage effective date options for qualified individuals who have experienced similar qualifying events.

We request comments on this proposal.

iv. Loss of coverage special enrollment period (§155.420(d)(1)(iii))

Section §155.420(d)(1) establishes a special enrollment period for qualified individuals who lose certain types of coverage, including minimum essential coverage. As described in paragraph (d)(1)(iii), qualified individuals who lose certain types of Medicaid pregnancy-related coverage not considered minimum essential coverage may also qualify for this special enrollment period. This is to ensure that women losing eligibility for coverage of pregnancy-related services that often meet their primary and specialty healthcare needs are not left without the option to enroll in a QHP through an Exchange after they lose access to those services.

We propose to revise paragraph (d)(1)(iii) to include women who lose access to healthcare services that they were receiving through CHIP coverage for their unborn child. While CHIP coverage for unborn children, provided based on the definition of a child described in 42 CFR 457.10, is considered minimum essential coverage for the unborn child, it is not considered minimum essential coverage for the pregnant woman. Nonetheless, these pregnant women may receive a set of health services comparable to those available to women enrolled in Medicaid pregnancy-related coverage. For this reason, pregnant women who have received prenatal care as part of CHIP coverage for their unborn child may apply and be determined eligible for a hardship exemption from the FFEs so that they are not required to also maintain minimum essential coverage during that time.

The proposed revision to paragraph (d)(1)(iii) would provide a pathway to coverage for new mothers who lose access to healthcare services provided through unborn child CHIP

coverage following the birth of their child, and who are otherwise eligible to enroll in a QHP through the Exchange. Under paragraph (c)(2) of this section, these qualified individuals would have up to 60 days before or after the loss of access to CHIP unborn child coverage to qualify for the loss of coverage special enrollment period and enroll in a QHP. If they select a plan prior to their loss of CHIP unborn child coverage, their Exchange coverage would begin as soon as the first day of the month following the loss of coverage. If they select a plan after the loss of CHIP unborn child coverage, their Exchange coverage would begin either the first of the following month or following regular, prospective coverage effective dates at the option of the Exchange, as provided under paragraph (b)(2)(iv). We believe that this revision is needed to ensure a pathway to coverage for women in the 17 states that offer unborn child CHIP coverage, so that they may maintain access to continuous coverage after the birth of their child.

We request comments on this proposal.

iv. Technical amendment (§155.420(d)(10)(i))

We propose to make a technical amendment to update the cross reference to 26 CFR 1.36B-2T in §155.420(d)(10)(i), regarding the special enrollment period for victims of domestic abuse or spousal abandonment. The temporary regulation under section 36B of the Code originally cited has now been finalized without change to the definition cited in this special enrollment period. Therefore, this technical correction would not in any way alter the parameters of this special enrollment period.

b. Effective dates for terminations (§155.430)

Section 155.430 specifies the termination dates for Exchange enrollees. Paragraph (d)(1)(i) of §155.430 defines “reasonable notice” as at least 14 days before the requested effective date of termination. Paragraph (d)(2) sets forth three possible effective dates for

enrollee-initiated terminations made in accordance with paragraph (b)(1): (1) the termination date specified by the enrollee, if the enrollee provides reasonable notice; (2) 14 days after the termination is requested by the enrollee, if the enrollee does not provide reasonable notice; or (3) on a date on or after the date on which the termination is requested by the enrollee, if the enrollee's QHP issuer agrees to effectuate termination in fewer than 14 days, and the enrollee requests an earlier termination effective date. Further, current paragraph (d)(2)(iv) sets the QHP termination effective date for enrollees newly eligible for Medicaid, CHIP, or the basic health program as the day before the individual is determined eligible for Medicaid, CHIP, or the basic health program.

While the 14-day “reasonable notice” rule was created to provide issuers ample termination transaction processing time, we believe that most Exchanges and issuers have the operational capability to make enrollee-initiated terminations effective in fewer than 14 days—and often do so on the same day of enrollee request. When asked, issuers have not informed HHS of any challenges in processing these same-day transactions. Therefore, we propose to remove paragraphs (d)(2)(i) through (d)(2)(iii) and align the effective dates for all enrollee-initiated terminations on the date on which the termination is requested by the enrollee or on another prospective date selected by the enrollee.

To further align termination effective dates, we also propose removing existing paragraph (d)(2)(iv), which states that the QHP termination date for an enrollee newly determined eligible for Medicaid, CHIP or a basic health program is the date before the Medicaid, CHIP, or basic health program eligibility determination. We do not provide QHP termination dates according to eligibility for other forms of coverage, such as Medicare or employer-sponsored coverage. This rule singles out the Medicaid/CHIP/basic health program enrollee population for an earlier

termination date than other Exchange consumers, causing unnecessary confusion for consumers and issuers. Consumers may also be determined eligible through the State Medicaid agency, instead of the Exchange, resulting in challenges in coordinating effective dates through the State and the Exchange and its issuers. The removal of paragraph (d)(2)(iv) may limit enrollees' ability to retroactively terminate QHP coverage when it overlaps with Medicaid or CHIP, which could result in consumers being unable to recoup premiums paid for periods when the enrollee was enrolled in QHP coverage through the Exchange and gains retroactive eligibility for Medicaid or CHIP. However, these types of retroactive terminations can lead to major challenges for consumers as Medicaid/CHIP providers may not cover claims reversed by the QHP—leading to unexpected out-of-pocket costs for consumers.

Consolidating these termination effective date scenarios—based on reasonable notice or the reason for termination—into one option for consumers would help streamline operations for Exchanges and issuers. Allowing enrollees to terminate their coverage immediately or on a future date of their choosing also would provide consumers with greater control over ending their QHP coverage and would help minimize or eliminate overlaps in coverage. Such flexibility would also allow Exchanges to send termination transactions to issuers that do not need subsequent adjustment, reducing the need for casework or direct consumer contact with issuers to request earlier termination dates as permitted under paragraph (d)(2)(iii).

We believe that streamlining these termination dates would not negatively affect issuer or Exchange operations, but we invite comment from Exchanges, issuers, and other stakeholders on any burdens these rule changes may impose, as well as whether we should make the changes at the option of the Exchange or the issuer.

6. Definitions (§155.500)

a. This section defines terms that are relevant to this subpart. We propose to amend the definitions of “Appeal request” and “Appeals entity” by adding a cross reference to proposed section §155.716(e)” to align with other the other proposals discussed throughout this proposed rule.

7. Eligibility Standards for Exemptions (§155.605)

a. Hardship exemptions (§155.605(d))

Section 1311(d)(4)(H) of the PPACA and section 5000A(e)(5) of the Code allow individuals to seek an exemption from the individual shared responsibility provision due to a lack of affordable coverage based on an individual’s projected income. Section 155.605(d)(2) establishes the circumstances under which an Exchange must determine an applicant eligible for an exemption due to lack of affordable coverage based on projected income. For determining whether affordable coverage is available, paragraph (d)(2) states that the Exchange should use the standards specified in section 5000A(e)(1) of the Code which, among other things, specifies that the Exchange should use, for individuals not eligible for employer- sponsored coverage, the annual premium for the lowest-cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides.

However, market instability has resulted in limited offerings of plans on the Exchanges in many regions, and there may be individuals who live in a rating area without a bronze plan. Under the current regulation, the Exchange would not be able to make a determination as to whether an individual not eligible for employer-sponsored coverage who lives in a rating area without a bronze plan is eligible for the exemption due to lack of affordable coverage based on projected income. We propose to amend paragraph §155.605(d)(2)(iv), to allow an Exchange to make a determination of lack of affordable coverage based on projected income for individuals

not eligible for employer-sponsored coverage using the annual premium for the lowest cost Exchange metal level plan available in the individual market through the Exchange in the State in the rating area in which the individual resides if there is no bronze level plan sold through the Exchange in that rating area. Absent this proposed change, individuals may lack access to affordable coverage, but be unable to qualify for an exemption determination from the Exchange due to the Exchange's inability to calculate whether coverage is unaffordable due to the absence of a bronze plan in that rating area. Under the proposed amendment to §155.605(d)(2), Exchanges would use the amount of the lowest cost Exchange metal level plan available to the individual when no bronze level plan is available.

We invite comment on this proposal.

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 an individual shared responsibility payment. 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(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(d)(2)(iv), certain employed individuals are exempt if, on an individual basis, the cost of self-only 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 of HHS 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.

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 in the 2015 Market Standards Rule (79 FR 30302), and we stated that 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.³⁸

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

³⁸ 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.

calculated by the CMS Office of the Actuary.³⁹ (As discussed elsewhere in this preamble, we are proposing the 2019 premium adjustment percentage to be 1.2516634051, (or an increase of about 25 percent over the period from 2013 to 2018). This reflects an increase of about 7.7 percent over the 2018 premium adjustment percentage (1.2516634051/1.1617303196).

As the measure of income growth for a calendar year, we established in the 2017 Payment Notice that we would use per capita personal income (PI). Under the approach finalized in the 2017 Payment Notice, and using the NHEA data, the rate of income growth for 2019 is the percentage (if any) by which the most recent projection of per capita PI for the preceding calendar year (\$53,729 for 2018) exceeds per capita PI for 2013 (\$44,555), carried out to ten significant digits. The ratio of per capita PI for 2018 over the per capita PI for 2013 is estimated to be 1.2059028167 (that is, per capita income growth of about 20.6 percent). This reflects an increase of about 4.5 percent relative to the increase for 2013 to 2017 (1.2059028167/1.1540603665) used in last year's rule.

Thus, using the 2019 premium adjustment percentage proposed in this rule, the excess of the rate of premium growth over the rate of income growth for 2013 to 2018 is $1.2516634051/1.2059028167$, or 1.0379471610. This results in a proposed required contribution percentage for 2019 of 8.00×1.0379471610 or 8.30 percent, when rounded to the nearest one-hundredth of one percent, an increase of 0.25 percentage point from 2018 (8.30358 - 8.05317). The excess of the rate of premium growth over the rate of income growth also is used for

³⁹ 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 preceding year exceeds the most recent NHEA estimate of per enrollee employer-sponsored insurance premiums for 2013.

determining the applicable percentage in section 36B(b)(3)(A) of the Code and the required contribution percentage in section 36B(c)(2)(C) of the Code.

We seek comment on whether there are other measures of premium growth or income growth that we could use to calculate the required contribution percentage.

8. Eligibility Process for Exemptions

Paragraph 155.610(h)(2) describes the timeframe during which the Exchange will accept an individual's application for a hardship exemption. We are proposing to make a technical correction to paragraph 155.610(h)(2) to reflect the prior redesignation of paragraph 155.605(g)(1), which describes the criteria for a hardship exemption, to paragraph 155.605(d)(1) in the 2017 Payment Notice.⁴⁰

We seek comment on this proposal

9. Exchange Functions: Small Business Health Options Program

We previously interpreted the PPACA's provisions regarding the SHOPs to require that all SHOPs provide for employer eligibility, employee eligibility, and certain enrollment functions, including premium aggregation services.

We recognize that SHOPs, including SBE-FP for SHOP and FF-SHOPs, continue to face challenges and, to accommodate those challenges and to provide SHOPs with more flexibility in operating their programs, we propose to allow SHOPs to operate in a leaner fashion beginning for plan years beginning on or after January 1, 2018. If the proposals of this rule are finalized, the changes would become effective as of the effective date of the final rule. In the 2018 Payment Notice, HHS finalized the removal of a participation provision that had required certain

⁴⁰ 81 FR 12346, March 8, 2016.

QHP issuers to participate in an FF-SHOP in order to participate in an FFE. As a result, HHS expects that there will be a significant decrease in the number of issuers in the FF-SHOPs in the 2018 plan year and therefore, also expects fewer enrollments in the FF-SHOPs and SBE-FPs utilizing the Federal platform for SHOP. With the anticipated significant decreases in QHP issuer participation and enrollment beginning in 2018, it is not cost effective for the Federal government to continue to maintain certain FF-SHOP functionalities, collect significantly reduced user fees on a monthly basis, maintain the technologies required to maintain an FF-SHOP Web site and payment platform, generate enrollment and payment transaction files, and perform enrollment reconciliation. Specifically, as previously signaled,⁴¹ we are proposing to remove regulatory burden on SHOPs by removing several of the existing requirements imposed upon the SHOPs, focusing on removing requirements to provide certain functionality that is not expressly required by the PPACA, while still ensuring appropriate implementation of statutorily required functions of the SHOP. Under this proposal, employer groups that are currently enrolled, or will enroll in a SHOP QHP for plan years that begin prior to January 1, 2018, would enroll in a SHOP QHP consistent with the current SHOP regulations. If this rule is finalized as proposed, the changes would take effect for plan years beginning on or after January 1, 2018 as of the effective date of the final rule.

Under the proposed approach, SHOPs would no longer be required to provide employee eligibility, premium aggregation, and online enrollment functionality for plan years beginning on or after January 1, 2018, effective on the effective date of the final rule, if finalized as proposed.

⁴¹ Centers for Medicare & Medicaid Services Offers New Health Coverage Enrollment Option for Small Business (May 15, 2017), available at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-05-15.html>.

If these proposals are finalized as proposed, the FF-SHOPs and the SBE-FP for SHOPs would take advantage of this flexibility, and SBEs would continue to have the flexibility to operate a SHOP in the way that they choose in accordance with applicable Federal and State law. Notably, we received comments to the Request for Information that provided support for this proposed enrollment approach. Moreover, few SBEs currently utilize a similar enrollment approach as is being proposed as a transitional measure that was expected to extend through plan years beginning in 2018. These SBEs have already inquired about the possibility to continue permitting enrollment of their SHOP consumers through a participating QHP SHOP issuer, or a SHOP-registered agent or broker, for plan years beginning in 2019 and beyond.⁴² Additionally, these SBEs have each indicated that this enrollment method has contributed to reduced SHOP Exchange programmatic expenses, which is critical for SBEs to maintain financial sustainability as required by section 1311(d)(5)(A) of the PPACA.

To reflect the proposed changes for plan years beginning on or after January 1, 2018, effective on the effective date of the final rule, if finalized as proposed, we are proposing modifications throughout the requirements applicable in the SHOPs. However, because some groups' plan years that begin prior to the effective date of the rule finalizing this proposal will continue beyond the effective date of the rule finalizing this proposal, both the existing requirements and the proposed requirements would need to be in place simultaneously. For this reason, we propose to make many of the existing regulatory sections regarding SHOP applicable for plan years beginning prior to January 1, 2018 only, and propose new regulatory sections

⁴² Extension of state-based SHOP Direct Enrollment Transition (April 18, 2016), available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/1332-and-SHOP-Guidance-508-FINAL.pdf>.

applicable for plan years beginning on or after January 1, 2018. After the effective date of this rule, the new regulatory sections will be effective for all 2018 plans, regardless of whether they started prior to the effective date of the rule. Except as described in this rule, we propose that these new regulatory sections would mirror the existing regulatory sections.

Specifically, we propose to amend §§155.705, 155.715, 155.720, 155.725, 155.730, 155.735, 155.740, 156.285 and 157.205 to make each section applicable only to plan years beginning prior to January 1, 2018. Additionally, we propose to introduce mirroring new sections, applicable for plan years beginning on or after January 1, 2018, at §§155.706, 155.716, 155.721, 155.726, 155.731, 155.741, 156.286 and 157.206. We do not propose a new section mirroring current §155.735, as further explained later in this preamble. We also propose minor changes to §155.700. These are described in the sections that follow. We also propose additional changes related to the proposed new approach to SHOP in §§155.106, 155.200, and 156.350, to define the streamlined enrollment approach that groups enrolling in a SHOP QHP in a SBE-FP would take, if the proposals in this rule were to become finalized. In light of the substantial changes proposed throughout this document, we intend to make conforming amendments and to update all applicable cross references in these and other regulations, including §§147.102, 147.104, 155.500, 156.200, and 156.340. We solicit comment on any additional cross-references that should be amended.

If this proposal is finalized, SHOPS that opt to operate in a leaner fashion, such as the FF-SHOPS, would still assist qualified employers who are small employers in facilitating the enrollment of their employees in QHPs offered in the small group market in the State, consistent with section 1311(b)(1)(B) of the PPACA, because the basic functionalities of an Exchange would still be provided. Under the proposed approach, SHOPS would continue to be required to

certify plans for sale through the SHOP, and the following features would still be available: an Internet Web site that displays and provides QHP information, a premium calculator that generates estimated prices of the available QHPs, and a call center to answer questions related to the SHOP. Further, small employers would continue to obtain an eligibility determination from the SHOP Web site but would enroll in a SHOP QHP by working with a SHOP-registered agent or broker, or with a QHP issuer participating in a SHOP to complete the enrollment process.

An enrollment completed by working with a SHOP-registered agent or broker, or with a QHP issuer participating in a SHOP under the proposed flexibilities, would be considered to be an enrollment through the SHOP, and an employer would be considered to have offered its employees coverage through a SHOP for purposes of section 45R of the Code (the Small Business Health Care Tax Credit), if the employer: (1) obtains from the SHOP a favorable determination of eligibility to participate in the SHOP; (2) enrolls in a SHOP QHP offered by an issuer; and (3) chooses to have the enrollment identified as being through the SHOP. If an enrollment meets this definition, the QHP issuer would be required to conduct enrollment with all applicable SHOP rules and policies.

Because the SHOP would be required to determine employer eligibility to participate in the SHOP only, and not be required to determine employer group members' eligibility to enroll, it would only be responsible for handling appeals as they relate to an employer's eligibility in the SHOP, as currently described in §155.740. If, under the flexibilities described here, employer group members enrolled in a SHOP QHP needed to file an appeal related to their SHOP coverage, they generally would file the appeal directly with the insurance company, or could take advantage of other appeals mechanisms under applicable State and Federal law. If an employer group member, under the approach proposed throughout this document, believed that he or she

were entitled to a SHOP special enrollment period, but was denied that special enrollment period, the employer group member could file a complaint with the SHOP and the SHOP would investigate. SHOP special enrollment periods would continue to be available to enrollees who experience specified qualifying events. If the proposed changes are finalized, SHOPs that use the new flexibilities, such as the FF-SHOPs, would no longer have the information required to determine employer group members' eligibility for special enrollment periods. Therefore, issuers wishing to participate in such a SHOP would be required to administer special enrollment periods.

SHOPs opting to operate in a leaner fashion, like the FF-SHOPs, would continue to provide employers with the option to offer a choice of plans, consistent with section 1312(a)(2) of the PPACA, by continuing to allow employers to offer their employees a choice of plans, either by coverage level, or, in some States, by participating QHP issuer. Employers would be able to see the SHOP plans available, by coverage level and issuers, in their area using the plan comparison tool available on a SHOP Web site. To streamline enrollment through a SHOP, the employer would maintain the ability to offer their employees a choice of plans across issuers. Employers who choose to offer a choice of plans to employees would contact the participating QHP issuers, whose plans they would like to offer to their employees, to obtain the application information necessary in order to enroll in coverage.

Once the necessary information required to enroll is obtained from the QHP issuer or issuers or from the SHOP-registered agent or broker, the employer could disseminate the application information to its employees. The employer could later collect the information from its employees and send it to the applicable QHP issuer or issuers or the SHOP-registered agent or broker. Employers generally would also be responsible for collecting monthly premium

payments from employees and sending them to the appropriate issuers. While initially offered to support employers' option to offer a choice of plans across issuers, premium aggregation services are not a service mandated by the PPACA and therefore may be altered or removed, as proposed in this proposed rule. SHOP-registered agents and brokers would be able to assist employers perform these tasks, if the employer chooses to work with a SHOP-registered agent or broker.

Additionally, to further support employers' option to offer a choice of plans across issuers, under the proposed approach, an employer's minimum participation rate would continue to be calculated at the employer level, though the SHOPS would not be involved in calculating it, and the FF-SHOPS would no longer calculate it. Participating QHP issuers would not be permitted to deny enrollment on the basis of failure to meet minimum participation requirements to employers who have been determined eligible to participate in the SHOP, and who have met the applicable minimum participation rate, as specified by the SHOP, even if only one employee in a group wishes to enroll with a particular issuer.

Under the proposed approach, SHOPS would also still be able to administer the provision at section 1304(b)(4)(D) of the PPACA that guarantees continuing eligibility for growing small employers by limiting the validity of an employer's eligibility determination such that it terminates when the employer makes a change that could end its eligibility under §155.710(b), by requiring the employer to submit a new single employer application to the SHOP if the employer makes a change that could end its eligibility under §155.710, and by requiring issuers to be able to distinguish SHOP enrollments from non-SHOP enrollments. Under the proposed flexibilities, issuers would be expected to rely on the determination of eligibility to reflect the

employer's ongoing eligibility to participate in the SHOP and the IRS would have the option to follow up with an employer for additional information if necessary.

HHS understands that the changes outlined in this proposed rule, if finalized, would allow SHOPs to adopt changes (and we propose that the FF-SHOPs would adopt such changes) that result in a substantial departure from current operations for participating SHOP QHP issuers, employers, and enrollees. We recognize that if this proposed rule is finalized, it would be effective on the effective date of the final rule, and thus could take effect after the first date that employers can complete an enrollment that takes effect on or after January 1, 2018. It is important to note that employer groups currently enrolled in a SHOP plan that began in 2017 in a SHOP that would opt to operate in a leaner fashion would not be affected until their plan year ends, as the current regulations will be in effect for the entirety of a plan that began in 2017. The current regulations will also be in place for the beginning of plan year 2018 for those plans that start before the effective date of the rule. But, after the effective date of the rule, any finalized regulations pertaining to plan year 2018 will be effective for all plans that begin or began in 2018, regardless of whether they started prior to the effective date. HHS acknowledges that this transition will create challenges and is concerned about employers enrolling between when rates become available for plan years beginning in 2018 and when the proposed flexibilities in this rule would go into effect. We seek comment on how to best ease this transition.

HHS also recognizes that if the proposals are finalized and take effect after rates become available for plan years beginning in 2018, employers participating in an FF-SHOP that complete the enrollment process for a plan that would take effect on or after January 1, 2018, but prior to the effective date of the final rule could begin the enrollment process on the existing SHOP Web site, and might receive billing and premium aggregation services through the SHOP Web site for

only a short time period in 2018 before any final version of these proposals could take effect. If SHOP enrollment processes that would no longer be required to be provided by the SHOP were discontinued when the rule took effect, issuers and small employers could experience a disruption in the processing of payments or subsequent enrollments, which could result in loss of coverage due to non-payment of premiums that might affect an employer's ability to claim the Small Business Health Care Tax Credit. This approach would also result in complex data transfers between a SHOP and issuers. Nonetheless, not allowing SHOPs to operate in a leaner fashion as soon as possible would cause SHOPs to continue to incur substantial financial and operational burdens, and would undermine the goal of achieving financial sustainability, as referenced above. This is why the proposals in this proposed rule would apply as of the effective date of the final rule, and any finalized regulations pertaining to plan year 2018 will be effective for all plans that begin or began in 2018, regardless of whether they started prior to the effective date. Issuers that intend to use the FF-SHOP and SBE-FP for SHOP systems that will no longer be required under the new regulations are encouraged to inform HHS of their intention to do so as soon as possible, so that HHS may work through the necessary operational, technology, and transition issues to establish manual procedures to accommodate them. Manual procedures could include premium aggregation services and processing of enrollments in SHOP QHPs.

We seek comment on these proposals, including on any other regulatory provisions that should be changed to reflect the changes described here.

a. Standards for the establishment of a SHOP (§155.700)

Section 155.700 outlines the general requirements to establish a SHOP and defines certain terms specific to SHOPs. We propose to amend §155.700(a) by adding paragraph (a)(1) to make the current requirements applicable for only plan years beginning prior to January 1,

2018. We propose to add paragraph (a)(2) to describe the general requirements applicable for plan years beginning on or after January 1, 2018. Proposed paragraph (a)(2) more closely aligns with the statutory language in section 1311(b)(1)(B) of the PPACA than existing paragraph (a), and would specify that SHOPs must assist qualified employers in facilitating the enrollment of their employees in small group market QHPs. We believe that the PPACA does not have to be interpreted to require SHOPs to facilitate the enrollment of qualified employees into QHPs, as is specified by the current regulation. Instead, we believe it can also be interpreted in a less burdensome way, to require SHOPs to assist qualified employers in facilitating employees' enrollment into QHPs, which would still be provided for under our proposals. If finalized, these changes would become effective as of the effective date of the final rule. We seek comment on this proposal.

- b. Functions of a SHOP (§155.705) for plan years beginning prior to January 1, 2018.
(§155.705)

As discussed in the following section, we propose to modify the regulatory requirements regarding functions of a SHOP for plan years beginning on or after January 1, 2018 and to introduce those requirements in a new §155.706. To reflect the proposal that the requirements currently in §155.705 would apply only for plan years beginning before January 1, 2018, we propose to amend the heading of §155.705 and add paragraph (f), to state that the section would apply only for plan years that begin prior to January 1, 2018. We discuss the proposed new §155.706 below.

- c. Functions of a SHOP for plan years beginning on or after January 1, 2018. (§155.706)

Section 155.705 describes required Exchange functions that are specific to SHOPs. To permit SHOPs to operate in a leaner fashion for plan years beginning on or after January 1, 2018,

we are proposing several changes to the required functions of a SHOP. If finalized, these changes would become effective as of the effective date of the final rule. Under these proposals, which we propose to introduce in new §155.706, certain functions that are currently required would become optional for SHOPs for plan years beginning on or after January 1, 2018, and the FF-SHOPs would not provide them. With the exception of the proposed changes to the functions described here, the functions would remain the same as in §155.705. The proposals described in this section would become effective on the effective date of the final rule, if finalized as proposed.

We propose only to include the paragraphs in current paragraph (b)(3) of §155.705, that would be applicable to plan years beginning on or after January 1, 2018, maintaining the currently applicable policy requiring SHOPs to allow employers to select a level of coverage and to offer a choice of QHPs across that level of coverage, and permitting SHOPs to allow employers to offer a choice of all QHPs from a single issuer, or another method of providing employer choice. To provide additional flexibility, we also propose to codify that State SHOPs may, as the FF-SHOPs have, offer employers a choice of SADPs. To reflect the proposals described in §156.150(b) of this document, we propose that SHOPs could and FF-SHOPs would allow employers to offer a choice of SADPs across a selected level of coverage, if such levels of coverage are available. In the event that no SADP coverage levels are available, employers would be able to offer a choice of all SADPs offered in an area. We also propose conforming amendments to the structure of this paragraph.

Because, as discussed earlier in this preamble, premium aggregation services are not mandated by the PPACA and to maximize the flexibilities associated with operating a SHOP, we propose to remove required functions related to premium aggregation. Specifically, we propose

that the only premium aggregation function from §155.705(b)(4) that would be applicable in plan years beginning on or after January 1, 2018, would be an amended version of the function in §155.705(b)(4)(ii)(A), relating to the continuation of coverage. State-based Exchanges would be permitted to continue providing remaining premium aggregation services in their SHOPs currently described at §155.705(b)(4) if they choose to do so. SHOPs electing not to provide premium aggregation services, like the FF-SHOPs, would still be required to provide an opportunity for employers to offer employees a choice of plans. In SHOPs not offering premium aggregation services, we expect that employers generally would receive premium bills from each of the plans or issuers with which an employee enrolls and would pay premiums to each such plan or issuer. Section 155.705(b)(4)(ii)(A) (which we propose to include in a revised form in §155.706) describes the process through which the SHOP may enter into an agreement with a qualified employer related to the administration of continuation coverage. Under the proposed approach for enrollment in a SHOP QHP for plan years beginning on or after January 1, 2018, the FF-SHOPs would no longer facilitate the collection of premiums. Therefore, we propose that §155.706(b)(4) would mirror §155.705(b)(4)(ii)(A) but would not include the provision that permits the FF-SHOPs to limit the service to the collection of premiums related to the requirements under 29 U.S.C. 1161, et seq.

Paragraph (b)(7) of §155.705 describes the SHOP function related to QHP availability in merged markets and paragraph (b)(8) describes the function related to QHP availability in unmerged markets. We propose to include these functions in §155.706(b)(7) and (b)(8).

However, under the proposal to streamline SHOP enrollment for plan years beginning on or after January 1, 2018, we propose to change the references to a “qualified employee” to an

“employer group” in both paragraphs, as the SHOP would no longer be required to process employee enrollments under the proposed approach.

Paragraph (b)(10) of §155.705 establishes requirements related to minimum participation rates and SHOP coverage; we propose to include these requirements in §155.706(b)(10), with certain modifications. In order to facilitate employers’ ability to offer employees a choice of plans through a SHOP, as is required under section 1312(a)(2) of the PPACA, §155.705(b)(10) requires that any minimum participation rate applicable in a SHOP be calculated based on the rate of employee participation in the SHOP, rather than on the rate of participation in any particular QHP or QHPs of any particular issuer. In the FF-SHOPs, this requirement has been implemented through the requirements currently outlined at §155.705(b)(10)(i)-(iii). Currently, the Federally-facilitated SHOPs calculate a group’s minimum participation rate based on the information provided by the employer and the employees during the online enrollment process. Under the proposed approach, the SHOP would not be required to collect the enrollment information needed to calculate a group’s minimum participation rate. Under this proposal, issuers would be permitted to use their established practices allowed under State law for groups enrolling in their certified SHOP plans for plan years beginning on or after January 1, 2018, so long as they comply with §147.104, and so long as the minimum participation rate is calculated based on the level of participation in the SHOP instead of on the level of participation in any one QHP or with any one issuer (that is, so long as SHOP participation is measured at the employer group level). Issuers participating in the FF-SHOPs would be required to adhere to the level of participation as would continue to be specified in §155.706(b)(10) and issuers in State SHOPs would be subject to any minimum participation rate established by the SHOP, consistent with this provision. We also propose that §155.706(b)(10) would not include the language in

§155.705(b)(10)(i) because it applies to plan years beginning before January 1, 2016, and would therefore not be applicable for the period covered in §155.706. We also propose to clarify that, under the proposed approach, the reference in proposed §155.706(b)(10) to the time the employer submits the SHOP group enrollment would be interpreted to mean the time when the employer submits a complete group enrollment or renewal to the QHP issuer or SHOP-registered agent or broker, applicable.

Section 155.705(b)(11) specifies the requirements related to an online premium calculator. For plan years beginning on or after January 1, 2018, we propose to modify these requirements and include the modified requirements in §155.706(b)(11). Specifically, §155.706(b)(11) would specify that the premium calculator described in §155.205(b)(6) must facilitate the comparison of available QHPs. This would reflect that SHOPs would no longer be required to maintain enrollment and premium payment information or administer premium billing, and therefore, would no longer necessarily have employer contribution information. If this proposal is finalized, the SHOPs would be required to maintain a calculator that facilitates the comparison of available QHPs and would generate premium estimates, but would no longer be required to reflect any employer contribution. Therefore, we propose to not include the requirements in §155.705(b)(11)(i) or (ii) in §155.706(b)(11), since these reflect methods SHOPs would use for determining employer contributions. In the FF-SHOPs and SBE-FPs for SHOP, this premium calculator would be where an employer or SHOP-registered agent or broker could go to see a complete listing of all the QHPs available in a given area. The tool has served and would continue to serve as a resource for employers and SHOP-registered agents and brokers. Because we believe the premium calculator requirement at section 1311(d)(4)(G) of the PPACA could be interpreted to apply to only individual market Exchanges based on its reference to APTCs and

CSRs, which are not available through SHOPS, we believe that this proposal is consistent with the statute.

Section 155.705(c) generally requires a SHOP to provide data related to eligibility and enrollment of a qualified employee to the applicable individual market Exchange. For plan years beginning on or after January 1, 2018, we propose that this requirement would apply only in SHOPS that collect employee enrollment data related to eligibility and enrollment of a qualified employee, unless the SHOP is operated pursuant to §155.100(a)(2).

Finally, we propose in paragraph (e) that the provisions of the section would be applicable for plan years beginning on or after January 1, 2018, effective on the effective date of the final rule, if finalized as proposed.

d. Eligibility determination process for SHOP for plan years beginning prior to January 1, 2018 (§155.715)

As discussed in the following section, we propose to modify the regulatory requirements regarding the eligibility determination process for SHOP for plan years beginning on or after January 1, 2018, effective on the effective date of the final rule, if finalized as proposed, and to introduce those requirements in a new §155.716. To reflect the proposal that the requirements currently in §155.715 would apply only for plan years beginning before January 1, 2018, we propose to amend the heading of §155.715 and add paragraph (h), to state that the section would apply only for plan years that begin prior to January 1, 2018.

e. Eligibility determination process for SHOP for plan years beginning on or after January 1, 2018. (§155.716)

Section 155.715 describes the SHOP eligibility determination process for employers and employees. We propose to add new §155.716 to describe the eligibility determination process for

SHOPs for plan years beginning on or after January 1, 2018. With the exception of the proposed changes to the process described here, the process would remain the same as in §155.715.

However, this new section would modify and remove some of the requirements in §155.715.

The proposals described in this section would be effective on the effective date of the final rule, if finalized as proposed.

Section 155.715(a) requires that before permitting the purchase of coverage in a QHP, the SHOP must determine that the employer or individual who requests coverage is eligible. Under current regulations, this requirement means that employers and employees must complete an application to participate in the SHOP. Accordingly, the FF-SHOPs have established certain operational requirements related to submitting an application through the FF-SHOP Web site, including creating an account on the FF-SHOP Web site, (for employers) providing information on the business (including location, Employer Identification Number, and number of employees), and identity verification.

To reduce the barriers on employers to obtain SHOP coverage, we propose in §155.716 that SHOPs must determine that the employer who requests coverage is eligible, but that SHOPs generally would not always need to do so before the issuer permits the purchase of coverage in a QHP through a SHOP, for plan years beginning on or after January 1, 2018. This would generally permit an employer to purchase a QHP before obtaining a determination of SHOP eligibility and confirming with the issuer the status of the enrollment as being through the SHOP. As further explained in the preamble to §156.286, issuers would be expected to establish processes to ensure that they can accurately identify which enrollments are considered SHOP enrollments and which are not considered SHOP enrollments. We would encourage employers to obtain an eligibility determination from the SHOP as close to the date in which they purchase a

SHOP QHP. We also are considering establishing a limit on how long an employer can wait between purchasing the QHP and obtaining the determination of eligibility for that QHP to be considered purchased through the SHOP. We solicit comments on whether to establish such a limit, and how long it should be.

As a condition of claiming the Small Business Health Care Tax Credit, small employers must be prepared to provide sufficient proof that they meet applicable criteria. Part of the employer's responsibility in providing evidence that it is a small employer eligible for the Small Business Health Care Tax Credit includes the ability to verify not only the purchase of a SHOP QHP, but the ability to produce a favorable eligibility determination from a SHOP. Therefore, employers applying for the Small Business Health Care Tax Credit are also encouraged to obtain an eligibility determination from the SHOP in the taxable year in which they intend to apply for the credit.

Section 155.715(b) requires the SHOP to accept SHOP applications from both employers and employees, and §155.715(c) provides for the verification of both employer and employee eligibility. For plan years beginning on or after January 1, 2018, we propose to provide SHOPs flexibility to forgo providing for employee eligibility determinations and related functionality and obligations (and the FF-SHOPs would pursue this flexibility). If finalized, these changes would become effective as of the effective date of the final rule. We propose that SHOPs would not be required to accept applications by employees or determine eligibility of employees because, under the proposed approach to enrollment in a SHOP, SHOPs would not be required to interact with employees. Proposed paragraphs (b) and (c) of §155.716 would still require SHOPs to accept a SHOP single employer application form from employers, and to verify employer eligibility subject to provisions like those currently in §155.715(c)(2) through (4). We intend to

update the single employer applications that employers applying to participate in SHOPs would use to reflect our proposed changes to §155.730 described elsewhere in this preamble. Employee information is primarily collected for purposes of enrollment, and therefore would not be necessary to the operation of a leaner SHOP under our proposed approach. State-based SHOPs that intend to maintain more robust SHOP functionalities, in lieu of the flexibilities in this proposal, would be permitted to continue to determine employee eligibility. We believe this proposal is consistent with the statute because, as noted above, the PPACA does not have to be interpreted to require SHOPs to provide for employee enrollment functionality, and does not define qualified employees.

Paragraph (d) of §155.715 describes the eligibility adjustment period. We propose to include in §155.716(d) these requirements as they relate to eligibility for employers. However, because SHOPs would not be required to accept applications from employees, we propose not to include the requirements in §155.715(d)(2), relating to eligibility for employees, in new §155.716. We also propose to add language to reflect that SHOPs also must address inconsistencies in employer eligibility information received from sources other than those used in the employer eligibility process described in §155.715(c).

To reflect our proposed changes to the employer eligibility verification process, as further described in this section and in the preamble to §157.205, and our proposal not to include a section mirroring §155.735 regarding terminations, we are adding a requirement in the paragraphs mirroring paragraphs (d)(3)(i) and (e) of §155.715 to require the SHOP to notify employers not only of a denial of the employer's eligibility to participate in the SHOP, but also of a termination of the employer's eligibility to participate in the SHOP.

Paragraph (f) of §155.715 specifies the requirement that the SHOP notify an employee of his or her eligibility to enroll in a SHOP. Because we would not be requiring SHOPs to determine employee eligibility for plan years beginning on or after January 1, 2018, we propose not to include this requirement in §155.716. SHOPs that continue to provide employee eligibility functionality should continue notifying employees of their eligibility. Under the proposed approach for SHOP flexibilities for plan years beginning on or after January 1, 2018, we anticipate that the participating QHP issuer or employer would determine the method of employee enrollment and notification, consistent with otherwise applicable Federal or State law.

Paragraph (g) of §155.715 describes the requirements surrounding communication between the SHOP and QHP issuers in the event of an employer withdrawing from the SHOP and the notification of qualified employees of an employer's withdrawal from SHOP. Under the proposed approach for SHOPs beginning for plan years that begin on or after January 1, 2018, the enrollment and disenrollment processes would be addressed between the employer and the issuer or the agent or broker. Therefore, we are not proposing to include these requirements in §155.716.

We further propose in paragraph (f) of §155.716 that an employer's determination of eligibility to participate in the SHOP obtained under paragraph (a) remains valid until the employer makes a change that could end its eligibility under §155.710(b). This could include terminating offers of coverage to employees maintaining full-time status, growing to be a large employer without having maintained continuous SHOP coverage, or moving its principal business address or eligible employee worksites out of the SHOP service area. The employer would be required under new regulations proposed in part 157 to take further action upon termination of the validity of the determination of eligibility to participate in a SHOP to submit a

new application for determination of eligibility or to withdraw from participation in the SHOP.

We are considering requiring SHOPS to acknowledge an employer's withdrawal from participation in the SHOP within a reasonable time. Alternatively, we are considering requiring that employers reapply to determine their SHOP eligibility on an annual basis. We seek comment on these proposals. Under the proposals described herein, a SHOP would no longer be required to operate an enrollment system, where information such as an employee roster or employee worksite would generally be collected and stored. Because employers would no longer use a SHOP's systems to report and document these changes, employers must inform the SHOP if their business status changes.

We propose to specify in paragraph (g) that the provisions in §155.716 would be applicable for plan years beginning on or after January 1, 2018. If finalized as proposed, these changes would become effective as of the effective date of the final rule.

We seek comment on these proposals.

f. Enrollment of employees into QHPs under SHOP for plan years beginning prior to January 1, 2018 (§155.720)

Section 155.720 contains requirements related to the enrollment of employees into QHPs under SHOP. To reflect that our proposed approach would no longer require SHOPS to provide functionality related to enrollment of employees for plan years beginning on or after January 1, 2018, effective on the effective date of the final rule, if finalized as proposed, we propose to amend the heading of §155.720 and add paragraph (j), to state that the section would apply only for plan years that begin prior to January 1, 2018.

Specifically, we propose that the requirement in paragraph (b) of §155.720 that SHOPS establish a timeline and process for QHP issuers and employers to follow regarding purchasing

coverage and processing of enrollment would not be applicable for plan years that begin on or after January 1, 2018. SBEs that choose to maintain their current operations may continue establishing enrollment timelines, as State law and SHOP technology permit. We also propose that the requirements to transmit enrollment information on behalf of qualified employers and employees to QHP issuers as described in current paragraph (c), and to process payments as described in current paragraph (d) would not apply after plan year 2017, since SHOPs may not have enrollment or payment information to transmit. We propose that the requirement in paragraph (e) that SHOPs ensure a QHP issuer notifies a qualified employee enrolled in a QHP of the effective date of his or her coverage would not apply for plan years beginning on or after January 1, 2018 because SHOPs may not have the enrollment information necessary to enforce this requirement, if the proposed approach became final. We anticipate QHP issuers would notify employees in accordance with applicable State law. Additionally, after plan year 2017 plans have ended, we propose not to require SHOPs to reconcile enrollment information as described in paragraph (g), as SHOPs would not have enrollment files to reconcile with issuers. We also propose that the requirements described in current paragraph (h), which requires a SHOP to notify a qualified employee's employer in the event the qualified employee terminates his or her SHOP coverage, would no longer apply for plan years beginning on or after January 1, 2018. If finalized, these changes would become effective as of the effective date of the final rule. Under the proposed approach, SHOPs may not have that information to communicate to the qualified employee's employer.

g. Record retention and IRS reporting for plan years beginning on or after January 1, 2018 (§155.721)

Our proposed approach would not require SHOPs to provide functionality related to enrollment of employees for plan years beginning on or after January 1, 2018, and we are therefore proposing that §155.720 would be inapplicable for those plan years, effective on the effective date of the final rule, if finalized as proposed. However, there are requirements in that section related to record retention and IRS reporting that would continue to be applicable with some modifications. We propose to include modified versions of these requirements in a new §155.721, titled “Record retention and IRS Reporting for plan years beginning on or after January 1, 2018.”

We propose that all SHOPs would still be required to maintain records of employer eligibility for 10 years, as described in paragraph (f). Because SHOPs utilizing the proposed flexibilities, like the FF-SHOPs, would not have information on employees, we do not propose to continue requiring that SHOPs maintain information on employees.

Section 155.720(i) describes the information the SHOP is currently required to communicate to the IRS for purposes of the Small Business Health Care Tax Credit. We propose to modify the reporting for plan years beginning on or after the effective date of the rule finalizing this proposal to require SHOPs to send the IRS information about the employers determined eligible to purchase a SHOP QHP only upon the request of the IRS. We believe providing the IRS with a list of employers determined eligible to participate in a SHOP, at the IRS’s request, fulfills HHS’s reporting responsibility. SBEs that currently report all the information required by existing §155.720(i) and will continue to collect such information related to an employer’s eligibility and enrollment in a SHOP are encouraged to continue reporting this information to assist the IRS in administering the Small Business Health Care Tax Credit. As mentioned earlier in this document, employers in all States must be able to provide

sufficient evidence that they meet all the necessary eligibility requirements for the Small Business Health Care Tax Credit, if they intend to apply for it. The IRS may ask employers to produce the aforementioned evidence and employers have a responsibility to produce it. Further, employers may work with their issuer to verify their contribution information, employee enrollment information and any other applicable information required to apply for the Small Business Health Care Tax Credit through their tax filings.

h. Enrollment periods under SHOP for plan years beginning prior to January 1, 2018 (§155.725)

As discussed in the following section, we propose to modify the regulatory requirements regarding enrollment periods under a SHOP for plan years beginning on or after January 1, 2018, and to introduce those requirements in a new §155.726. To reflect the proposal that the requirements currently in §155.725 would apply only for plan years beginning before January 1, 2018, we propose to amend the heading of §155.725 and add paragraph (l), to state that the section would only apply for plan years that begin prior to January 1, 2018. If finalized, these changes would become effective as of the effective date of the final rule. We discuss the proposed new §155.726 below.

i. Enrollment periods under SHOP for plan years beginning on or after January 1, 2018. (§155.726)

Section 155.725 describes enrollment periods under SHOP, including the timeline under which employer groups must enroll in SHOP coverage, and the notices the SHOP is required to send related to enrollment periods. We propose to introduce a new §155.726, which would retain the rolling enrollment and minimum participation rate provisions of §155.725(b) and (k), but would remove the requirements applicable to enrollment periods under SHOP other than those

related to special enrollment periods for plan years beginning on or after January 1, 2018, to reflect the increased flexibility we are proposing. The proposals described in this section would be effective on the effective date of the final rule, if finalized as proposed.

Section §155.725(a) requires that SHOPs ensure that enrollment transactions are sent to QHP issuers and that such issuers adhere to coverage effective dates in accordance with this section. We propose that many previously required enrollment and election periods would no longer apply for plan years beginning on or after January 1, 2018. State-based SHOPs that continue to provide online enrollment functionality would be able to continue to adhere to these requirements. However, under the proposed approach, some SHOPs (including the FF-SHOPs) may not have enrollment information to communicate to the issuers and may not want to continue setting and enforcing coverage effective dates under the previously specified requirements. In SHOPs, like the FF-SHOPs, that pursue the proposed approach, we anticipate that most enrollment timelines, deadlines, and coverage effective dates in SHOPs would be set by employers and issuers consistent with applicable State law and otherwise applicable Federal law. We do, however, believe that, under the proposed approach, the SHOP should be responsible for ensuring that QHP issuers adhere to the remaining required enrollment periods and their corresponding coverage effective dates. Therefore, we propose to include this requirement in §155.726(a).

Paragraph (c) of §155.725 states that the SHOP must provide qualified employers with an annual election period prior to completion of the employer's plan year and paragraph (d) of §155.725 requires the SHOP to provide notice of that period in advance of that period. Given that, under the proposed approach for SHOPs for plan years beginning on or after January 1, 2018, SHOPs would not be required to process enrollments, we propose that these requirements

would not apply for plan years beginning on or after January 1, 2018. We anticipate that participating QHP issuers in SHOPs pursuing the proposed approach, like in the FF-SHOPs, would be responsible for setting any requirements around renewals, annual employer election periods, and annual employee open enrollment periods, based on their current practices, and subject to applicable State law and otherwise applicable Federal law, including §§147.104 and 147.106. For similar reasons, we propose that the requirements in §155.725(e), which requires the SHOP to set a standard open enrollment period for qualified employees, and §155.725(f), which requires the SHOP to send a notice to the employee about the open enrollment period, would not apply for plan years beginning on or after January 1, 2018.

Section 155.725(g) requires SHOPs to establish and maintain enrollment and coverage effective dates, including waiting periods, for newly qualified employees. However, our proposed amendments at paragraphs (b), (c)(1), and (d)(2) of §155.715 would remove the requirement for SHOPs to perform employee eligibility determinations, accept and process single employee SHOP application forms, as well as verify employee eligibility for plan years beginning on or after January 1, 2018. Furthermore, our proposed amendments to remove paragraphs (c) and (d) of §155.725 would remove the requirement for SHOPs to maintain enrollment records for plan years beginning on or after January 1, 2018. SHOPs that utilize these proposed flexibilities, like the FF-SHOPs, may be unable to satisfy the requirements in §155.725(g). To align with these proposed amendments, we propose that the requirements in §155.725(g) would not apply for plan years beginning on or after January 1, 2018. Instead, we anticipate that enrollment timelines, deadlines, and coverage effective dates for newly qualified employees in SHOPs that pursue the proposed approach would be set by employers and issuers consistent with applicable State law and otherwise applicable Federal law, including §147.116.

Further, as noted above, issuers offering plans in SHOPs would still be required to adhere to the guaranteed availability requirements set in §147.104(b)(1)(i) and the special enrollment period requirements in proposed §155.726(c).

We also propose that the requirement in §155.725(h)(1) that a SHOP establish the effective dates of coverage for initial and annual group enrollments would not apply for plan years beginning on or after January 1, 2018. Because SHOPs utilizing the proposed flexibilities, like the FF-SHOPs, would no longer be involved in processing group enrollments, and would therefore not be able to hold issuers accountable to these enrollment deadlines, we believe it is more appropriate to permit QHP issuers in SHOPs to set their own enrollment timelines. However, SBEs would be permitted to continue establishing these effective dates. We are also proposing to remove paragraph (h)(2) for plan years beginning on or after January 1, 2018, which establishes the effective dates for initial and annual group enrollments in FF-SHOPs, because the FF-SHOPs intends to utilize the proposed flexibilities. We anticipate that issuers in SHOPs that pursue this approach, like in FF-SHOPs, would set enrollment timelines for employer groups participating in these SHOPs, based on their current practices, and consistent with the market rules set forth in §§147.104 and 147.106, and otherwise applicable State law.

We propose that the special enrollment periods specified in §155.725(j) would continue to be applicable in the SHOPs for plan years beginning on or after January 1, 2018, and propose to include these in §155.726(c). We also propose that the requirements regarding special enrollment periods in §155.725(j)(3) would apply for plan years beginning on or after January 1, 2018. However, we propose to modify the SHOPs' responsibilities with respect to special enrollment periods. As stated earlier in this preamble, under our proposed approach for SHOPs beginning in plan years starting on or after January 1, 2018, SHOPs would no longer be required

to provide functionality related to enrollment of employees. For SHOPs that pursue the proposed approach, like the FF-SHOPs, issuers would preliminarily be responsible for completing enrollments, and so we expect issuers would implement enrollment periods. We are therefore proposing to modify the requirements to reflect that the SHOP's proposed role is not to provide special enrollment periods, but to ensure that QHP issuers offering coverage through the SHOP provides the special enrollment periods set forth in regulation.

We seek comment on these proposals.

- j. Application standards for SHOP for plan years beginning prior to January 1, 2018 (§155.730)

As discussed in the following section, we propose to modify the regulatory requirements regarding application standards of a SHOP for plan years beginning on or after January 1, 2018 and to introduce those requirements in a new §155.731. To reflect the proposal that the requirements currently in §155.730 would apply only for plan years beginning before January 1, 2018, we propose to amend the heading of §155.730 and add paragraph (h), to state that the section would apply for only plan years that begin prior to January 1, 2018, effective on the effective date of the final rule, if finalized as proposed.

- k. Application standards for SHOP for plan years beginning on or after January 1, 2018. (§155.731)

Section 155.730 describes the requirements for employer and employee applications in the SHOPs. We propose to modify these requirements for plan years beginning on or after January 1, 2018, and to introduce these modified requirements in §155.731. With the exception of the proposed changes to the requirements described here, the requirements would remain the

same as in §155.730. The proposals in this section would be effective on the effective date of the final rule, if finalized as proposed.

Because under the proposed approach to SHOP enrollment for plan years beginning on or after January 1, 2018, QHP issuers would complete the process of enrolling qualified employees into coverage in SHOPs, it would not be necessary for a SHOP to collect information necessary for purchasing coverage. Therefore, we propose to modify the information collection requirements related to the single employer application to require SHOPs to collect only information that would be necessary for SHOPs to determine employer eligibility to participate in the SHOP under §155.710(b). To more closely align the description of the data elements collected with those standards for eligibility to participate, we propose to require the SHOP to collect the employer name and address of the employer's locations; information sufficient to confirm that the employer is a small employer; the Employer Identification Number; and information sufficient to confirm that the employer is offering, at a minimum, all full-time employees' coverage in a QHP through a SHOP. SHOPs could collect other information, at their option subject to the limitations in §155.716(c)(2) and §155.731(f).

Paragraph (c) of 155.730 requires the use of a single employee application. We propose that this requirement would not apply for SHOP beginning for plan years starting on or after January 1, 2018, as the information collected in this application would no longer be necessary, since the SHOP would no longer process employees' enrollment.

Section 155.730(d) permits a SHOP to use a model single employer application and model single employee application provided by HHS and §155.730(e) permits the use of HHS-approved alternatives to these model applications. We also propose to maintain these options, but for consistency with the proposal described throughout this preamble, we propose not to

reference a model single employee application. We expect to update the model single employer application for consistency with the elements described in proposed §155.731(b).

Paragraph (g) of §155.730 describes additional application safeguards for SHOP employer and employee applications, which we propose to maintain in §155.731(f) with minor amendments to reflect the proposal to eliminate the requirement to collect a single employee application. We also propose in new paragraph (g) to state that §155.731 is only applicable for plan years beginning on or after January 1, 2018. If finalized, these changes would become effective as of the effective date of the final rule.

We seek comment on these proposals.

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

Section 155.735 outlines requirements related to terminations of SHOP coverage or enrollment. Under our proposed approach, described in detail in the preamble to earlier sections of this proposed rule, the process of completing enrollments, as well as terminating coverage, could be completed by issuers, and would not be required to be completed by the SHOPs. Issuers would be expected to comply with otherwise applicable State and Federal law regarding terminating coverage, the timelines and effective dates for termination, and any notice requirements, including those at §§147.106 and 156.285. Accordingly, we propose that this section would be applicable for only plan years beginning prior to January 1, 2018, as described in the proposed amendment to the heading and new paragraph (h), effective on the effective date of the final rule, if finalized as proposed. SHOPs maintaining current enrollment functions would be encouraged to set termination guidelines and distribute notices for terminations based on nonpayment of premiums or loss of employee eligibility, unless State law requires QHP issuers to send the notices. Because SHOPs, such as the FF-SHOPs, would no longer be required to

enroll groups into a SHOP QHP, they would no longer be required to maintain the ability to terminate coverage. We believe proposed new §§155.716 and 157.206 sufficiently address terminations of eligibility for participation in a SHOP. We seek comments on this proposal.

m. SHOP employer and employee eligibility appeals requirements for plan years beginning prior to January 1, 2018 (§155.740)

As discussed in the following section, we propose to modify the regulatory requirements regarding employer and employee eligibility appeals in SHOP for plan years beginning on or after January 1, 2018, and to introduce those modified requirements in a new §155.741. To reflect the proposal that the requirements currently in §155.740 would apply only for plan years beginning before January 1, 2018, effective on the effective date of the final rule, if finalized as proposed, we propose to amend the heading of §155.740 and add paragraph (p), to state that the section would apply only for plan years that begin prior to January 1, 2018.

n. SHOP employer and employee eligibility appeals requirements for plan years beginning on or after January 1, 2018. (§155.741)

Section 155.740 describes the SHOP eligibility appeals process for employers and employees. These provisions describe the applicable definitions, the general requirements to provide for appeals, and employers' and employee's rights to appeal an eligibility determination from the SHOP.

To continue to provide for employer eligibility appeals, we propose to add new §155.741, mirroring §155.740, with the following exceptions. Because we propose elsewhere that the requirement to provide employees with eligibility determinations and the requirement in §155.715(f) regarding notification of employee eligibility would no longer apply in plan years beginning on or after January 1, 2018, we propose not to include a paragraph mirroring

§155.740(d), which describes employees' rights to appeal. We also propose to omit other references to employee appeal rights, to add references to provide for appeals of terminations of eligibility to participate in a SHOP, and to update cross-references as applicable.

We propose in paragraph (o) that the provisions of §155.741 would only be applicable to plan years beginning on or after January 1, 2018, effective on the effective date of the final rule, if finalized as proposed.

We seek comments on these proposals.

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

1. FFE and SBE-FP User Fee Rates for the 2019 Benefit Year (§156.50)

Section 1311(d)(5)(A) of the PPACA 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 PPACA directs HHS to operate an Exchange within the State. Accordingly, in §156.50(c), we specified that a participating issuer offering a plan through an FFE or SBE-FP must remit a user fee to HHS each month that is equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for FFEs and SBE-FPs for the applicable benefit year, and the monthly premium charged by the issuer for each policy under the plan where enrollment is through an FFE or SBE-FP.

OMB Circular No. A-25R establishes Federal policy regarding user fees; it specifies that a user fee 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 through 2018, issuers seeking to participate in an FFE in the 2019 benefit year 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 for the 2019 benefit year 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; and
- Certification processes for QHPs (including ongoing compliance verification,

recertification and decertification).

OMB Circular No. A-25R further states that user fee charges should generally be set at a level that is 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). Activities performed by the Federal government that do not provide issuers participating in an FFE with a special benefit are not covered by this user fee.

Based on estimated contract costs, enrollment and premiums for the 2019 benefit year, we propose to maintain the 2019 benefit year user fee rate for all participating FFE issuers at 3.5 percent of total monthly premiums. We seek comment on this proposal.

State-based Exchanges on the Federal platform enter into a Federal platform agreement with HHS to leverage the systems established for the FFEs to perform certain Exchange functions, and to enhance efficiency and coordination between State and Federal programs. Accordingly, in §156.50(c)(2), we specified that an issuer offering a plan through an SBE-FP must remit a user fee to HHS, in the timeframe and manner established by HHS, equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for SBE-FPs for the applicable benefit year, unless the SBE-FP and HHS agree on an alternative mechanism to collect the funds from the SBE-FP or State instead of direct collection from the SBE-FP issuers. The benefits provided to issuers in SBE-FPs by the Federal government will include use of 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 PPACA, and enrollment in QHPs under §155.400. As previously discussed, OMB Circular No. A-25R established Federal policy regarding user fees, and specified 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 user fee rate for SBE-FPs is calculated based on the proportion of FFE costs that are associated with the FFE information technology infrastructure, the consumer call center infrastructure, 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 eligibility determinations for enrollment in QHPs and other applicable State health subsidy programs as defined at section 1413(e) of the PPACA, and personnel who perform the functions set forth in §155.400 to facilitate enrollment in QHPs. Based on this methodology, 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 plans offered through an SBE-FP. This fee would support FFE operations associated with providing the services described above. We seek comment on this proposal.

We will continue to examine contract cost estimates for the special benefits provided to issuers offering QHPs on the FFEs and SBE-FPs for the 2019 benefit year as we finalize the FFE and SBE-FP user fee rates, which will be reflected in the final rule. Additionally, outreach and education efforts will be evaluated annually and funded at the appropriate level. We seek comment on the proposed FFE and SBE-FP user fee rates.

As we describe elsewhere in this proposed rule, for plan years beginning on or after January 1, 2018, effective on the effective date of the final rule, if finalized as proposed, we are proposing to remove employee eligibility, premium aggregation, and online enrollment functionality through the FF-SHOPs for FFE and SBE-FP SHOP issuers. Given the changes to the functionality for the FF-SHOPs, HHS would not provide these special benefits through the FF-SHOPs after the effective date of the rule finalizing this proposal. Therefore, HHS would not assess a user fee on issuers offering QHPs through FF-SHOPs for FFE or SBE-FP SHOP issuers because these user fees are currently only charged to issuers who receive special benefits from enrolling individuals through the FF-SHOPs' platform. In instances where enrollment did occur through the Federal platform, for example, for plan years beginning prior to the effective date of the final rule, HHS will continue charging SHOP issuers monthly FFE or SBE-FP user fees, as applicable.

2. **Essential Health Benefits Package**

Section 2707(a) of the PHS Act, as added by the PPACA, directs health insurance issuers that offer non-grandfathered health insurance coverage in the individual or small group market to ensure that such coverage includes the EHB package, which is defined under section 1302(a) of the PPACA to include coverage that provides for the EHB defined by the Secretary under section 1302(b) of the PPACA; limits cost sharing in accordance with section 1302(c) of the PPACA; and provides either the bronze, silver, gold, or platinum level of coverage, or is a catastrophic plan under sections 1302(d) and (e) of the PPACA. Section 1302(b) of the PPACA states that the Secretary is to define EHB, except that EHB must include at least the following general categories and the items and services covered within the categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. Additionally, section 1302(b)(2) of the PPACA states that the Secretary must ensure that the scope of EHB for the 10 EHB categories be equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. Furthermore, section 1302(b)(2) of the PPACA states, in defining and revising EHB, that the Secretary is to submit a report to the appropriate committees of Congress containing a certification from the CMS Chief Actuary that such EHB are equal in scope to the benefits provided under a typical employer plan. In defining and revising the 10 EHB categories, the Secretary must also provide notice and an opportunity for public comment. Additionally, section 1302(b)(4)(G) and (H) of the PPACA require the Secretary to periodically review and update the definition of EHB and

provide a report to Congress that contains assessments related to the need to update the definition of EHB.

Section 1302(b)(4) of the PPACA requires the Secretary, in defining the EHB, to: (1) ensure that such EHB reflect an appropriate balance among the categories so that benefits are not unduly weighted toward any category; (2) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life; (3) take into account the healthcare needs of diverse segments of the population, including women, children, persons with disabilities, and other groups; (4) ensure the health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life; and (5) provide that a QHP shall not be treated as providing coverage for EHB unless it meets certain requirements for coverage of emergency services.

To implement section 1302(b) of the PPACA, HHS defined EHB based on a benchmark plan approach, which provided at §156.100 for the States' selection from one of 10 base-benchmark plans, including the largest health plan by enrollment in any of the three largest small group insurance products by enrollment, any of the largest three employee health benefit plan options by enrollment offered and generally available to State employees in the State, any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by aggregate enrollment that is offered to all health-benefits-eligible Federal employees under 5 USC 8903, or the coverage plan with the largest insured commercial non-Medicaid enrollment offered by a health maintenance organization operating in the State. States were required at §156.110 to supplement their base-benchmark plan from §156.100 to ensure the 10 EHB

categories were being covered to establish the State's EHB-benchmark plan. Section 156.110 also ensures that the EHB-benchmark plan meets the standards of nondiscrimination and balance of benefits, and allows habilitative services to be determined by the State.

We believe that States should have additional choices with respect to benefits and affordable coverage. As such, we are proposing to provide States with additional flexibility in their selection of an EHB-benchmark plan for plan year 2019 and later plan years. In addition to granting States more flexibility regulating their markets, we believe these changes would permit States to modify EHB to increase affordability of health insurance in the individual and small group markets beginning in 2019. We propose that the current EHB-benchmark plan selection would continue to apply for any year for which a State does not select a new EHB-benchmark plan under this proposal. We seek comment on all aspects of this proposal. We also seek comment on the timing of this proposed policy, and specifically whether this policy should start with the 2019 plan year, as proposed, or with the 2020 plan year.

For plan years further in the future, we are considering establishing a Federal default definition of EHB that would better align medical risk in insurance products by balancing costs to the scope of benefits. The benefits of a Federal default could outweigh the potential impact on flexibility afforded to States, but we are also considering allowing States continued flexibility to adopt their own EHB-benchmark plans, provided they defray costs that exceed the Federal default. The National Academy of Medicine previously recommended a similar approach to HHS in their report on *Essential Health Benefits: Balancing Costs and Coverage*.⁴³ We understand that in developing this type of default definition there are trade-offs in adjusting

⁴³ Institute of Medicine, "Essential Health Benefits: Balancing Coverage and Cost." October 6, 2011. Available at <http://www.nationalacademies.org/hmd/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx>

benefits and services. For instance, as part of this approach, we could establish a national benchmark plan standard for prescription drugs that could balance these tradeoffs and provide a consistent prescription drug default standard across States. We anticipate publishing further details on such an approach and gathering stakeholder input as we explore this longer-term approach. For now, we solicit initial comments on this longer-term approach, particularly with regards to setting a national prescription drug benefit standard under a Federal default EHB definition and the trade-offs in adjusting benefits from the current EHBs.

a. State selection of benchmark plan for plan years beginning prior to January 1, 2019 (§156.100)

To reflect the proposed options in §156.111 for States to adopt new EHB-benchmark plans for plan years 2019 and later, we propose to make conforming changes to §156.100 to explicitly state that this selection applies only through plan years beginning in 2018, and §156.111 applies for plan years beginning after 2018.

b. State selection of EHB-benchmark plan for plan years beginning on or after January 1, 2019 (§156.111)

i. States' EHB-benchmark plan options (§156.111(a))

We propose adding new §156.111, which would provide States with the **flexibility to update their EHB-benchmark plans more frequently and to select among more options.**

Specifically, we propose that a State may change its EHB-benchmark plan by: (1) selecting the EHB-benchmark plan that another State used for the 2017 plan year⁴⁴ under §156.100 and

⁴⁴ The State's EHB-benchmark plans used for the 2017 plan year are based on plans from a previous plan year, but we occasionally refer to them as 2017 plans because these plans are applicable as the State's EHB-benchmark plans in 2017.

§156.110; (2) replacing one or more EHB categories of benefits under §156.110(a) in its EHB-benchmark plan used for the 2017 plan year with the same categories of benefits from another State's EHB-benchmark plan used for the 2017 plan year under §156.100 and §156.110; or (3) otherwise selecting a set of benefits that would become the State's EHB-benchmark plan, provided that the EHB-benchmark plan does not exceed the generosity of the most generous of among a set of comparison plans. Under this third option, the comparison plans would be the State's EHB-benchmark plan used for the 2017 plan year and the plans described in §156.100(a)(1) for the 2017 plan year, supplemented as necessary under §156.110. These plans would include the **largest health plan by enrollment** in each of the three largest small group insurance products by enrollment from the State's 2017 EHB-benchmark plan options.⁴⁵ The intention of this proposal is to **provide flexibility and the option for stability**. Specifically, the proposal would allow States the **flexibility to change their EHB-benchmark plans annually**. At the same time, this proposed policy would also allow States that prefer to maintain their current EHB-benchmark plans to do so without action.

Option 1: Select another State's EHB-benchmark plan

The first option proposed in paragraph (a)(1) would permit a State to select one of the EHB -benchmark plans used for the 2017 plan year by another State. This option would increase the number of selection options for each State without necessarily requiring extensive analysis on the part of a State because all States' current benchmark plan documents are publicly

⁴⁵ The Essential Health Benefits: List of the Largest Three Small Group Products by State for 2017 is available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Top3ListFinal-5-19-2015.pdf>. States' EHB-benchmark plans used for the 2017 plan year are able at https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Final-List-of-BMPs_4816.pdf.

available.⁴⁶ We are not proposing to change the State mandate policy at §155.170 under this option. Under this proposed policy, we propose that benefits mandated by State action prior to or on December 31, 2011, could continue to be considered EHB under §155.170, and would not require the State to defray the costs. However, if a State selects an EHB-benchmark plan from another State using this option, the selecting State would still be required to defray the cost of any benefits included in that State's EHB-benchmark plan that are benefits mandated by the selecting State after December 31, 2011, and that are subject to defrayal under the current regulations.⁴⁷ For example, if State A selects the EHB-benchmark plan of State B, State A would be required to defray the cost of any benefits included in State B's EHB-benchmark plan that are required to be provided by State A's action after December 31, 2011, and that are subject to defrayal under current regulations. We solicit comments on this proposal, including on the application of the State mandate policy under this proposal and on whether other flexibilities are needed by States under this proposed option, such as allowing a State to select its EHB-benchmark plan from any of the 10 previous base-benchmark plan options available to the State or other States under §156.100, supplemented as necessary under §156.110.

Option 2: Replace category or categories from another State's EHB-benchmark plan

⁴⁶ Benefits and limits described in the available benchmark plan documents on CMS's Web site may not be fully applicable due to other laws and regulations. For instance, under section 2711 of the PHS Act, as added by the PPACA, issuers may not impose dollar limits on EHBs. When dollar limits are specified in available benchmark plan documents, States would have removed the dollar limits or converted them to non-dollar limits when interpreting and applying EHB policy. CMS recognizes States as the primary enforcers of EHB policy. Thus, when a State would use a benchmark plan that originated in another State under any proposals under §156.111, we would defer to the selecting State's implementation of the benefits and limits consistent with otherwise applicable law, even when such interpretation differs from the originating State's interpretation. This applies throughout the proposals under §156.111. All States' current benchmark plan documents are posted on CCIIO's Web site at <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html>.

⁴⁷ Pursuant to 45 CFR 155.170, the State must make payments to defray the cost of additional required benefits either to an enrollee, as defined in 45 CFR 155.20, or directly to the QHP issuer on behalf of the enrollee.

Paragraph (a)(2) would allow a State to partially replace its current EHB-benchmark plan, using EHB-benchmark plans used by other States for the 2017 plan year. Under this option, we propose that a State may replace any EHB category or categories of benefits in its EHB-benchmark plan from the 10 required EHB categories with the same category or categories of benefits from another State's EHB-benchmark plan used for the 2017 plan year. For example, a State may select the prescription drug coverage from another State's EHB-benchmark plan (which might include a different formulary drug count) and a third State's EHB-benchmark plan hospitalization category. This option would allow States to make precise changes to their EHB-benchmark plans by adjusting specific categories of benefits.

Similar to the option proposed in paragraph (a)(1), we also propose that benefits mandated by State action prior to or on December 31, 2011, could continue to be considered EHB under this proposal in accordance with §155.170, and would not require the State to defray their costs. However, if a State uses this option to replace one or more categories of its EHB-benchmark plan used for the 2017 plan year with a category or categories of benefits from another State's EHB-benchmark plan used for the 2017 plan year, the selecting State would be required to defray the cost of any benefits included in the categories of benefits from the other State's EHB-benchmark plan that are mandated by the selecting State's action after December 31, 2011 and that are subject to defrayal under current regulations. For example, if State A replaces a category of benefits in its EHB-benchmark plan with a category of benefits from State B's EHB-benchmark plan, State A must defray the cost of any benefits in that category mandated by State A after December 31, 2011 that are included in the replacement category of benefits and that are subject to defrayal under current regulations. We solicit comments on this proposed option, including on the application of the State mandate policy under this proposal and on

whether other flexibilities are needed by States under this proposed option, such as allowing States to select their categories of benefits from any of the 10 previous base-benchmark plan options available to the State or other States under §156.100, supplemented as necessary under §156.110.

Option 3: **Select a set of benefits to become the State's EHB-benchmark plan**

Lastly, under paragraph (a)(3), we propose that the State could select a set of benefits that would become its EHB-benchmark plan using a different process, so long as the new EHB-benchmark plan does not exceed the generosity of the most generous among a set of comparison plans. Under this option, the set of comparison plans would be the State's EHB-benchmark plan used for the 2017 plan year and the plans described in §156.100(a)(1) that were available as base-benchmark plan options for the 2017 plan year, supplemented as necessary under §156.110. These plans would include the largest health plan by enrollment in each of the three largest small group insurance products by enrollment from the State's base-benchmark options for the 2017 plan year. We believe this proposed limit on the generosity of the plan benefits would help to ensure that States select EHB in a manner that is equal to the scope of benefits provided under a typical employer plan, while minimizing the opportunity for a State to select EHB in a manner that would significantly decrease affordability for patients. While this proposed option would allow more flexibility to States in establishing an EHB-benchmark plan than other proposed options, this option would be the most resource intensive for the State. For example, a State selecting this option would need to have a formulary drug list that would be used to establish the State's EHB-benchmark plan drug count for the purposes of §156.122(a)(1), which could be more labor intensive for the State than selecting another State's EHB-benchmark plan prescription drug category of benefits that already exists and is publicly available for review.

Furthermore, this option requires that the State determine an EHB-benchmark plan's generosity, and we propose that the State would determine if its proposed EHB-benchmark plan does not exceed the generosity of the most generous of a set of comparison plans using an actuarial certification, developed by an actuary who is a member of American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies. For this actuarial certification, we propose that the State could determine generosity in the same manner as we would use to measure whether the plan is equal in scope of benefits provided under a typical employer plan, described later in this section. We solicit comments on this proposed standard and approach to calculating the generosity of plans' benefits.

We also recognize that the increased flexibility offered to States under this proposed option to define an EHB-benchmark plan for 2019 and later years could allow a State to embed any desired benefit mandate into the EHB-benchmark plan, without any requirement to defray the obligation. For this reason, we propose to apply the benefit mandate defrayal policy under §155.170 to this option. Specifically, we propose that benefits mandated by State action prior to or on December 31, 2011 could continue to be considered EHB under this proposal according to §155.170, and would not require State defrayal. However, if a State selects its EHB-benchmark plan using this option, the State must continue to defray the cost of any benefits mandated by State action after December 31, 2011 that are subject to defrayal under current regulations. For example, if the State selects a set of benefits to become its EHB-benchmark plan under paragraph (a)(3), any benefits mandated by that State after December 31, 2011 that are subject to defrayal under current regulations would not be considered EHB, and the State would be required to defray the cost of any such benefits included in the State's EHB-benchmark plan under this proposed option.

We solicit comments on this proposal and all of the proposed options in this section, including whether a different approach is needed to defray the cost of any benefits mandated by State action, on our proposed approach to limit a State's new EHB-benchmark plan such that it does not exceed the generosity of the comparison plans and on whether other options should be provided to States to select their EHB-benchmark plans beyond the three proposed options.

ii. The requirements for States' EHB-benchmark plans (§156.111(b)-(d))

For all of the proposed options for States to select a new EHB-benchmark plan, we also propose that a State's EHB-benchmark plan must meet certain requirements established under the PPACA with regard to EHB coverage, scope of benefits, and notice and opportunity for public comment. In paragraph (b)(1), we propose to require that the State's EHB-benchmark plan provide an appropriate balance of coverage for the 10 EHB categories of benefits as established at §156.110(a) and under section 1302(b)(1) of the PPACA. The intention of this proposed requirement is to ensure that the State's EHB-benchmark plan selection meets the requirement to cover at least the 10 EHB categories, including the items and services covered in those categories.

In paragraph (b)(2), we propose to define requirements regarding the scope of benefits that must be provided by a State's EHB-benchmark plan. In paragraph (b)(2)(i), we propose that the State's EHB-benchmark plan must be equal in scope of benefits to what is provided under a typical employer plan. This proposed requirement reflects section 1302(b)(2) of the PPACA, which requires the Secretary to ensure that the scope of the EHB is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. We recognize that the scope of benefits covered by employer plans varies, including variations based on State laws, consumers' purchasing preferences, and local markets. We believe it is appropriate to recognize

this variation in the definition of a typical employer plan. We also believe that, although State laws (for example, laws with benefit mandates) may affect the scope of benefits in plans available in a given State, it is important that a Federal definition of a typical employer plan maximize States' flexibility to choose an EHB-benchmark plan, so that States are not constrained in their selection. Therefore, we propose to define a typical employer plan as an employer plan within a product (as these terms are defined in §144.103 of this subchapter) with substantial enrollment in the product of at least 5,000 enrollees sold in the small group or large group market, in one or more States, or a self-insured group health plan with substantial enrollment of at least 5,000 enrollees in one or more States. We also seek comment on whether the definition of a typical employer plan should reflect in substantial part a plan that would be typical in the State in question, and whether an appropriate way to measure typicality in that case would be to provide that the typical employer plan be defined to also have at least 100 enrollees enrolled in that plan or product in the applicable State. We seek comment broadly on whether typicality should be defined in other ways, including whether it should be based upon the State's 10 base-benchmark plan options for plan year 2017, supplemented as required to become the State's EHB-benchmark plan under §156.110, or on whether the definition of a typical employer plan for this purpose should be limited to plans that already cover all 10 EHB categories. We also solicit comment on whether the proposed typical employer plan definition should exclude self-insured plans, since States may not have the ability to obtain the required information on those plans.

Under the proposed definition of a typical employer plan as a plan with enrollment of at least 5,000 enrollees in one or more States, we believe that the State's option to select another State's EHB-benchmark plan at proposed §156.111(a)(1) would automatically meet this

requirement because each of the available options is an employer plan that had substantial enrollment. We solicit comment on the proposed definition of a typical employer plan, including on whether we should provide additional guidance or requirements for the definition of a typical employer plan, such as requiring that the plan selected as a typical employer plan is from a recent year after December 31, 2013, requiring that the plan provide minimum value, or requiring that the plan selected as a typical employer plan not be an indemnity plan or an account-based plan like a health reimbursement arrangement. We also solicit comment on whether actuaries could develop a standard of practice for a benefit comparison calculation to determine that a plan is equal to the scope of benefits provided under a typical employer plan that could also apply to determine that a State's EHB-benchmark plan does not exceed the generosity of the most generous plan in accordance with Option 3 under proposed §156.111(a)(3).

We specifically seek comment on CMS's draft example of an acceptable methodology for comparing benefits of a State's EHB-benchmark plan selection to the benefits of a typical employer plan.⁴⁸ The purpose of this draft document is to outline an example of one approach actuaries could follow when comparing benefits in order to complete the required actuarial certification and associated actuarial report under proposed §156.111(e)(2)(i) for typicality described later in this section. We are particularly interested in comments on this draft methodology from the actuarial community. We further request that commenters submit comments to this draft document as part of their comments to this proposed rule.

⁴⁸ The *Draft Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection to Benefits of a Typical Employer Plan As Proposed under the HHS Notice of Benefit and Payment Parameters for 2019 (CMS-9930-P)* is available on CCIIO's Regulation and Guidance webpage at <https://www.cms.gov/cciio/resources/regulations-and-guidance/index.html>.

In paragraph (b)(2)(ii), we propose that the State's EHB-benchmark plan must not have benefits unduly weighted towards any of the categories of benefits at §156.110(a) as established under section 1302(b)(4)(A) of the PPACA. The purpose of this proposed provision is to ensure the State's EHB-benchmark plan selection reflects an appropriate balance among the categories. Additionally, in paragraph (b)(2)(iii), we propose that the State's EHB-benchmark plan must provide benefits for diverse segments of the population, including women, children, persons with disabilities, and other groups as established under section 1302(b)(4)(C) of the PPACA.

We propose at paragraph (c), that the State must provide reasonable public notice and an opportunity for public comment on the State's selection of an EHB-benchmark plan. We believe that some States already provided public notice and an opportunity for public comment in their current EHB-benchmark plan selection processes completed for prior plan years. Recognizing that States have their own processes in place to provide notice and opportunity for public comment, we propose that States would determine what constitutes a reasonable public notice and public comment process. We remind States that any public participation processes must continue to comply with applicable Federal civil rights laws, including national standards that ensure access to individuals with disabilities. We solicit comments on whether the State should be required to post the public notice on their Web site, whether other requirements are needed for States' public notice and comment processes, and what those requirements should be. We propose that this process would apply whenever a State changes its EHB-benchmark plan in accordance with proposed §156.111(a).

Lastly, we propose at paragraph (d) that a State must notify HHS of the selection of a new EHB-benchmark plan by a date to be determined by HHS for each applicable plan year. We also propose that if the State does not make a selection by the annual selection date, the State's

EHB-benchmark plan for the applicable plan year would be that State's EHB-benchmark plan applicable for the prior plan year.

Taken together, these proposed requirements are intended to align with statutory requirements. With the exception of the proposed change in this proposed rule to the substitution provision at §156.115(b), we intend to retain the current issuer requirements related to EHB at §§156.115, 156.122,⁴⁹ and 156.125 and those requirements would continue to apply to all plans subject to the EHB requirements.

In addition to these proposed requirements in selecting the State's EHB-benchmark plan, States may also wish to consider the impact of the EHB-benchmark plan's scope of benefits on the availability of premium tax credits and cost-sharing reductions for enrollees in the State, as the premium tax credit is based on the amount of premiums allocable to EHB and cost-sharing reductions provide reduced cost sharing for EHB only.⁵⁰ We solicit comments on these proposals and whether other requirements are needed.

iii. Data collection for State's EHB-benchmark plans for 2019 plan year and later (§156.111(e))

⁴⁹ 45 CFR 156.122(a)(1) establishes that, generally, a health plan does not provide EHB unless it covers at least the greater of: 1) one drug in every United States Pharmacopeia (USP) category and class; or 2) the same number of prescription drugs in each category and class as the EHB-benchmark plan. Under the current version of the USP Medicare Model Guidelines (MMG) drug classification system used for the EHB drug count at §156.122(a)(1), this proposal means that all plans required to comply with EHB will continue to have to cover at least one drug in the Anti-Addiction/ Substance Abuse Treatment Agents (Opioid Reversal Agent) class. Naloxone is currently the only active ingredient in the Opioid Reversal Agent class, and as a result all plans required to comply with EHB would be required to continue to cover at least one form of naloxone under this proposed policy. This was previously addressed in the 2018 Letter to Issuers in the Federally-facilitated Marketplaces available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces-and-February-17-Addendum.pdf>.

⁵⁰ The definition of EHB also has an impact on the annual limitation on cost sharing at section 1302(c) of the PPACA (which is incorporated into section 2707(b) of the PHS Act) and the prohibition of annual and lifetime dollar limits at section 2711 of the PHS Act, as added by the PPACA.

For States that opt to select a new EHB-benchmark plan under §156.111(a) in any given year, we propose to establish the data collection requirements under proposed §156.111(e). We propose a State must submit documents in a format and manner specified by HHS by a date determined by HHS.

Specifically, paragraph (e)(1) would require documentation that would confirm that the State's EHB-benchmark plan complies with the requirements under proposed §156.111(a), (b) and (c), which includes the requirement that the 10 EHB categories of benefits are covered under the State's EHB-benchmark plan. This documentation would also include information on which selection option under proposed §156.111(a) the State is using, including whether the State is using another State's EHB-benchmark plan.

For a State selecting an EHB-benchmark plan under proposed §156.111(a)(2) or (3), paragraph (e)(2) would require the State to submit an actuarial certification and an associated actuarial report from an actuary, who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies, affirming that the State's EHB-benchmark plan is equal in scope of benefits provided under a typical employer plan. We solicit comments on whether this actuarial certification should also be required for a State selecting an EHB-benchmark plan under proposed §156.111(a)(1). Additionally, we also propose that if the State is selecting its EHB-benchmark plan using §156.111(a)(3) that allows the State to otherwise select a set of benefits that would become its EHB-benchmark plan, that this actuarial certification would affirm that the new EHB-benchmark plan does not exceed the generosity of the most generous among the set of comparison plans specified in paragraph (a)(3). Specifically, we propose that the actuarial certification and associated actuarial report would be required to be in accordance with generally accepted actuarial principles and methodologies.

This would include complying with all applicable Actuarial Standards of Practice (ASOP) (including but not limited to ASOP 41 on actuarial communications). For example, ASOP 41 includes disclosure requirements, including those that apply to the disclosure of information on the methods and assumptions being used.

The purpose of this provision is to ensure that the scope of EHB is equal in scope of benefits provided under a typical employer plan and to provide the information to support the certification from the Chief Actuary of CMS for the Secretary to submit along with a report to Congress, consistent with section 1302(b)(2)(B) of the PPACA. As described previously, we are seeking comment on a draft methodology for comparing benefits of a State's EHB-benchmark plan selection to the benefits of a typical employer plan.⁵¹ We solicit comment on this proposed actuarial certification and associated actuarial report and on whether the draft methodology should be the required approach for the State's actuarial certification and associated actuarial report.

Paragraph (e)(3) would require the State to submit the State's EHB-benchmark plan document that reflects the benefits and limitations, including the medical management requirements, a schedule of benefits and, if the State is selecting its EHB-benchmark plan using the option in paragraph (a)(3) of this section, a formulary drug list in a format and manner specified by HHS similar to current §156.120. The purpose of this provision is to ensure that the State's EHB-benchmark plan has a clearly defined set of covered benefits and limits. For a State that chooses an EHB-benchmark plan under proposed §156.111(a)(1), the State may submit the

⁵¹ The *Draft Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection to Benefits of a Typical Employer Plan As Proposed under the HHS Notice of Benefit and Payment Parameters for 2019 (CMS-9930-P)* is available on CCIIO's Regulation and Guidance webpage at <https://www.cms.gov/cciio/resources/regulations-and-guidance/index.html>.

plan document from the other State's EHB-benchmark plan used for the 2017 plan year to fulfill this proposed requirement. For a State that selects an EHB-benchmark plan under proposed §156.111(a)(2), the State would create a combined plan document by pulling parts of the plan documents from the other State's or States' benchmark plan documents. States may need to make conforming edits in the other States' plan documents to align language and terminology when pulling language from other States' plan documents. For a State that chooses the option proposed at §156.111(a)(3), the State may need to develop a plan document for this purpose. Additionally, under proposed §156.111(e)(3), if the State is selecting its EHB-benchmark plan using the option in §156.111(a)(3) of this section, we propose that the State must also include a formulary drug list for the State's EHB-benchmark plan in a format and manner specified by HHS. Specifically, the State would need to submit a formulary drug list in the format and manner specified by HHS, which is a separate template from the plan document. We also propose for the purposes of a benefit, such as pediatric dental, that is defined by another program under the State's EHB-benchmark plan, the State may submit a separate document that reflects the benefits and limitations, including the medical management requirements and a schedule of benefits comparable to how States that defined their dental coverage using their State's CHIP programs have done previously. Otherwise, regardless of which option the State is using to select a new EHB-benchmark plan, the State would be expected to submit one comprehensive plan document for the entire State's EHB-benchmark plan benchmark selection.

Lastly, paragraph (e)(4) would require the State to submit documentation specified by HHS, which is necessary to operationalize the State's EHB-benchmark plan. This documentation would be used to provide public resources on a State's EHB-benchmark plan and support related templates and tools. We propose that this documentation would include having the State submit a

complete and accurate EHB summary chart that reflects the State's EHB-benchmark plan and aligns with the documentation that we currently make publicly available on a State's EHB-benchmark plan. The purpose of this provision is to ensure that State's EHB-benchmark plan can be operationalized. For States that choose §156.111(a)(1) or (a)(2) where the State is developing its benchmark plan based on another State's EHB-benchmark plan, the State could develop this document utilizing information from the EHB summary chart that is currently publicly available.⁵²

Like our current approach to the EHB-benchmark plan policy, we propose that HHS would post the State's EHB summary document and the State's EHB-benchmark plan document that reflects the benefits and limitations, including the medical management requirements and a schedule of benefits that may include a new formulary drug count on CCIIO's Web site. In addition to posting those documents, we are also considering posting the State's EHB-benchmark plan confirmations proposed at §156.111(e)(1). In preparation for the short timeframes for States to submit such documents in time for issuers to design plans for plan years 2019 and 2020, we propose that the deadline for States' submission of the required documents for the State's EHB-benchmark plan option would be March 16, 2018, for the 2019 plan year and July 1, 2018, for the 2020 plan year.⁵³ Due to the short timeframes for 2019, we would not be able to update the Plans and Benefits Template Add-in file used in the Plans and Benefits

⁵² All States' current benchmark plan documents are posted on CCIIO's Web site at <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html>.

⁵³ Due to the proposed tight timeframe for 2019, we would not be able to allow States to submit additional documentation or changes to submitted documents after the deadline. Any questions or issues that a State has about the EHB-benchmark plan documents would need to be asked and resolved prior to the State's submission deadline.

Template for States for 2019.⁵⁴ For 2020, we would plan to update the Add-in file to reflect the State's EHB-benchmark plan.

We propose that in order for a State's selection of a new EHB-benchmark plan from the proposed options to be accepted, the State's new EHB-benchmark plan must comply with the associated EHB regulatory and statutory requirements, including those under this proposed rule. If a State's EHB-benchmark plan selection does not meet these regulatory and statutory requirements, the State's current EHB-benchmark plan would continue to apply. We solicit comments on the proposed processes and deadlines for the 2019 and 2020 plan years.⁵⁵ We also solicit comments on the proposed data collection and associated documents and whether other specifications for these documents are needed.

c. Provision of EHB (§156.115)

We are also proposing additional flexibility for States by revising the rules regarding EHB benefit category substitution. Currently, EHB compliant plans are required to provide benefits that are substantially equal to the EHB-benchmark plan, but are allowed to substitute benefits within categories, if allowed by the State, provided that the benefits are actuarially equivalent to the benefit that is being replaced. Substitutions of prescription drug benefits are not permitted.⁵⁶ We first introduced the concept of benefit substitution in the 2011 EHB Bulletin.⁵⁷

⁵⁴ Instead, we would only plan to post the State's EHB-benchmark documents, including an updated drug count, on CCHIO's Web site. This means that for 2019 the State would be expected to instruct its issuers on how to manually change the State's current Add-in file to align with the State's EHB-benchmark plan.

⁵⁵ For the 2019 plan year, HHS would post States' EHB-benchmark plan documents after the proposed State submission deadline, which would likely be in April 2018.

⁵⁶ See §156.115(b)(1)(iii), as established in the EHB Rule. Additionally, §156.122(a)(1) specifies that plans that provide EHB must cover at least the greater of: (i) One drug in every United States Pharmacopeia (USP) category and class; or (ii) The same number of prescription drugs in each category and class as the EHB-benchmark plan. Additionally, as discussed in the HHS Notice of Benefit and Payment Parameters for 2016 Final Rule (80 FR 10817)

The EHB Bulletin considered whether to permit benefit substitution between benefit categories. Some commenters supported wide latitude for substitution, while others opposed substitution both within and across categories. In the EHB Rule, we finalized at §156.115(b)(1) that substitution could only occur within the statutorily required benefit categories (other than prescription drug benefits), not between different benefit categories.

In an effort to promote greater flexibility, consumer choice, and plan innovation through coverage and plan design options, we propose modifying paragraph (b)(1)(ii) to allow for substitution to occur within the same EHB category and between EHB categories, as long as the substituted benefit is actuarially equivalent to the benefit being replaced and is not a prescription drug benefit. The plan with substitutions must still provide benefits that are substantially equal to the EHB-benchmark plan, must provide an appropriate balance among the EHB categories such that benefits are not unduly weighted towards any category, and must provide benefits for diverse segments of the population. It is generally the State's responsibility to assess that EHB compliant plans adhere to these requirements.

We believe this modification at §156.115(b)(1)(ii) balances the value of comparability of plan benefits with opportunities for plan innovation and provision of benefit choice in the market. Under this approach, to comply with the EHB requirements, plans that exercise the flexibility to substitute benefits within or between EHB categories must be able to demonstrate actuarial equivalency of substituted benefit categories in accordance with the requirements in

preamble for §156.122, if a plan is covering drugs beyond the number of drugs covered by the benchmark, all of these drugs are EHB and must count towards the annual limitation on cost sharing.

⁵⁷ Essential Health Benefits Bulletin, Center for Consumer Information and Insurance Oversight (December 16, 2011), available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.

paragraph (b)(2) of this section. These protections would ensure that substitution within or between benefit categories would balance adequate coverage for patients with plan innovation.

We also note that nothing in this proposal would prohibit plans required to provide EHB from imposing non-dollar limits, unless otherwise prohibited by Federal law.⁵⁸ In addition, we note that the regulation would continue to defer to States, which would continue to have the option to set criteria for benefit substitution, enforce a stricter standard on benefit substitution, or prohibit it altogether consistent with paragraph (b) of this section. We solicit comments on this proposed change, including on whether other flexibilities with regard to substitution are needed and whether additional standards are necessary to assess the scope and quality of benefits being substituted between categories. Additionally, we are particularly interested in comments on this proposal that provide examples of how issuers may be able to utilize this additional proposed flexibility to meaningfully substitute benefits between categories. We also seek comment on examples of substitution that issuers would be interested in pursuing.

d. Premium adjustment percentage (§156.130)

Section 1302(c)(4) of the PPACA directs the Secretary of HHS to determine an annual premium adjustment percentage, which is used to set the rate of increase for three parameters detailed in the PPACA: the maximum annual limitation on cost sharing (defined at §156.130(a)); the required contribution percentage used to determine eligibility for certain exemptions under section 5000A of the Code; and the assessable payment amounts under section 4980H(a) and (b)

⁵⁸ See Frequently Asked Questions on Essential Health Benefits Bulletin (February 17, 2012), Q9, available at <https://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf> and the EHB rule. As finalized in the EHB Rule, issuers of QHPs were permitted to make actuarially equivalent substitutions within statutory categories under §156.115(b)(1)(ii). Therefore, and as further explained in the EHB FAQ, plans are permitted to impose non-dollar limits, consistent with other guidance, that are at least actuarially equivalent to the annual dollar limits.

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 in the annual 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 estimates and projections of average per enrollee employer-sponsored insurance premiums from the NHEA, which are calculated by the CMS Office of the Actuary. Accordingly, using the employer-sponsored insurance data, the premium adjustment percentage for 2019 is the percentage (if any) by which the most recent NHEA projection of per enrollee employer-sponsored insurance premiums for 2018 (\$6,396) exceeds the most recent NHEA estimate of per enrollee employer-sponsored insurance premiums for 2013 (\$5,110).⁵⁹ Using this formula, the proposed premium adjustment percentage for 2019 is 1.2516634051 or approximately 25 percent. Based on the proposed 2019 premium adjustment percentage, we propose the following cost-sharing parameters for calendar year 2019.

- i. Maximum annual limitation on cost sharing for calendar year 2019.

⁵⁹ We note that the 2013 premium used for this calculation has been updated to reflect the latest NHEA data. See “NHE Projections 2016-2025 – Tables” available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html> in Tables 1 and 17. A detailed description of the NHE projection methodology is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2016.pdf>.

Under §156.130(a)(2), for the 2019 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 2019, 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 dollars. Using the premium adjustment percentage of 1.2516634051 for 2019 as proposed 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, 2013,⁶⁰ we propose that the 2019 maximum annual limitation on cost sharing would be \$7,900 for self-only coverage and \$15,800 for other than self-only coverage. This represents an approximately 7 percent increase above the 2018 parameters of \$7,350 for self-only coverage and \$14,700 for other than self-only coverage.

e. Reduced maximum annual limitation on cost sharing (§156.130)

Sections 1402(a) through (c) of the PPACA 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 part 156, subpart E, we specified that QHP issuers must provide cost-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

⁶⁰ See <http://www.irs.gov/pub/irs-drop/rp-13-25.pdf>.

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 PPACA, section 1402(c)(1)(B)(ii) of the PPACA 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 PPACA (that is, 73 percent, 87 percent, or 94 percent, depending on the income of the enrollee). Accordingly, we propose to continue 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 2019 maximum annual limitation on cost sharing would be \$7,900 for self-only coverage and \$15,800 for other than self-only 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 2019 benefit year and our proposed results.

Consistent with our analysis in the 2014 through 2018 Payment Notices, we developed three test silver level QHPs, and analyzed the impact on AV of the reductions described in the PPACA to the estimated 2019 maximum annual limitation on cost sharing for self-only coverage (\$7,900). The test plan designs are based on data collected for 2017 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 2019, the test silver level QHPs included a PPO with typical cost-sharing structure (\$7,900 annual limitation on cost sharing, \$2,350 deductible, and 20 percent in-network coinsurance rate), a PPO with a lower annual limitation on cost sharing (\$5,250 annual limitation on cost sharing, \$3,050 deductible, and 20 percent in-network

coinsurance rate), and an HMO (\$7,900 annual limitation on cost sharing, \$3,375 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, \$500 emergency department visit, \$25 primary care office visit, and \$55 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 2019 AV Calculator and observed how the reductions in the maximum annual limitation on cost sharing specified in the PPACA affected the AVs of the plans. We found that the reduction in the maximum annual limitation on cost sharing specified in the PPACA for enrollees with a household income between 100 and 150 percent 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 levels (94 and 87 percent, respectively). In contrast, the reduction in the maximum annual limitation on cost sharing specified in the PPACA 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.

In prior years, we have found that for individuals with household incomes of 250 to 400 percent of the FPL, without any change in other forms of cost sharing, any reduction in the maximum annual limitation on cost sharing will cause an increase in AV that exceeds the maximum 70 percent level set in the statute. In the Market Stabilization Rule, we analyzed the effect of reducing the maximum annual limitation on cost sharing based on how we calculated the 2018 reduced maximum annual limitation on cost sharing. We stated that we were not certain what the AV spread of plan designs will be under the finalized policy, whether issuers will in fact reduce the AVs of their base silver plans to the lower end of the de minimis range, and whether issuers will retain plan designs above the 70 percent AV range and that we would monitor 2018 standard silver plan designs. As a result, we did not reduce the maximum annual limitation on cost sharing for individuals with household incomes between 250 and 400 percent FPL.⁶¹

We seek comment on this analysis and the proposed reductions in the maximum annual limitation on cost sharing for 2019.

We note that for 2019, as described in §156.135(d), States are permitted to submit for approval by HHS State-specific datasets for use as the standard population to calculate AV.⁶² No State submitted a dataset by the September 1, 2017 deadline.

⁶¹ 2014 Payment Notice, 78 FR at 15481; Market Stabilization Rule. 82 FR at 18370-18371.

⁶² The annual deadline for submitting State specific data for the AV Calculator was announced August 15, 2014. See <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/final-state-avc-guidance.pdf>.

TABLE 10: Reductions in Maximum Annual Limitation on Cost Sharing for 2019

Eligibility Category	Reduced Maximum Annual Limitation on Cost Sharing for Self-only Coverage for 2019	Reduced Maximum Annual Limitation on Cost Sharing for Other than Self-only Coverage for 2019
Individuals eligible for cost-sharing reductions under §155.305(g)(2)(i) (that is, 100-150 percent of FPL)	\$2,600	\$5,200
Individuals eligible for cost-sharing reductions under §155.305(g)(2)(ii) (that is, 150-200 percent of FPL)	\$2,600	\$5,200
Individuals eligible for cost-sharing reductions under §155.305(g)(2)(iii) (that is, 200-250 percent of FPL)	\$6,300	\$12,600

f. Application to stand-alone dental plans inside the Exchange (§156.150)

Section 1302(d)(2) of the PPACA directs the Secretary to issue regulations on the calculation of AV and its application to the levels of coverage. In the 2013 EHB Rule, HHS finalized the requirements for the calculation of AV for stand-alone dental plans. Specifically, §156.150 prohibits SADPs from using the AV Calculator used by other individual and small group market plans and requires SADPs to cover the pediatric dental EHB at one of two AV levels, within an allowable de minimis variation of +/- 2 percentage points.

We are proposing to remove the requirement for SADP issuers to meet the low (70 percent +/- 2 percentage points) and high (80 percent +/- 2 percentage points) AV levels specified in §156.150(b). Specifically, we are proposing to remove paragraph (b). SADP issuers would offer the pediatric dental EHB without selecting or calculating an AV level of that coverage. SADP issuers would continue to be held to the annual limitation on cost sharing for the pediatric EHB, as required in paragraph (a), and provide the pediatric dental EHB as required by §155.1065, in order to be certified as QHPs.

The PPACA does not specifically require SADP issuers to offer coverage at the high and low levels of AV. By removing the AV level requirement, SADP issuers will have the

opportunity to offer more flexible plan designs to consumers. In previous comments, SADP issuers had noted that it is difficult to meet the low AV requirements and offer preventive care without cost sharing, which consumers are accustomed to in the large group market. Issuers could offer SADPs at varying premiums and levels of coverage, so long as they continue to offer the pediatric dental EHB and annual limitations on cost sharing. We believe that this will allow consumers to select from a greater variety of plans and find one that is more likely to meet their specific needs.

We seek comment on this proposal.

3. Qualified Health Plan Minimum Certification Standards

a. Qualified health plan certification (Subpart C)

In the Market Stabilization final rule, HHS finalized several standards to affirm the traditional role of States in overseeing their health insurance markets while reducing the regulatory burden of participating in Exchanges for issuers. We believe that robust participation of QHP issuers in Exchanges will facilitate consumer access to affordable coverage. In recognition of the call to return to States their traditional authority to regulate health plans and to streamline QHP certification processes, HHS proposes to continue to enhance the State flexibilities in QHP certification that began for plan year 2018 by identifying areas where States are already performing reviews that are duplicative of the Federal QHP certification process and incorporating these reviews into the QHP certification process. In addition to empowering States, these proposals would reduce issuer burden.

In the Market Stabilization final rule, we finalized two proposals related to QHP certification for plan year 2018 around network adequacy (§156.230) and essential community providers (§156.235) that we now propose for the 2019 benefit year and beyond. Specifically,

with respect to network adequacy, we propose to rely on the States' reviews in States in which an FFE is operating, provided the State has a sufficient network adequacy review process. For the 2019 benefit year and beyond, we propose to defer to the States' reviews in States with the authority to enforce standards that are at least equal to the "reasonable access standard" defined in §156.230 and means to assess issuer network adequacy. In States that do not have the authority and means to conduct sufficient network adequacy reviews, we propose for the 2019 benefit year and beyond to rely on an issuer's accreditation (commercial, Medicaid, or Exchange) from an HHS-recognized accrediting entity, which we propose would include the three accrediting entities HHS has previously recognized for the accreditation of QHPs: the National Committee for Quality Assurance, URAC, and Accreditation Association for Ambulatory Health Care.⁶³ Unaccredited issuers would be required to submit an access plan as part of the QHP application. To show that the QHP's network meets the requirement in §156.230(a)(2), the access plan would need to demonstrate that an issuer has standards and procedures in place to maintain an adequate network consistent with the National Association of Insurance Commissioners' Health Benefit Plan Network Access and Adequacy Model Act (the Model Act is available at <http://www.naic.org/store/free/MDL-74.pdf>). We propose to further coordinate with States to monitor network adequacy, for example, through complaint tracking. With respect to QHP certification review for the essential community provider (ECP) standard, we propose for the 2019 benefit year and beyond that we will continue to allow issuers to use the ECP write-in process to identify ECPs that are not on the HHS list of available ECPs and will

⁶³ Recognition of Entities for the Accreditation of Qualified Health Plans 77 FR 70163 (November 23, 2012) and Approval of an Application by the Accreditation Association for Ambulatory Health Care (AAAHC) To Be a Recognized Accrediting Entity for the Accreditation of Qualified Health Plans 78 FR 77470 (December 23, 2013).

maintain the 20 percent ECP standard. We believe this standard will substantially reduce the regulatory burden on issuers while preserving adequate access to care provided by ECPs. As in previous years, if an issuer's application does not satisfy the ECP standard, the issuer would be required to include as part of its application for QHP certification a satisfactory narrative justification describing how the issuer's provider networks, as presently constituted, provide an adequate level of service for low-income and medically underserved individuals and how the issuer plans to increase ECP participation in the issuer's provider networks in future years. At a minimum, such narrative justification would include the number of contracts offered to ECPs for the applicable plan year; the number of additional contracts an issuer expects to offer and the timeframe of those planned negotiations; the names of the specific ECPs to which the issuer has offered contracts that are still pending; and contingency plans for how the issuer's provider network, as currently designed, would provide adequate care to enrollees who might otherwise be cared for by relevant ECP types that are missing from the issuer's provider network.

We also previously outlined areas where HHS will rely on State reviews of QHP certification standards for States with FFEs starting in plan year 2018, including States with FFEs that perform plan management functions in partnership with HHS, in The Guidance to States on Review of Qualified Health Plan Certification Standards in Federally-facilitated Marketplaces for Plan Years 2018 and Later,⁶⁴ released on April 13, 2017. We intended these changes to help streamline the QHP certification process and avoid duplicative Federal and State efforts. In that guidance, we provided that in FFE States that do not perform plan management functions, HHS will continue to review QHP data for these States, but will rely on State review

⁶⁴ <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/QHP-Certification-Reviews-Guidance-41317.pdf>.

for licensure and good standing standards required at §156.200(b)(4), and for network adequacy standards required at §156.230. For FFEs in States performing plan management functions, HHS will continue to rely on State plan data review for QHP certification standards, including for service area and prescription drug formulary outliers and non-discrimination in cost sharing. We will continue to review plan data relating to Federal funds or plan display on HealthCare.gov, such as cost-sharing reduction plan variation at §156.420 and annual re-enrollment at §155.335(j). We do not propose any changes to the approach described in this guidance.

To further streamline QHP certification by avoiding duplicative reviews, we also announced in the QHP Rate Outlier Analysis for Plan Year 2018 and Beyond⁶⁵ that we would rely on States to identify rate outliers for purposes of QHP certification,⁶⁶ except for those States that do not have an Effective Rate Review Program. These changes were intended to allow States and issuers greater flexibility in facilitating the certification of plans best suited to their markets, while avoiding duplicative State and Federal activities. We do not propose any changes to the approach described in this guidance.

For Plan Years 2019 and later, HHS proposes to further expand the role of States in the QHP certification process for FFEs, including FFEs where the State performs plan management functions. Specifically, we propose to defer to States for additional review areas, including accreditation requirements at §156.275, compliance reviews at §156.715, minimum geographic area of the plan's service area at §155.1055, and quality improvement strategy reporting at

⁶⁵ https://www.regtap.info/uploads/library/QHP_RateOutlier_FAQ_5CR_071017.pdf.

⁶⁶ This review generally identifies rates that are relatively low compared to other QHP rates in the same rating area. The identification of a QHP rate as an outlier does not necessarily indicate inappropriate rate development; instead, this information helps inform the determination of whether certifying the QHP to be offered on the Exchange would be in the interest of consumers.

§156.1130, if feasible and appropriate. We believe States currently perform reviews in these areas that are duplicative of the Federal reviews for QHP certification. As a result, we do not believe this policy would require States to undertake additional reviews or change existing reviews to match the Federal standards for QHPs. We seek comment on whether States are performing work in these areas, and whether there are more or different areas of review for which it would be appropriate for the FFEs to defer to State reviews for QHP certification. We seek comment regarding the potential benefits as well as challenges or unintended consequences that States and issuers may encounter if States performed increased roles in QHP certification reviews by taking on the reviews noted above, or other, additional reviews. We also seek comment on the impact for QHP issuers participating in multiple States and across Exchange types. HHS anticipates outlining plan year 2019 QHP certification standards in future guidance, including outlining areas where States performing plan management functions have flexibility to follow a different approach. We also propose to amend §156.200(b)(2) by adding a cross reference to proposed §155.706 to align with other proposals in this rule.

b. Additional standards specific to SHOP for plan years beginning prior to January 1, 2018 (§156.285)

As discussed in the following section, we propose to modify the regulatory requirements regarding additional standards specific to SHOP for plan years beginning on or after January 1, 2018 and to introduce those requirements in a new §156.286. To reflect the proposal that the requirements currently in §156.285 would apply only for plan years beginning before January 1, 2018, we propose to amend the heading of §156.285 and add paragraph (f), to state that the section would only apply for plan years that begin prior to January 1, 2018. We discuss the proposed new standards applicable for plan years beginning on or after January 1, 2018 in the

following section. These changes would be effective on the effective date of the final rule, if finalized as proposed.

c. Additional standards specific to SHOP for plan years beginning on or after January 1, 2018 (§156.286)

Section 156.285 currently describes the requirements on QHP issuers participating in SHOPs to accept enrollment and payment information from a SHOP on behalf of an employer or enrollee. As discussed above, we propose to amend §156.285 to make it only applicable for plan years beginning prior to January 1, 2018, and to modify the additional standards specific to QHP issuers participating in SHOPs applicable for plan years beginning on or after January 1, 2018 through the introduction of a new §156.286. New §156.286 would include only those standards that have been applicable under §156.285 that would continue to apply to the SHOPs under the proposed approach discussed earlier in this preamble, with minor modifications and clarifications. The proposals described in this section would be effective on the effective date of the final rule, if finalized as proposed.

We propose to retain §156.285(a) as §156.286(a), but, to reflect the proposal that a SHOP would not be required to process enrollments and payments, to require issuers to accept payment not only from the SHOP, but from a qualified employer or enrollee or a SHOP. We also propose not to include the requirement currently in §156.285(a)(4)(ii), as the Federally-facilitated SHOPs would no longer be involved in premium payments. For the same reason, we also propose a narrower version of §156.285(b) as §156.286(b), requiring only that issuers adhere to the enrollment periods and processes established by the SHOP consistent with §155.726, and establish uniform enrollment timelines and processes for qualified employers and group members. We also propose in §156.286(c) to include only those requirements from §156.285(c)

that do not relate to the payment and enrollment processes that we have proposed would no longer be required.

We also propose not to include a paragraph mirroring paragraph (d) of §156.285. This would reflect our proposal to remove the requirements contained in current §155.735, and generally not to impose coverage related timelines on issuers of QHPs through the SHOPs for plans beginning on or after January 1, 2018. We propose to include a paragraph mirroring §155.285(e) as §156.286(d).

Finally, under our proposed approach, SHOPs would no longer be required to provide employee enrollment functionality. When enrollments are completed by working with SHOP issuers or SHOP-registered agent or brokers, it may not always be immediately apparent to the issuer whether the enrollment is through the SHOP, and whether it is part of an employer's offering a choice of plans. To ensure that issuers offering QHPs through a SHOP do so in a manner that is consistent with our proposed interpretation of the SHOP provisions of the statute, we propose to add new paragraphs (e) and (f) in §156.286. These would require that QHP issuers offering a QHP through the SHOP accept enrollments from groups in accordance with the employer choice policies applicable to the SHOP under §155.706(b)(3), that they maintain processes sufficient to identify whether a group market enrollment is an enrollment through the SHOP, and they maintain records of SHOP enrollments for a period of 10 years following the enrollment. Proposed paragraph (f) also would require issuers to utilize a uniform enrollment form, as required by section 1311(c)(1)(F) of the PPACA. As noted in the preamble to §155.716, we intend to update the single employer application to reflect our proposed changes in §155.731. An issuer would be considered to satisfy this proposed requirement if it used that application form.

Finally, we propose in paragraph (g) to state that the requirements contained within §156.286 are only applicable for plan years beginning on or after January 1, 2018, effective on the effective date of the final rule, if finalized as proposed.

d. Meaningful difference standard for qualified health plans in the Federally-facilitated Exchanges (§156.298)

We propose to remove §156.298 to eliminate meaningful difference standards for QHPs offered through a Federally-facilitated Exchange or State-based Exchange on the Federal platform. Under this standard, in order to be certified as a QHP, a plan must be meaningfully different from all other QHPs offered by the same issuer of that plan within a service area and level of coverage in the Exchange. As defined in §156.298(b), QHPs are considered meaningfully different from other plans if a reasonable consumer would be able to identify one or more material differences among five key characteristics between the plan and other plans to be offered by the same issuer.

This meaningful difference standard was implemented to make it easier for consumers to understand differences between plans, and choose the right plan option for them. However, with fewer issuers participating in the Exchange, and fewer plans for consumers to choose from, we propose to remove these standards, as we no longer believe the requirement is necessary. We believe removing the meaningful difference standard would encourage plan design innovation, by providing more flexibility to issuers in designing plans, and thus increase plan offerings and choice for consumers.

e. Other considerations

We seek comment on ways in which HHS can foster market-driven programs that can improve the management and costs of care and that provide consumers with quality, person-

centered coverage. As we stated in the 2017 and 2018 Payment Notices, we believe that innovative issuer, provider, Exchange, and local programs or strategies can successfully promote and manage care, in a manner that contributes to 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 better meet the goals of affordability, quality, and access to care.

We are particularly interested in receiving comments on how we may encourage value based insurance design within the individual and small group markets and ways to support issuers in using cost sharing to incentivize more cost-effective enrollee behavior and higher quality health outcomes, in accordance with section 2713(c) of the PHS Act. Currently, under our rules, issuers have considerable discretion in the design of cost-sharing structures, subject to certain statutory AV requirements, non-discrimination law and rules, and other applicable law, such as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

We would like to encourage issuers to offer HDHPs that can be paired with an HSA as a cost effective options for enrollees. While the proportion of available HSA-eligible HDHPs has been stable in the FFEs, the percentage of enrollees in HDHPs has decreased slightly over the last 3 years as there are certain technical barriers for issuers in offering HDHPs in the EHB compliant market.⁶⁷ We are particularly interested in exploring how to use plan display options

⁶⁷ For instance, the maximum annual limitation on cost sharing established at section 1302(c) of the PPACA is increasing at a faster rate than the maximum out of pocket cost limits for HDHPs under section 223 of the Code.

on HealthCare.gov to promote the availability of HDHPs to applicants, and seek comment on how best to do so.

We are also interested in value based insurance designs that focus on cost effective drug tiering structures; address overused, higher cost health services; provide innovative network design that incentivizes enrollees to use higher quality care; and promote use of preventive care and wellness services. We solicit comments on how HHS can better encourage these types of plan designs, and whether any existing regulatory provisions or practices discourage such designs.

4. Standards for downstream and delegated entities (§156.340)

This section discusses the responsibilities of a QHP issuer and its applicable downstream entities. We propose to amend paragraph (a)(2) to add a cross reference to proposed §155.706 to align with other proposals made throughout this proposed rule.

5. Eligibility and Enrollment Standards for Qualified Health Plan Issuers on State-based Exchanges on the Federal Platform (§156.350)

Section 156.350 describes the eligibility and enrollment standards for issuers that offer QHP coverage in the SBE-FPs. Currently, §156.350(a)(1) and (2) state that for a QHP issuer to participate in an SBE-FP for SHOP, it must comply with the requirements at §156.285(a)(4)(ii) and §156.285(c)(5) and (c)(8)(iii), respectively. However, as discussed elsewhere in this proposed rule, to align with our proposal regarding the SHOPS, we are proposing that these referenced requirements at §156.285 would not be applicable for plan years beginning on or after January 1, 2018, effective on the effective date of the final rule, if finalized as proposed. We

Therefore, a plan that utilizes the maximum annual limitation on cost sharing under the PPACA would not meet the requirements to be an HDHP under the Code that could be paired with an HSA.

therefore propose to amend §156.350(a)(1) and (a)(2) to specify that they only apply through plan years beginning prior to January 1, 2018.

We seek comment on these proposals.

6. Minimum Essential Coverage

a. Other coverage that qualifies as minimum essential coverage (§156.602)

A CHIP program is a type of government-sponsored coverage, defined under title XXI of the Act that provides low-cost health coverage to children in low-income families that do not otherwise have health coverage. States may be eligible to receive Federal funds to initiate and expand such programs. A CHIP buy-in program, a “full pay” option where a covered family pays the full premium typically without any Federal or State assistance, often provides similar or identical benefits as the State CHIP program for children in families that do not financially qualify for the State’s CHIP program.⁶⁸ CHIP buy-in programs are not authorized or funded under title XXI of the Act, and therefore are not government-sponsored minimum essential coverage under section 5000A(f)(1)(A) of the Code. However, CHIP buy-in programs may be recognized as minimum essential coverage by the Secretary in consultation with the Secretary of the Treasury, pursuant to the Secretary’s authority under section 5000A(f)(1)(E) of the Code.

In considering whether to recognize coverage as minimum essential coverage under the application process provided for in §156.604, HHS generally evaluates whether the coverage complies with substantially all the requirements of title I of the PPACA that apply to non-grandfathered coverage in the individual market, including the essential health benefits

⁶⁸ Under IRS Notice 2015-37, individuals who may enroll in a CHIP buy-in program designated as MEC are eligible for MEC under the CHIP buy-in program for purposes of the premium tax credit under section 36B of the Code only if they are enrolled in the program.

requirements. Many CHIP buy-in programs have benefits identical to those offered through the State's CHIP program under title XXI; however, those benefits might not meet the "substantially all" standard as currently interpreted by HHS, due primarily to differences between the CHIP buy-in benefits and those offered under the EHB-benchmark plan. While the EHB benchmark plan includes benefits to address the healthcare needs of all individuals, including older adults, the CHIP buy-in programs only offer coverage to children. Consequently, States may need to increase the benefits, and as a result, the cost of CHIP buy-in programs in order to meet the "substantially all" standard. Based on discussions with States that sponsor CHIP buy-in programs, we understand that administering two programs with different benefits creates a resource burden on States.

Section 156.602 specifies the types of coverage that are designated as minimum essential coverage pursuant to the Secretary's authority under section 5000A(f)(1)(E) of the Code. We propose to amend this section to include coverage under a CHIP buy-in program that provides identical coverage to that State's CHIP program under title XXI of the Act.

We seek comment on this proposal, including its effects on the individual market risk pool.

We also seek comment on whether CHIP buy-in programs that provide greater coverage should be categorically designated as minimum essential coverage, without submitting an application, or whether such programs must submit an application so that HHS can evaluate any differences from the State's CHIP program under title XXI to ensure that the program substantially resembles the State's CHIP program under title XXI. For example, a CHIP buy-in program could impose less cost sharing or more generous benefits than the State's CHIP program under title XXI. We also seek comment on whether other types of government-

sponsored buy-in programs, such as Medicaid buy-in programs, should be recognized as minimum essential coverage without having to submit an application, and whether this proposal should apply to such programs.

b. Requirements for recognition as minimum essential coverage (§156.604)

We recognize that the benefits in some CHIP buy-in programs are similar but not identical to the State’s CHIP program under title XXI; for example, they impose greater cost sharing or reduced benefits in comparison with the State’s CHIP program under title XXI.

Under the proposed changes to §156.602, CHIP buy-in programs with benefits that differ at all from the State’s CHIP program under title XXI would still be required to submit an application with HHS if they wish to be recognized as minimum essential coverage. HHS would evaluate such programs based on the “substantially all” standard that currently applies under §156.604. We seek comment on whether HHS should create a new standard of review under which such programs must “substantially resemble” the State’s CHIP program under title XXI to qualify as minimum essential coverage under §156.604. The “substantially resemble” standard would not be as stringent as the “substantially all” standard, but would give HHS the flexibility to evaluate CHIP buy-in programs based on whether they are providing coverage similar to the State’s CHIP program under title XXI and are meeting the health requirements of the children enrolled in the coverage. We are not proposing to codify the “substantially resemble” standard in §156.604; however, we propose that the Secretary use the Secretary’s discretion and authority under section 5000A(f)(1)(E) of the Code to recognize as minimum essential coverage a CHIP buy-in program that provides coverage similar to the State’s CHIP program under title XXI or when the facts and circumstances indicate that the CHIP buy-in program should be recognized as

minimum essential coverage. We seek comment on this proposal, including its effects on the individual market risk pool.

7. Quality Rating System (§156.1120)

We recognize that social risk factors play a major role in health, and one of our core objectives is to improve patients' outcomes including reducing health disparities. In addition, we seek to ensure that the quality of care furnished by providers and health plans is assessed as fairly and accurately as possible under HHS quality reporting programs, including the Quality Rating System established under section 1311(c)(3) of the PPACA, while helping to ensure that individuals and populations receive high quality, person-centered care. In response to several comments we received from the Request for Information, we continue to assess ways to reduce burden and promote State flexibility in the implementation of all statutorily required Exchange quality programs, including the Quality Rating System, and we continue to prioritize strategies to improve the value for consumers. We received many comments in response to our request for public comment as part of the annual Quality Rating System Call Letter process, on whether we should account for social risk factors in the Quality Rating System, which provides quality ratings (or star ratings from 1 to 5 stars) that account for member experience, medical care and health plan administration for QHPs, offered through an Exchange. We are not proposing amendments to the Quality Rating System in this rule. We continue to evaluate what method or combination of methods would be most appropriate for accounting for social risk factors in the Quality Rating System as well as other HHS quality reporting programs. We have closely

reviewed related reports by the Office of the Assistant Secretary for Planning and Evaluation⁶⁹ and the National Academies of Sciences, Engineering, and Medicine.⁷⁰ In addition, we continue to await the results of the National Quality Forum trial⁷¹ on risk adjustment for quality measures. We continue to advance healthcare quality across QHPs, as well as providers, to improve outcomes of their enrollees with social risk factors without masking potential disparities or minimizing incentives to improve the outcomes for disadvantaged populations.

We seek comment as part of this rulemaking on types of social risk factors that may be most appropriate as well as the methods to account for social risk factors for QHP issuer quality reporting. Examples of social risk factors include: low income subsidy; race and ethnicity; and geographic area of residence. Approaches to account for social risk factors include stratifying measure scores or risk adjustment of a particular measure. We seek comment on which social risk factors could be used alone or in combination, current data sources where this information would be available, and whether other data should be collected to better capture the effects of social risk. We will take commenters' input into consideration as we continue to assess the appropriateness and feasibility of accounting for social risk factors in the Quality Rating System.

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

⁶⁹ Office of the Assistant Secretary for Planning and Evaluation. Report to Congress: Social Risk Factors and Performance under Medicare's Value-based Purchasing Programs. (December 21, 2016). Available at <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicare-value-based-purchasing-programs>.

⁷⁰ National Academies of Sciences, Engineering, and Medicine. Accounting for Social Risk Factors in Medicare Payment. (January 10, 2017). Available at <http://nationalacademies.org/hmd/reports/2017/accounting-for-social-risk-factors-in-medicare-payment-5.aspx>.

⁷¹ National Quality Forum socioeconomic status (SES) trial period Web site at <http://www.qualityforum.org/ProjectDescription.aspx?projectID=80124>.

We propose to amend paragraph (b)(2) of §156.1230 to conform with the proposed amendments to §155.221. The proposed change would require that, prior to a QHP issuer's Internet Web site being used to complete a QHP selection, the QHP issuer must engage a third party entity in accordance with §155.221 to demonstrate operational readiness and compliance with applicable requirements. For a discussion of the provisions of this proposed rule related to third party entities performing operational readiness reviews, please see the preamble to §155.221.

F. Part 157 – Employer Interactions with Exchanges and SHOP Participation

1. Qualified Employer Participation Process in a SHOP for Plan Years beginning prior to January 1, 2018 (§157.205)

As discussed in the following section, we propose to modify the regulatory requirements regarding the qualified employer participation process in a SHOP for plan years beginning on or after January 1, 2018 and to introduce those requirements in a new §157.206. To reflect the proposal that the requirements currently in §157.205 would apply only for plan years beginning before January 1, 2018, we propose to amend the heading of §157.205 and add paragraph (h), to state that the section would apply only for plan years that begin prior to January 1, 2018. These changes would be effective on the effective date of the final rule, if finalized as proposed.

2. Qualified Employer Participation Process in a SHOP for Plan Years beginning on or after January 1, 2018. (§157.206)

Section 157.205 describes requirements for participating SHOP employers. To reflect the proposal to allow SHOPs to operate in a leaner fashion, we are proposing several changes to the requirements related to qualified employer participation process in a SHOP for plan years beginning on or after January 1, 2018, and propose to introduce these requirements in §157.206.

With the exception of the proposed changes to the process described here, the process would remain the same as in §157.205. The proposals described in this section would be effective on the effective date of the final rule, if finalized as proposed.

Paragraph (d) of §157.205 requires a qualified employer to submit any contribution towards the premiums of any qualified employee according to the standards and processes described in §155.705. Because we are proposing that the requirements in §155.705 regarding employer contribution methods would not apply for plan years beginning on or after January 1, 2018, we also propose that the requirement in §157.705(d) would not apply for those plan years.

Paragraph (e)(1) of §157.205 describes obligations of qualified employers to employees hired outside of the initial or annual open enrollment periods. We propose in §157.206(d) that qualified employers must provide employees hired outside of the initial or annual open enrollment period with information about the enrollment process. We propose that the requirement in paragraph (e)(1) of §157.705, which requires qualified employers to provide these employees with an enrollment period in accordance with §155.725(g), would not be included in §157.206, as we are proposing that the requirement in §155.725(g) would not be applicable for plan years beginning on or after January 1, 2018. We also propose that the requirement in §157.205(e)(2) to provide information about the enrollment process in accordance with §155.725 would not apply for plan years beginning on or after January 1, 2018 to reflect the proposal that the process provided for in many of the provisions in §155.725 would not apply for those plan years.

We also propose that the requirements in §157.205(f) regarding the process for notifying the SHOP in the event the eligibility status of an employee, or employee's dependent has changed would not apply for plan years beginning on or after January 1, 2018. Under the

proposed approach for plan years beginning on or after January 1, 2018, SHOPs would not be required to process employee enrollment, so there would be no reason for all qualified employers to provide such information.

Further, we propose that the requirement in §157.205(g) that qualified employers adhere to the annual employer election period under §155.725(c) would not apply for plan years beginning on or after January 1, 2018. Elsewhere, we propose that the annual employer election period provision in §155.725(c) would not apply for those plan years, and this proposal would reflect that removal.

Finally, we propose in paragraph (e) of §157.206 to include new requirements for qualified employers reflective of the proposed approach for SHOPs generally. First, since we propose in §155.716(f) that an employer's determination of eligibility to participate in the SHOP remains valid until the employer makes a change that could end its eligibility under §155.710(b), we propose in §157.205(e)(1) that employers must submit a new application to the SHOP if the employer makes a change that could end its eligibility under §155.710 or withdraw from participation in the SHOP. Second, because under our proposed changes SHOPs would not be required to process group enrollments, and therefore would not necessarily communicate with QHP issuers about employer eligibility determinations, we propose to require employers to notify the QHP issuer of an unfavorable eligibility determination. However, we propose that the employer be required to provide the notification within 5 business days of the end of any applicable appeal process under §155.741. Specifically, the end of the appeal process could occur when the time to file an appeal lapses without an appeal being filed, when the appeal is rejected or dismissed, or when the appeal process concludes with an adjudication by the appeals entity, as applicable. We also propose in paragraph (e)(3) to describe the employer's obligations

regarding loss of eligibility to participate in a SHOP or termination of enrollment or coverage through the SHOP, if this proposed approach were to be finalized. Given that under the proposed approach there would not necessarily be communication between the SHOP and a participating QHP issuer regarding employer eligibility, enrollment, or terminations, there may be no way for the SHOP to notify an issuer in the event an employer becomes ineligible to participate in SHOP. Therefore, we propose to add paragraph (e)(3) to require employers to notify an issuer of a loss of eligibility to participate in SHOP, or a desire to terminate SHOP enrollment or coverage.

We propose in paragraph (f) of §157.205 that the section would apply for plan years beginning on or after January 1, 2018, only. If finalized, these changes would become effective as of the effective date of the final rule.

We seek comment on this proposal.

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

1. Reporting of Federal and State taxes (§158.162)

Section 2718 of the PHS Act requires that Federal and State taxes be reported, but that such amounts are to be excluded from premium revenue when calculating an issuer's MLR and accompanying rebates. However, the statute does not define what is included in Federal and States taxes. The MLR December 1, 2010, interim final rule (75 FR 74864) interprets this language and broadly describes Federal and State taxes that must be reported but are excluded from premiums in the MLR and rebate calculations, and Federal and State taxes that must be reported and are not excluded from premiums in MLR and rebate calculations. During our review of MLR reports submitted by issuers, HHS noted that some issuers were excluding employment taxes (such as the Federal Insurance Contributions Act (FICA), the Railroad Retirement Tax Act (RRTA), and the Federal Unemployment Act (FUTA) taxes; State

unemployment/reemployment insurance and State employment training taxes; and other similar taxes and assessments) from earned premiums in their MLR and rebate calculations, whereas most issuers were including employment taxes in earned premiums in the MLR and rebate calculations. In order to provide consistency and clarity for MLR reporting, HHS amended §158.162 in the 2016 Payment Notice (80 FR 10750) to specify that all issuers must include employment taxes in earned premiums and must not deduct such taxes in the MLR and rebate calculations starting with the 2016 MLR reporting year.

However, in light of the changes in the market landscape since §158.162 was amended in early 2015, HHS is considering whether revising the decision on the treatment of employment taxes may help improve market stability, particularly in the individual market, by providing an incentive for issuers to enter or remain in the market. In addition, in response to the Request for Information, we received several comments in favor of allowing issuers to deduct such taxes from these calculations. Therefore, we are inviting comments on whether, in order to encourage issuer participation and competition in the markets, HHS should revise paragraph (a)(2) and paragraph (b)(2)(iv) of §158.162 to allow all issuers to deduct Federal and State employment taxes from premiums in their MLR and rebate calculations, starting with the 2017 MLR reporting year for reports to be filed by July 31, 2018. We are not reconsidering the treatment of the other taxes that cannot be excluded from premiums in MLR and rebate calculations (for example, Federal taxes on investment income and capital gains) because we believe those taxes

can be distinguished from employment taxes and the NAIC had explicitly recommended to HHS that such taxes should not be excluded from premiums.⁷²

We solicit comments on this approach from all stakeholders, including on whether we should instead amend the MLR regulations to collect the employment tax data separately from other tax data as an informational item on the MLR Annual Reporting Form to gather data to inform a decision regarding whether to amend the regulation for future years, and whether changing the treatment of employment taxes would be likely to help improve market stability and competition.

2. Allocation of Expenses (§158.170)

For a discussion of the proposed amendment to §158.170(b) regarding the description of the allocation method for quality improvement activity (QIA) expenses, please see the preamble to §158.221.

3. Formula for Calculating an Issuer's Medical Loss Ratio (§158.221)

We propose amending §158.221 by adding new paragraph (b)(8) to provide issuers with an option to report quality improvement activity expenses as a single fixed percentage of premium amount starting with the 2017 MLR reporting year (for reports to be filed by July 31, 2018). We also propose making conforming amendments to §158.170(b) (Allocation of expenses) in order to recognize the new proposed option for reporting QIA expenses.

Section 2718(c) of the PHS Act tasked the NAIC with establishing standardized definitions and methodologies for calculating MLR and rebates, subject to the certification of the

⁷² National Association of Insurance Commissioners – Model Regulation Service, Regulation for Uniform Definitions and Standardized Methodologies for Calculation of the Medical Loss Ratio for Plan Years 2011, 2012 and 2013 per Section 2718 (b) of the Public Health Service Act (Oct 27, 2010), *available at* http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf.

Secretary. Consistent with the NAIC's recommendation to HHS,⁷³ the MLR interim final rule, published on December 1, 2010 (75 FR 74863), allows issuers to include in the MLR numerator expenditures for five categories of activities that improve health care quality. Accordingly, issuers are currently required to report QIA expenditures in alignment with the five separate categories codified in §158.150(b)(2)(i)-(v). Additionally, §158.170 requires issuers to use and disclose specific allocation methods to report expenses, including QIA expenditures.

However, in the course of conducting the MLR audits, HHS observed that the current MLR regulations require a substantial effort by issuers to accurately identify, track and report QIA expenses. HHS has also observed that, between 2011 and 2015, issuers that did report QIA expenses have reported spending, on average, a consistent percentage of premium on total QIA: approximately 0.7 percent in 2011, and 0.8 percent in 2012 through 2015.

Given issuers' relatively low and consistent reported expenditures on QIA and the significant burden associated with identifying, tracking and reporting these expenditures, we propose adding §158.221(b)(8) to permit issuers an option to report on their MLR reporting form a single QIA amount equal to 0.8 percent of earned premium in the relevant State and market, in lieu of tracking and reporting the issuer's actual expenditures for QIA, as defined in §158.150 and §158.151. Under this proposal, all issuers would be able to include 0.8 percent of earned premium in their MLR numerator as QIA expenses for the relevant State and market. This is in line with a comment received in response to the Request for Information requesting that the MLR formula be simplified. The accompanying proposed amendments to §158.170(b) would

⁷³ National Association of Insurance Commissioners – Model Regulation Service, Regulation for Uniform Definitions and Standardized Methodologies for Calculation of the Medical Loss Ratio for Plan Years 2011, 2012 and 2013 per Section 2718 (b) of the Public Health Service Act (Oct 27, 2010), *available at* http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf.

require issuers that elect the option to include 0.8 percent of earned premium for QIA expenses to indicate as such when describing the allocation method used for QIA expenses. Issuers that spend more than 0.8 percent of earned premium on QIA would have the option to report the total actual, higher amount spent and, if choosing this option, would have to report QIA in the five categories described in §158.150(b)(2)(i)-(v), as well as comply with the allocation of expenses requirements established under §158.170. We seek comment on this proposal.

4. Potential Adjustment to the MLR for a State's Individual Market (Subpart C)

We propose to amend 45 CFR part 158, subpart C to modify the process and criteria for the Secretary to determine whether to adjust the 80 percent MLR standard in the individual market in a State. This proposal is consistent with comments we received on the Request for Information requesting that issuers be allowed to include additional expenses in their MLR calculation, since States would be able to more easily request reductions of the individual market MLR standard, which would effectively enable issuers in those States to spend more premium on additional expenses.

Section 2718(d) of the PHS Act provides that the Secretary may adjust the MLR standard in the individual market if the Secretary determines it appropriate on account of the volatility of the individual market due to the establishment of Exchanges. The MLR December 1, 2010, interim final rule (75 FR 74864) set forth the framework for a State to request such an adjustment and the process and criteria for the Secretary to determine whether to grant a State's request. Subpart C of 45 CFR part 158 specifies that the adjustment request must be initiated by the State, the adjustment may be granted for up to 3 years at a time, the information that the State must provide to support its request, and the criteria that HHS may consider in making a determination. It also requires the Secretary to invite public comments on the adjustment

requests, allows States to hold optional public hearings, and enables States to request reconsideration of adverse determinations.

Section 158.301 specifies that an adjustment may be granted only if there is a reasonable likelihood that application of the 80 percent MLR standard may destabilize the individual market in a State. Because in the current environment, it generally is not the MLR standard in isolation but rather factors that, taken together, can contribute to instability of the individual market in certain States, the current framework restricts the States' ability to obtain adjustments to the MLR standard as part of innovative solutions for stabilizing their individual markets. Therefore, as outlined below, we propose to make amendments throughout subpart C of part 158 to allow for adjustments to the individual market MLR standard in any State that demonstrates that a lower MLR standard could help stabilize its individual market, and to streamline the process for applying for such adjustments to reduce burdens for States and HHS.

a. Standard for adjustment to the medical loss ratio (§158.301)

Currently, §158.301 permits the Secretary to adjust the MLR standard that must be met by issuers offering coverage in the individual market in a State for a given MLR reporting year, if the Secretary determines that the 80 percent MLR standard may destabilize the individual market in that State. For the reasons described above, we propose to amend §158.301 to permit the Secretary to adjust the individual market MLR standard in any State if the Secretary determines that there is a reasonable likelihood that an adjustment to the 80 percent MLR standard will help stabilize the individual market in that State. We seek comment on this proposal.

b. Information regarding the State's individual health insurance market (§158.321)

We propose to amend §158.321 to modify the information that a State must submit to the Secretary with its request for an adjustment to the 80 percent MLR standard in its individual market. Currently, §158.321 requires the State to describe the State MLR standard and formula for assessing compliance (§158.321(a)), its market withdrawal requirements (§158.321(b)), and the mechanisms available to the State to provide consumers with options for alternate coverage (§158.321(c)). This information is used to determine what a State is able to do to mitigate instability in its individual market without an adjustment to the MLR standard. Because we seek to make the MLR adjustment process less burdensome on States and make adjustments available to enable States to develop innovative solutions for stabilizing their individual markets, we propose to remove the requirements in §158.321(a) through (c). Further, all States must follow the Federal minimum standards for the MLR calculation, market withdrawals, and guaranteed issue and limits on health status ratings; therefore, we believe it is not necessary for a State to include this information as part of its MLR adjustment request. Additionally, we propose to redesignate paragraph (d) as paragraph (a) and to revise the redesignated paragraph to describe the information the State must submit regarding the State's individual health insurance market, as outlined below.

Current regulations require a State to provide detailed individual market enrollment and premium data for each issuer at the product level as well as each issuer's market share of the individual market in the State (§158.321(d)(1)). We consider this requirement unduly burdensome and propose to replace it at §158.321(a)(2) with a requirement to submit information on total number of enrollees (life-years and covered lives) for each type of coverage sold or renewed in the State's individual market, as described in more detail below. We believe that enrollment data on life-years and covered lives for each type of individual market coverage,

rather than the number of individual enrollees by product, would provide sufficient information because the much more granular product-level detail is not necessary for HHS to evaluate the likelihood and magnitude of enrollees potentially moving from one type of coverage to the other and the impact this may have on the State individual market's risk pool and market competition. "Life-years," which the MLR Annual Reporting Form Instructions define as member-months divided by 12, generally represent average enrollment over the course of a year, while "covered lives" are defined in those Form Instructions as enrollment on the last day of the year. Similarly, we propose to eliminate the requirement currently in §158.321(d)(1) to submit product-level premium data in favor of the total earned premium data in the proposed §158.321(a)(1) as described below, and to eliminate the §158.321(d)(1) requirement to submit the issuer's individual market share because HHS can determine it based on the MLR data available to HHS.

Section 158.321(d)(2) also currently requires States to submit information regarding the total earned premium (§158.321(d)(2)(i)), agent and broker commissions (§158.321(d)(2)(iv)), and risk-based capital (RBC) level (§158.321(d)(2)(viii)), for each issuer that offers individual market coverage to more than 1,000 enrollees. We consider this information to continue to be relevant to determining the health of a State's individual market and whether an adjustment to the MLR standard could help stabilize the market. We therefore propose to continue to require States to include information on total earned premium (proposed §158.321(a)(1)) and total agent and broker commission expenses (proposed §158.321(a)(3)) for each type of coverage sold or renewed in the State's individual market, as described in more detail below, as well as the RBC level (proposed §158.321(a)(5)), which, due to the manner in which RBC is calculated, would only be appropriate to report at the issuer level, rather than for each type of coverage. We also propose to revise the accompanying regulation text for these data elements for readability. We

further propose that State requests should include information on total incurred claims (proposed §158.321(a)(1)) for each type of individual market coverage described below, in lieu of the current more burdensome requirement to provide reported and estimated individual market MLRs (§158.321(d)(2)(ii) through (iii)).

We propose to modify these requirements to require States to only include the information for each issuer actively offering individual market coverage. In most States, only a few issuers are actively participating, while the majority of issuers that have policies in force are not active and generally cover a much smaller percentage of the market. HHS can obtain the limited information on such issuers that would be relevant to analyzing a State's request from the combination of the MLR data available to HHS and the data on active issuers provided by the State, rather than requiring a State to submit data on these issuers as part of its request for an adjustment. We also propose to add a new §158.321(b) to require that a State request include the individual market data required in the proposed new §158.321(a)(1) through (4) and (6) separately for each issuer actively offering individual market plans in that State group by the following categories, as applicable: on-Exchange, off-Exchange, grandfathered health plans as defined in §147.140, coverage that meets the criteria for transitional policies outlined in applicable guidance⁷⁴, and non-grandfathered single risk pool coverage, in order to enable the Secretary to assess the situation in the State's individual market and to appropriately evaluate the State's proposal. Proposed new §158.321(b) would also require the State to report the RBC information at the issuer level for each issuer actively offering coverage in the State's individual

⁷⁴ See, for example, CMS "Insurance Standards Bulletin Series – Information – Extension of Transitional Policy through Calendar Year 2018 (February 23, 2017) available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Extension-Transitional-Policy-CY2018.pdf>.

market. A State would not be required to provide information on student health insurance coverage as defined in §147.145 or individual market excepted benefits as defined in §148.220.

To further reduce the burden on States, we propose to remove the requirements to provide net underwriting profit for each issuer's total business in the State and after-tax profit and profit margin for the individual market and total business in the State (§158.321(d)(2)(vii)), as well as to rename the remaining requirement to provide the individual market "net underwriting profit" to "net underwriting gain" to more accurately reflect the accounting term (proposed §158.321(a)(4)). We believe data on the individual market net underwriting gain provides sufficient information because an issuer's total gain or loss in a State does not necessarily impact the issuer's decision to participate in the individual market. We also propose to delete the requirement to provide information on estimated MLR rebates (§158.321(d)(2)(v)) to reduce the burden on States because HHS can estimate rebate amounts based on available data. Additionally, we propose to revise the language at current paragraph §158.321(d)(2)(ix), proposed to be redesignated at §158.321(a)(6), to require the State to provide information not only on notices by issuers covered in §158.321(a) of market exits, but also the equally or more pertinent issuer notices of beginning to offer coverage in the individual market, as well as ceasing or commencing offering individual market coverage on the Exchange or in specific geographic areas (for example, counties); and to add a new §158.321(c) to require similar information on issuers not actively offering coverage in the individual market that have indicated an intent to enter or exit the individual market, including ceasing or commencing offering individual market coverage on the Exchange or in specific geographic areas. Lastly, we recognize that in many situations the information proposed to be required in §158.321(a) will only be available for the preceding calendar year, but we propose to provide States with an

option to also include information for the current year (where available), which may be more relevant if a State makes a request in a later part of the year.

We seek comment on this proposal.

c. Proposal for adjusted medical loss ratio (§158.322)

To reduce the burden on States, we propose to remove paragraphs (a), (c) and (d) of §158.322, which would remove the requirements for a State to justify how its proposed adjustment was determined, and to estimate rebates that would be paid with and without an adjustment because HHS can make these estimates instead of the State. Consistent with our proposed changes to §158.301, we propose to revise §158.322 to require the State to both provide its proposed, adjusted MLR standard and explain how this proposed standard would help stabilize its individual market. We also propose to delete current paragraph (b), which requires an explanation of how an adjustment would permit issuers to adjust current business models and practices in order to meet an 80 percent MLR as soon as is practicable, to further reduce burden on States submitting adjustment requests.

We seek comment on this proposal.

d. Criteria for assessing request for adjustment to the medical loss ratio (§158.330)

Section 158.330 lists the criteria that the Secretary may consider in determining whether to approve a State request to adjust the 80 percent MLR standard for the individual market. We are proposing amendments throughout the section to reflect the proposal in §158.301 to allow adjustments if the Secretary determines the adjustment would help stabilize the individual market in that State, and the proposed changes to the information requirements in §158.321. These changes are intended to further streamline the process and reduce burdens for States and HHS. Specifically we propose conforming amendments to the introductory text of §158.330 to provide

that the Secretary may consider the identified criteria when assessing whether an adjustment to the individual market MLR standard would be reasonably likely to help stabilize the individual market in a State that has requested such an adjustment. We propose to replace the information currently outlined at §158.330(a)(1)-(4) regarding individual market issuers reasonably likely to exit the State with information regarding the number and financial performance of issuers actively offering individual market coverage on-Exchange, off-Exchange, grandfathered health plans as defined in §147.140, coverage that meets the criteria for transitional policies outlined in applicable guidance, and non-grandfathered single risk pool coverage; the number of issuers reasonably likely to cease or begin offering such individual market coverage in the State; and the likelihood that an adjustment would increase competition in the State's individual market, including in underserved areas (proposed §158.330(a)). We propose to delete the existing criteria captured at §158.330(b) related to consideration of the number of individual market enrollees covered by issuers that are reasonably likely to exit the State's individual market absent the requested adjustment because the goal of a State request for adjustment may be to ensure that health insurance coverage is available to all, rather than a certain percentage of, consumers who want it, and that consumers not only have coverage, but also a choice of several issuers. We propose conforming amendments to the criteria currently captured at §158.330(c), proposed to be redesignated at §158.330(b), regarding whether an adjustment might improve consumers' access to agents and brokers. Similar to the proposed amendments to §158.321 described above to remove the requirement for States to provide information on available mechanisms to provide alternate coverage, we propose to replace the current criteria outlined at §158.330(d)(1)-(5) with consideration of information on the capacity of any new issuers or issuers remaining in the individual market to write additional business in the event one or more issuers were to cease or

begin offering individual market coverage on Exchanges, in certain geographic areas, or in the entire individual market in the State (proposed §158.330(c)). We propose to retain and modify the existing criteria at §158.330(e), proposed to be redesignated at §158.330(d), on the impact on premiums charged, and on benefits and cost sharing provided, to consumers by issuers remaining in or entering the individual market in the event one or more issuers were to cease offering individual market coverage on the Exchange, in certain geographic areas, or in the entire individual market in the State. Finally, the proposed amendments retain the existing criteria at §158.330(f), proposed to be redesignated at §158.330(e), for consideration of any other relevant information submitted by the State.

We seek comment on this proposal.

e. Treatment as a public document (§158.341)

Because the format in which States may submit requests for adjustments may not comply with Federal requirements for documents posted on Federal Web sites, some of these documents may not be able to be posted directly to the applicable Federal Web site. For example, a State may submit spreadsheets containing data or copies of issuer letters in a format that is not accessible for individuals with visual impairments. However, HHS is committed to transparency and making this information promptly available to the public. Therefore, we propose to amend §158.341 to reflect that Federal requirements for documents posted on Federal Web sites may not permit these documents to be posted, and to specify that instructions for the public to access information on requests for adjustment to the MLR standard submitted by States will be provided on the Secretary's Internet Web site.

f. Subsequent requests for adjustment to the medical loss ratio (§158.350)

We propose to make conforming amendments to §158.350, which describes the information that a State must submit with a subsequent request for an adjustment to the MLR standard, to make this information consistent with our proposed changes to §158.301 and §158.330.

We seek comment on this proposal.

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 12. 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 the required issues under section 3506(c)(2)(A) of the PRA for the following information collection requirements.

A. Wage Estimates

To derive wage estimates, we generally used data from the Bureau of Labor Statistics to derive average labor costs (including a 100 percent increase for fringe benefits and overhead) for estimating the burden associated with the ICRs.⁷⁵ Table 11 in this proposed rule presents the mean hourly wage (calculated at 100 percent of salary), the cost of fringe benefits and overhead, and the adjusted hourly wage.

As indicated, employee hourly wage estimates have been adjusted by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly across employers, and because methods of estimating these costs vary widely across studies. Nonetheless, there is no practical alternative, and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

⁷⁵ See May 2016 Bureau of Labor Statistics, Occupational Employment Statistics, National Occupational Employment and Wage Estimates at https://www.bls.gov/oes/current/oes_nat.htm. For State Government Employees see NAICS 999200 - State Government, excluding schools and hospitals (OES Designation) https://www.bls.gov/oes/current/naics4_999200.htm.

TABLE 11: Adjusted Hourly Wages Used in Burden Estimates

Occupation Title	Occupational Code	Mean Hourly Wage (\$/hr.)	Fringe Benefits and Overhead (\$/hr.)	Adjusted Hourly Wage (\$/hr.)
Business Operation Specialist*	13-1199	\$31.59	\$31.59	\$63.18
Operations Manager	11-1021	\$58.70	\$58.70	\$117.40
Software Developers, Systems Software	15-1133	\$53.17	\$53.17	\$106.34
Actuary	15-2011	\$54.87	\$54.87	\$109.74
Actuary*	15-2011	\$40.41	\$40.41	\$80.82
Financial Examiner*	13-2061	\$33.02	\$33.02	\$66.04
Financial Analyst*	13-2051	\$34.39	\$34.39	\$68.78
Financial Manager*	11-3031	\$45.83	\$45.83	\$91.66
Lawyer*	23-1011	\$44.87	\$44.87	\$89.74
Secretaries and Administrative Assistants, Except Legal, Medical, and Executive	43-6014	\$17.38	\$17.38	\$34.76
Commissioner**		\$58.45	\$58.45	\$116.90
Market Research Analyst	13-1161	\$33.95	\$33.95	\$67.90

* Denotes occupations where wages were obtained for State Government employees (https://www.bls.gov/oes/current/naics4_999200.htm).

** Data on compensation of State Insurance Commissioners collected by the Council of State Governments and compiled by Ballotpedia (<http://www.ballotpedia.org>). The wage data used in the burden estimates include the cost of fringe benefits and the adjusted hourly wage.

B. ICRs Regarding State Flexibility for Risk Adjustment (§153.320)

We are proposing to allow State regulators to request a reduction in the calculation of Statewide average premium, beginning for the 2019 benefit year. HHS would require any State that intends to request this flexibility to submit its proposal for an adjustment to the Statewide average premium in the small group market within 30 calendar days after publication of the proposed HHS notice of benefit and payment parameters for the applicable benefit year for timely review and issuer notification prior to rate setting. The burden associated with this requirement is the time and effort for the State regulators to submit its proposal to HHS. We estimate that it will take a business operations specialist 32 hours (at a rate of \$63.18 per hour) to prepare the request and 16 hours for a senior manager (at a rate of \$117.40 per hour) to review the request and transmit it electronically to HHS. We estimate that each State seeking a reduction

in the average premium calculation will incur a burden of 48 hours at a cost of approximately \$3,900 per state to comply with this reporting requirement (32 hours for the insurance operations analyst and 16 hours for the senior manager). Although we are unable to precisely estimate the number of States that will make this request, we expect that no more than 25 States will make these requests annually, resulting in a total annual burden of approximately 1,200 hours with an associated total cost of \$97,504. We seek comment on this estimated burden. We propose to revise the current information collection approved under OMB control number 0938-1155: Standards Related to Reinsurance, Risk Corridors, Risk Adjustment, and Payment Appeals, to account for this additional burden.

C. ICRs Regarding Risk Adjustment Data Validation and 500 Billable Member Months (§153.630)

We propose that, beginning with 2017 benefit year risk adjustment data validation, issuers with 500 billable member months or fewer that elect to establish and submit data to an EDGE server would not be subject to the requirement to hire an initial validation auditor or submit initial validation audit results. Issuers at or below the 500 billable member months threshold would have their risk score adjusted by a default error rate equal to the lower of either the national average negative error rate, or the average negative error rate within a State, as set forth in the 2018 Payment Notice. We note that, beginning with 2018 benefit year risk adjustment data validation, these issuers would not be subject to random sampling under the materiality threshold discussed below, and would continue to not be subject to the requirement to hire an initial validation auditor or submit initial validation audit results, but would have their risk scores adjusted by a default error rate annually. We note that if the proposal to implement a

central tendency approach to payment adjustments is finalized, then it is possible no adjustment would occur for issuers below this threshold.

HHS estimates that not requiring issuers that have 500 or fewer billable member months Statewide to conduct an initial validation audit beginning in the 2017 benefit year would exempt 50 issuers from an initial validation audit and reduce administrative costs for each issuer by 828 hours with an estimated cost reduction on average of up to \$100,000. The total burden reduction for all 50 issuers would be 41,400 hours with an associated reduction in cost of \$3,520,000. The postponement of the materiality threshold to the 2018 benefit year would not impact issuer burden relative to previous estimates for the risk adjustment data validation program included in the 2014 and 2015 Payment Notices, particularly given that the program has been converted to a pilot for the first 2 years of operation. We propose to revise the current information collection approved under OMB control number 0938–1155: Standards Related to Reinsurance, Risk Corridors, Risk Adjustment, and Payment Appeals, to account for this reduction in burden.

D. ICRs Regarding Health Insurance Issuer Rate Increases: Disclosure and Review Requirements—Applicability (§154.103)

We propose to modify §154.103(b) to exempt student health insurance coverage as defined in 45 CFR 147.145 from the Federal rate review requirements. Because we would no longer be reviewing rates for student health insurance coverage, we expect to collect less information for the 2019 plan or policy year than collected for previous years. This would lead to a reduction in burden related to the submission and review for issuers and States. We estimate that 75 student health insurance issuers will no longer be required to submit rate increases to HHS. We estimate that each rate review submission takes 11 hours for an actuary (at a rate of \$109.74 per hour) to prepare, and that each issuer would submit an average of 2.5 plans, at an

estimated annual cost of \$3,018, resulting in a total reduction in the annual burden to issuers of approximately 2,063 hours and an associated reduction in cost of approximately \$226,339. We estimate that States would no longer submit rate increases for 188 student health insurance plans to HHS. We estimate a reduction in burden to States of one hour per plan for an actuary (at a rate of \$80.82 per hour) to prepare and electronically submit the appropriate materials, for a total reduction in burden of approximately 188 hours annually with an associated cost reduction of approximately \$15,194. We propose to revise our current burden estimate approved under OMB control number 0938–1141: Rate Increase Disclosure and Review Reporting Requirements, to reflect the reduced burden on States and issuers.

E. ICRs Regarding Rate Increases Subject to Review (§154.200)

We propose to amend §154.200 to establish a 15 percent default threshold for reasonableness review. We expect this to reduce burden for some issuers because Part II of the Rate Filing Justification (Consumer Justification Narrative) is only required for increases that meet or exceed the threshold. Based on rate filings for the 2018 plan year, we estimate a burden reduction of approximately 17 percent, or 129 fewer Narratives. We reached this estimate by counting the number of submissions with a product subject to review due to an increase between 10 percent and 14.9 percent. We estimate that each Consumer Justification Narrative takes 0.5 hours for an actuary (at a rate of \$109.74 per hour) to prepare and electronically transmit this document to HHS. We estimate a total reduction in burden of 65 hours and an associated cost reduction is \$7,078. We propose to revise our current burden estimate approved under OMB control number 0938–1141: Rate Increase Disclosure and Review Reporting Requirements, to reflect the reduced burden on issuers.

F. ICRs Regarding the Small Business Health Options Program (SHOP)

We are proposing to grant additional flexibilities, effective on the effective date of the final rule, if finalized as proposed, and applicable for plan years beginning on or after January 1, 2018, to SHOPs, to qualified employers and employees enrolling in SHOP plans, and to participating QHP issuers and SHOP-registered agents and brokers in how they interact with a SHOP. Under the proposals outlined throughout this document, SHOPs would no longer be required to provide enrollment, premium aggregation services, and online enrollment functionality through a SHOP Web site. Instead, small groups would enroll in a SHOP plan through a SHOP-registered agent or broker or through a participating QHP issuer participating in a SHOP. If this rule is finalized as proposed, the FF-SHOPs would follow the approach as outlined. SBEs would have the flexibility to operate a SHOP in a way that meets the needs of their State and complies with the regulatory flexibilities outlined herein.

Under the proposed approach, several pieces of information currently being collected by a SHOP would no longer be collected by a SHOP, or, the way in which the information is collected would change. For example, employers, employees, and agents and brokers may be required to provide the information currently collected by a SHOP to an issuer for the purposes of enrollment in a SHOP plan. The SHOP however, would not be the entity collecting the information and the Federal government thus would experience a reduction in burden. Under the proposals described throughout this rule, employers and employees would no longer be required to visit a SHOP Web site in order to enroll in a SHOP plan and a SHOP would no longer be required to have the capability or the need to collect enrollment information. Employers would however, be required to apply to the SHOP to obtain an eligibility determination, as described in §155.710, at which point the employer would be asked to provide: (1) Employer name and address of employer's locations; (2) Information sufficient to confirm the employer is a small

employer; (3) Employer Identification Number (EIN); and (4) Information sufficient to confirm that the employer is offering, at a minimum, all full-time employees coverage in a QHP through a SHOP. Under current regulations, the employer provides, and a SHOP collects, this information as part of enrolling in a SHOP QHP through a SHOP. HHS previously estimated that an employer needed two hours to complete the eligibility determination when it was included as part of enrolling in a SHOP QHP and that 6,000 employers would complete an application annually to determine their eligibility through a SHOP Web site. Based on these criteria, HHS estimated that the total annual burden for 6,000 employers was 12,000 hours, with a total annual cost of \$561,240 to complete the SHOP application and eligibility determination process. With the proposed flexibilities, HHS estimates that for each employer, an administrative assistant would need less than 5 minutes (at rate of \$34.76 per hour) to complete the required eligibility determination. Under the proposed flexibilities, employers would also no longer be required to create an account on an FF-SHOP Web site in order to complete the eligibility determination or enroll in a SHOP QHP. Therefore, HHS estimates that it would cost an employer approximately \$3 to complete an eligibility determination. Assuming that 6,000 employers would complete an eligibility determination, HHS estimates that the total annual burden would be approximately 500 hours, with an estimated total cost of \$17,400. This would result in a net burden reduction of 11,500 hours and a net cost reduction of approximately \$543,840 annually. Under the proposals in §157.206(e)(1), employers would be responsible for submitting a new eligibility determination or, submitting a notice of withdrawal, in the event the group experienced a change that would impact the group's eligibility to participate in a SHOP. Under the proposals in §157.206(e)(2), employers would also be required to notify their QHP issuer(s) of a determination of ineligibility. Finally, employers would also, under §157.206(e)(3)

be required to notify their issuer(s) of their intent to no longer participate in a SHOP. While these proposals would require employers to communicate with issuers in ways they do not under current SHOP enrollment practices, HHS does not anticipate that these practices would increase the burden on employers as they, under current practice, must notify the SHOP of changes in eligibility and termination. Although the proposals in §155.716 impose an information collection requirement, the information that would be collected is no different from what is already approved under OMB control number 0938–1193: Data Collection to Support Eligibility Determinations and Enrollment for Small Businesses in the Small Business Health Options, and therefore we are not proposing to revise the information collection at this time.

Employees, under the proposals to §155.716 would not experience an increase in burden. Under the proposals described throughout this proposed rule, employees would no longer be required to visit an FF-SHOP Web site to create an account, or, for any application or enrollment purpose, but they may need to provide similar information to an agent or broker or issuer as a condition of enrollment into a SHOP QHP. HHS previously estimated that 60,000 employees completed an application annually, each spending approximately one hour to complete an online application through an FF-SHOP Web site. The estimated annual burden was 60,000 burden hours with an annual cost of \$1,025,400. With the proposed flexibilities to a SHOP as described in this rule, HHS predicts that the burden on employees to complete an online application would shift as no application would be provided through a SHOP Web site, but the information may be required by an agent or broker or an issuer in order for the employee to complete an enrollment into a SHOP QHP. The proposals described throughout this proposed rule will allow agents and brokers and issuers to enroll consumers in SHOP plans using the channels they are most familiar with, potentially reducing the burden of enrolling SHOP groups. This information collection is

currently approved under OMB control number 0938–1194: Data Collection to Support Eligibility Determinations and Enrollment for Employees in the Small Business Health Options Program. Therefore, we are not proposing to revise the information collection at this time.

Current regulations, found throughout §§155.705, 155.715, 155.720, 155.725, require SHOPs to generate certain notices. These notices may include: (1) notices of annual election periods, (2) notices to employers of employee coverage terminations, (3) notices of application inconsistencies, (4) notices of appeal rights and instructions, (5) notices of employee and employer eligibility, (6) notices of employer withdrawal, (7) (in FF-SHOPs only) notices to employees if a dependent turns 26 and is no longer eligible for dependent coverage, (8) billing invoices, successful and unsuccessful payment confirmation notices, and (9) past due payment notices. In prior guidance, HHS previously estimated costs for paper notices in an FF-SHOP. In that estimate, HHS assumed that 80 percent of enrollees requested electronic notices and 20 percent of enrollees requested paper notices. HHS estimated that mailing paper notices costs a SHOP Exchange \$0.53 per notice. HHS determined that SHOPs sent approximately 48,000 notices to enrollees when (1) a dependent became ineligible to remain on the plan, (2) successful payment was processed, and (3) a payment was unsuccessful in the last year. Assuming that 20 percent of enrollees would opt to receive paper notices instead of electronic notifications, HHS estimated that approximately 9,600 notices would be sent, costing FF-SHOPs approximately \$5,088. Under the proposed flexibilities, the SHOPs would only be required to send notices of employer eligibility and appeals. This cost would not directly be transferred to issuers as issuers may already be required to send such notices per other applicable State and Federal Law. This collection is currently approved under OMB control number 0938–1207: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes,

and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment. If this approach is finalized as proposed, issuers would be required to collect premiums, as premium aggregation services would no longer be provided by the SHOPs that take advantage of the proposed flexibilities. HHS does not anticipate a significant increase of issuers' burden in this scenario, as it is not significantly different from their current operating practices.

G. ICRs Regarding States Defining the Essential Health Benefits (§156.111(e))

We propose at §156.111(e) to revise the collection of data for selection of States' EHB-benchmark plans for plan years beginning on or after January 1, 2019. This proposal includes the documentation that States would be required to submit if the State chooses to change its EHB-benchmark plan. For this purpose, we propose to amend the currently approved information collection (OMB Control Number: 0938-1174) to reflect the proposed policy. Because §156.111(e) would replace the current data collection requirements at §156.120, we would update the current EHB-benchmark plan selection to account for the proposed new regulation and any associated burden with this requirement that would fall on those States that choose to reselect their EHB-benchmark plan. Under the previous benchmark plan selection policy, 29 States selected one of the 10 base-benchmark plan options and 22 States defaulted. The current policy did not allow for States to make an annual selection. The proposed regulation would allow States to modify their EHB-benchmark plans annually, but would not require them to respond to this ICR for any year for which they did not change their EHB-benchmark plan. As such, for purposes of this proposed regulation, we estimate that 10 States would choose to make a change to their EHB-benchmark plans in any given year (total of 30 States over 3 years within the authorization of this ICR) and would respond to this ICR.

The proposals at §156.111(e)(1) would require the State to provide confirmation that the State's EHB-benchmark plan selection complies with certain requirements, including those under proposed §156.111(a), (b), and (c). To complete this requirement, we estimate that a financial examiner would require 4 hours (at a rate of \$66.04 per hour) to fill out, review, and transmit a complete and accurate document. We estimate that it would cost each State \$264 to meet this reporting requirement, with a total annual burden for all 10 States of 40 hours and an associated total cost of \$2,642.

The proposals in §156.111(e)(2) would further require the State to submit an actuarial certification and associated actuarial report of the methods and assumptions when selecting proposed options under §156.111(a)(2) and (3). Specifically, the actuarial certification that is being collected under this ICR would be required to include an actuarial report that complies with generally accepted actuarial principles and methodologies. This would include complying with all applicable ASOPs (including ASOP 41 on actuarial communications). For example, ASOP 41 on actuarial communications includes disclosure requirements, including those that apply to the disclosure of information on the methods and assumptions being used for the actuarial certification and report. The actuarial certification for this proposed requirement is provided in a template and includes an attestation that the standard actuarial practices have been followed or that exceptions have been noted. The signing actuary would be required to be a Member of the American Academy of Actuaries. We are also seeking comment on a draft document entitled *Draft Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection to Benefits of a Typical Employer Plan As Proposed*

*under the HHS Notice of Benefit and Payment Parameters for 2019 (CMS-9930-P)*⁷⁶ that would provide an example of method an actuary could use to develop this actuarial certification and report.

We estimate that an actuary, who is a member of the American Academy of Actuaries, would require 16 hours (at a rate of \$80.82 per hour) on average for §156.111(e)(2). This would include the certification and associated actuarial report from an actuary to affirm, in accordance with generally accepted actuarial principles and methodologies that the State's EHB-benchmark plan definition is equal in scope of benefits provided under a typical employer plan.

Additionally, this estimate of 16 hours would also apply if the State is selecting its EHB-benchmark plan using the option proposed at §156.111(a)(3). The option proposed at §156.111(a)(3) would also require the actuary to affirm that the State's selected EHB-benchmark plan does not exceed the generosity of the most generous among a set of comparison plans proposed §156.111(a)(3), including the State's EHB-benchmark plan used for the 2017 plan year and any of the State's base-benchmark plan options for the 2017 plan year described in §156.100(a)(1), supplemented as necessary under §156.110. For these calculations, the actuary would need to conduct the appropriate calculations to create and review an actuarial certification and associated actuarial report, including minimal time required for recordkeeping. The precise level of effort for the actuary certification and associated actuarial report under §156.111(e)(2) would likely vary depending on the State's approach to its EHB-benchmark plan and this certification requirement. For example, the State may only need to do one plan comparison for

⁷⁶ The *Draft Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection to Benefits of a Typical Employer Plan As Proposed under the HHS Notice of Benefit and Payment Parameters for 2019 (CMS-9930-P)* is available on CCIIO's Regulation and Guidance webpage at <https://www.cms.gov/cciio/resources/regulations-and-guidance/index.html>.

the purposes of both of these proposed certification requirements. Specifically, the State could use the same plan, such as the State's EHB-benchmark plan used for the 2017 plan year, to determine that the new State's EHB-benchmark plan is equal to the scope of benefits provided under a typical employer plan. The State could also use those findings to determine that because the new State EHB-benchmark plan is equal in scope of benefits to the State's EHB-benchmark plan used for the 2017 plan year, the new State EHB-benchmark plan does not exceed the generosity of the most generous of the set of comparison plans. We estimate that a financial examiner would require one hour (at a rate of \$66.04 per hour) to review, combine, and electronically transmit these documents to HHS, as part of a State's EHB-benchmark plan submission. Because this section of the proposed regulation would only apply to options 2 and 3 under proposed §156.111(a)(2) and (3), we are estimating that only two thirds of States (7 of the 10 States) would need to complete and submit this proposed documentation requirement. Therefore, we estimate that each State would incur a burden of 17 hours with an associated cost of \$1,359, with a total annual burden for 7 states of 119 hours at associated total cost of \$9,514. We seek comment on this estimate.

The proposals at §156.111(e)(3) would further require each State to submit its new EHB-benchmark plan documents. The level of effort associated with this requirement could depend on the State's selection of the EHB-benchmark plan options under the proposed regulation at §156.111(a). However, for the purposes of this estimate, we estimate that it would require a financial examiner (at a rate of \$66.04 per hour) 12 hours on average to create, review, and electronically transmit the State's EHB-benchmark plan document that accurately reflects the benefits and limitations, including medical management requirements and a schedule of benefits, resulting in a burden of 12 hours and an associated cost of \$792, with a total annual burden for

all 10 states of 120 hours and an associated cost of \$7,925. The burden for producing these documents is significantly higher than previous estimates because the previous data collection generally only required the State (or issuer) to transmit the selected benchmark plan document. In contrast, in some cases, the proposed §156.111(a) may result in the State needing to create a completely new document or significantly modify the current document to represent the plan document. Additionally, this estimate of 12 hours also includes the burden necessary for a State selecting the option at proposed §156.111(e)(3) where the State would also be required to submit a formulary drug list for the State's EHB-benchmark plan in a format and manner specified by HHS. Specifically, the burden for the State selecting this option would also likely vary as the State could use an existing formulary drug list or create its own formulary drug list separately for this purpose. To collect the formulary drug list, the State would be required to use the template provided by HHS and submit the formulary drug list as a list of RxNorm Concept Unique Identifiers (RxCUIs).

Lastly, the proposal at §156.111(e)(4) would require the State to submit the documentation necessary to operationalize the State's EHB-benchmark plan. This reporting requirement includes the EHB summary file that is currently posted on CCIIO's Web site, used as part of the QHP certification process, and integrated into HHS's IT Build systems that feed into the data that is displayed on HealthCare.gov. While this document would not be a new document, the burden associated with this document would be new for States. We estimate that it would require a financial examiner 12 hours, on average, (at a rate of \$66.04 per hour) to create, review, and electronically submit a complete and accurate document to HHS resulting in a burden of 12 hours and an associated cost of \$792, with a total annual burden for all 10 states of 120 hours and an associated cost of \$7,925.

Under the current policy, the burden estimates 226 respondents per year, for a total yearly burden total of 165 annual burden hours and a total annual associated cost of \$8,094 to meet these reporting requirements. Under the proposed policy related to EHB, we estimate that the total number of respondents would be 10 per year, for a total yearly burden of 399 hours and an associated cost of \$28,005 to meet these reporting requirements. The estimated burden associated with the proposed changes represents an increase of 234 hours (increase from 165 hours to 399 hours) and an annual costs increase of \$19,911 (from \$8,094 to \$28,005) over the approved information collection (OMB Control Number: 0938-1174).

As part of the update to this OMB Control Number: 0938-1174, we are also seeking comment on requirements for SADPs to submit voluntary reporting. This collection includes data on whether the issuer intends to offer SADP coverage, the anticipated Exchange market in which coverage would be offered, and the State and service area in which the issuer offers coverage. The burden associated with meeting this requirement includes the time and effort needed by the issuer to report on whether it intends to offer SADP coverage. We estimate that it will take one half hour for a health insurance issuer to meet this reporting requirement. We estimate that approximately 175 issuers will respond to this data collection. Therefore, we anticipate that the reporting requirement would require a market research analyst one half-hour annually to identify and submit the responsive records to CMS (at a rate of \$67.90 per hour), for a total cost of \$34 a year per reporting entity. This would result in an annual burden of 87.5 hours for all 175 issuers and a resulting estimated annual cost of \$5,941. OMB approvals are issued for three years; therefore, the aggregate burden for three years would be approximately 263 hours with an associated cost of approximately \$17,824. We seek comment on these proposed estimates.

H. ICRs Regarding Medical Loss Ratio (§§158.170, 158.221, 158.320-323, 158.340, 158.346, and 158.350)

We are proposing to amend §158.221 to allow issuers the option to report quality improvement activity expenses as a single fixed percentage of premium amount, and make conforming amendments to §158.170. We do not anticipate that implementing this provision would require significant changes to the MLR annual reporting form and the associated burden. The burden related to this collection is currently approved under OMB control number 0938-1164; Medical Loss Ratio Annual Reports, MLR Notices, and Recordkeeping Requirements.

We are also proposing to amend Subpart C to modify the data and narratives which a State must submit as part of the State's request for an adjustment to the MLR standard in the individual market for that State. There is no standardized application form associated with a State's request, but each request must contain certain data elements in order to receive consideration by the Secretary, which are described in §§158.320-158.323, 158.340, 158.346, and 158.350. The burden related to the proposed requirements was previously approved under OMB control number 0938-1114, Medical Loss Ratio (IFR) Information Collection Requirements and Supporting Regulations; the approval expired in 2014. We intend to reinstate this information collection, with modifications to reflect our proposed revisions to subpart C of part 158. This document serves as the 60-day notice to afford the public an opportunity to comment on this collection of information requirement. To obtain copies of a supporting statement and any related forms for the proposed collection summarized in this document, you may make your request using one of following: (1) access CMS's Web Site address at <http://www.cms.hhs.gov/PaperworkReductionActof1995>; (2) e-mail your request, including your

address, phone number, OMB Control Number 0938-1114, and CMS document identifier CMS-10361, to Paperwork@cms.hhs.gov; or (3) call the Reports Clearance Office at (410) 786-1326.

We are proposing to eliminate collection of the following information from a State requesting an adjustment: the State MLR standard and formula for assessing compliance (§158.321(a)), its market withdrawal requirements (§158.321(b)), and the mechanisms available to the State to provide consumers with options for alternate coverage (§158.321(c)); as well as the net underwriting profit for the total business in the State and the after-tax profit and profit margin for the individual market and total business in the State (§158.321(d)(2)(vii)), and the estimated rebate (§158.321(d)(2)(v)) of each issuer with at least 1,000 enrollees in the State. We expect this proposal to reduce the burden on States seeking an adjustment. We are also proposing to replace the requirement that a State requesting an adjustment must submit enrollment and premium data for every individual market issuer at the product level (§158.321(d)(1)) and the reported and estimated MLRs (§158.321(d)(2)(ii) and (iii)) for issuers with at least 1,000 enrollees, with total enrollment (life-years and covered lives), premium, and total incurred claims for only active individual market issuers, separately for five types of individual market coverage: on-Exchange plans, off-Exchange plans, grandfathered health plans as defined in §147.140, coverage that meets the criteria for transitional policies outlined in applicable guidance, and non-grandfathered single risk pool coverage. States would not be required to provide information on student health insurance coverage as defined in §147.145 or excepted benefits as defined in §148.220. We expect this proposal to result in a net reduction in burden on States seeking an adjustment. We are also proposing to continue to collect data on total agents' and broker's commission expenses and net underwriting gain (proposed to be redesignated from §158.321(d)(2)(iv) and (vi) to §158.321(a)(3) and (4), respectively) for only active individual

market issuers, but separately for the five types of coverage described above. We would continue to collect information on risk-based capital levels (proposed to be redesignated from §158.321(d)(2)(viii) to §158.321(a)(5)) at the issuer level. While this proposal would require more breakdown of the data than §158.321 currently requires, in most States there are more issuers with at least 1,000 enrollees than there are active issuers in the individual market, and consequently we expect that this proposal would have no net impact on the burden. Additionally, we are proposing to update §158.321(d)(2)(ix) to collect more specific information on issuer notices to the State of changes to participation in the State's individual market, rather than focusing exclusively on notices to exit the individual market. We do not expect this proposal to have an appreciable impact on the burden. We are further proposing to eliminate the requirement that a State requesting an adjustment provide information explaining and justifying how its proposed adjustment was determined and estimating rebates that would be paid with and without an adjustment (§158.322(a), (c), and (d)); as well as to replace what information a State must provide pursuant to §158.322(b) with a requirement to explain how the adjustment would help stabilize the State's individual market. We expect this proposal to reduce the burden. Lastly, we are proposing to update what information a State must submit with a subsequent request for adjustment pursuant to §158.350. We do not expect this proposal to change the burden.

Based on preliminary data analysis and previous State requests for adjustments, we estimate that approximately 22 States would submit applications in the first year that the proposed MLR adjustment process is codified. We estimate that it would take approximately 140 hours on average for each State to complete the application, including gathering and analyzing data, synthesizing information, and developing a proposal for an adjusted MLR standard. Specifically, we assume that the application would take a financial analyst approximately 96

hours (at a rate of \$68.78 per hour), an actuary 6 hours (at a rate of \$80.82 per hour), a financial manager 10 hours (at a rate of \$91.66 per hour), a lawyer 24 hours (at a rate of \$89.74 per hour), and the Commissioner 4 hours (at a rate of \$116.90 per hour) to assemble and review the various components of the application, resulting in total of burden for each state of 140 hours with an associated cost of \$10,626 per response, representing an estimated total burden reduction of 45 hours per response. The documents would be submitted electronically at minimal cost. We estimate that the total burden for 22 states to submit a request for an adjustment to the individual market MLR standard would be 3,080 hours with an associated cost of approximately \$233,767, with an estimated net total reduction in burden of 620 hours. We recognize that this burden may vary between States, as some States may have better access to the required application information elements, while other States may have to seek some of the required information from health insurance issuers in their States, which could increase their burden. Some States may, if providing the requested information is an undue burden, ask the Secretary to consider their application without some of the information elements. We seek comment regarding this information collection requirement.

I. Summary of Annual Burden Estimates for Proposed Requirements

TABLE 12: Proposed Annual Recordkeeping and Reporting Requirements

Regulation Section(s)	OMB control number	Respondents	Responses	Burden per Response (hours)	Total Annual Burden (hours)	Labor Cost of Reporting (\$)	Total Cost (\$)
§153.320	0938-1155	25	25	48	1,200	\$97,504.00	\$97,504.00
§156.111(e)(1)	0938-1174	10*	10	4	40	\$2,641.60	\$2,641.60
§156.111(e)(2)	0938-1174	7*	7	17	119	\$9,514.12	\$9,514.12

Regulation Section(s)	OMB control number	Respondents	Responses	Burden per Response (hours)	Total Annual Burden (hours)	Labor Cost of Reporting (\$)	Total Cost (\$)
§153.320	0938-1155	25	25	48	1,200	\$97,504.00	\$97,504.00
§156.111(3)	0938-1174	10*	10	12	120	\$7,924.80	\$7,924.80
§156.111(e)(4)	0938-1174	10*	10	12	120	\$7,924.80	\$7,924.80
§§158.320-323, 158.340, 158.346-350	0938-1114	22	22	140	3,080	\$233,766.72	\$233,766.72
-----	0938-1174	175	175	0.5	87.5	\$5,941.25	\$5,941.25
Total	--	207	234	--	4766.5	\$365,217.29	\$365,217.29

* Denote the same entities. For purposes of calculating the total, the highest value is used only once.

**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 12.

J. Submission of PRA-related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection and recordkeeping requirements. These requirements are not effective until they have been approved by the OMB.

To obtain copies of the supporting statement and any related forms for the proposed collections discussed above, please visit CMS's Web site at www.cms.hhs.gov/PaperworkReductionActof1995, or call the Reports Clearance Office at 410-786-1326.

We invite public comments on these potential information collection requirements. If you wish to comment, please submit your comments electronically as specified in the ADDRESSES

section of this proposed rule and identify the rule (CMS–9930–P), the ICR’s CFR citation, CMS ID number, and OMB control number.

ICR-related comments are due [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 risk adjustment program for the 2019 benefit year, as well as certain modifications that will promote State flexibility and control over their insurance markets, reduce burden on stakeholders, 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 the risk adjustment program, including the specific parameters applicable for the 2014, 2015, 2016, 2017, and 2018 benefit years. This rule proposes additional standards related to essential health benefits; cost-sharing parameters; qualified health plan certification; the Exchanges, including terminations, exemptions, eligibility and enrollment; AV for stand-alone dental plans; MEC; the rate review program; the medical loss ratio program; the Small Business Health Options Program; and FFE and SBE-FP 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)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

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.

Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a rule--(1) having an annual effect on the economy of \$100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as “economically significant”); (2) creating a

serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order. A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year), and a "significant" regulatory action is subject to review by OMB. HHS has concluded that this rule is likely to have economic impacts of \$100 million or more in at least 1 year, and therefore, meets the definition of "significant rule" under Executive Order 12866. Therefore, HHS has provided an assessment of the potential costs, benefits, and transfers associated with this rule.

The provisions in this proposed rule aim to improve the health and stability of the Exchanges, and to provide States with additional flexibility and control over their insurance markets. They would reduce regulatory burden, and reduce administrative costs for issuers and States, and would lower net premiums for consumers. Through the reduction in financial uncertainty for issuers and increased affordability for consumers, these provisions are expected to increase access to affordable health coverage. Although there is some uncertainty regarding the net effect on enrollment and premiums, we anticipate that the provisions of this proposed rule would help further HHS's goal of ensuring that all consumers have access to quality, affordable healthcare; that markets are stable; and that Exchanges operate smoothly.

In accordance with Executive Order 12866, HHS has determined that the benefits of this regulatory action justify the costs.

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 PPACA is to make affordable health insurance available to individuals who do not have access to affordable employer-sponsored coverage or government-sponsored coverage. The provisions within this proposed rule are integral to the goal of expanding coverage. For example, the risk adjustment program helps prevent risk selection and decrease the risk of financial loss that health insurance issuers might otherwise expect in 2019.

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 the risk adjustment program works as intended, and that States have more control and flexibility over essential health benefits, QHP certification and the operation and establishment of Exchanges. Affected entities such as QHP issuers would incur costs to comply with the proposed provisions, for example, those related to the functions of a SHOP; including calculating the minimum participation rate at the employer level and processing SHOP enrollments for employers and employees; and States would incur costs to comply with provisions regarding essential health benefits. 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 13 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 access to affordable health insurance coverage, reducing the impact of adverse selection, and stabilizing premiums in the individual and small group health

insurance markets and in an Exchange. We are unable to quantify certain benefits of this proposed rule – such as any reduction in burden related to changes in the timing related to States posting proposed and final rate filing information; increased flexibility for Exchanges related to the removal of certain requirements for Navigator programs and non-Navigator assistance personnel entities; increased access to the direct enrollment pathway stemming from permitting a third-party entity to conduct operational readiness reviews for agents, brokers, and issuers; benefits to Exchanges related to proposed simplifications of verification requirements; benefits to consumers, issuers or Exchanges related to the changes related to the special enrollment periods; increased flexibility for States relating to the proposals regarding the SHOP enrollment process; potential decreases in premiums to consumers related to removing actuarial value standards for SADPs; and reductions in burden associated with CHIP buy-in plans with identical coverage to the CHIP program under title XXI of the Act in the applicable State being automatically recognized as MEC – and certain costs – such as the costs incurred by small employers, agents and brokers, and potential increases in out-of-pocket costs to consumers related to removing actuarial value standards for SADPs; and costs to issuers, brokers, agents, and employers related to changes in SHOP enrollment procedures. The effects in Table 13 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 13 reflect direct administrative costs to health insurance issuers as a result of the proposed provisions, and include administrative costs associated with States requesting a reduction in the calculation of Statewide average premium for the State’s small group market for the purpose of risk adjustment, the reduction in costs relating to issuers and States having to no longer submit rate increases for student health insurance plans to HHS, and costs associated with

States seeking an adjustment to the MLR standard in the State's individual market that are estimated in the Collection of Information section of this proposed rule. The annual monetized transfers described in Table 13 include costs associated with SBE-FP user fees, the risk adjustment user fee paid to HHS by issuers, and reductions in rebate payments from issuers to consumers related to QIA and MLR adjustments. We are proposing to collect a total of \$38 million in risk adjustment user fees or \$1.68 per enrollee per year from risk adjustment issuers, which is less than the \$40 million in contract costs expected for benefit year 2017 when we established a similar \$1.68 per-enrollee-per-year risk adjustment user fee amount. As in 2018, the risk adjustment user fee contract costs for 2019 include additional costs for risk adjustment data validation; however, we expect reduced costs related to issuer outreach and education as issuers gain familiarity with the risk adjustment program, and enrollment remains steady in 2019 HHS risk adjustment covered plans compared to the billable member month enrollment estimated for 2018. Also, we expect a decrease in FFE user fee collections necessary as we estimate lower contract costs due to streamlining of FFE operations and an increase in premiums but also lower enrollment, resulting in a proposed user fee rate of 3.5 percent for 2019, which is the same as the FFE user fee rate established for 2014 through 2018 benefit years. However, the decrease in user fee collections required to support FFE functions for the 2019 benefit year will be similar to the updated costs for the 2018 benefit year, and the user fee rate will yield the same amount of transfers from FFE issuers to the Federal government as in the prior benefit year. Therefore, there are no changes to the FFE user fee transfers to include in Table 13. We are also proposing an SBE-FP user fee rate to be set at 3.0 percent for benefit year 2019, which is higher than the 2.0 percent SBE-FP user fee rate we finalized for the 2018 benefit year. In this rule, we

are also proposing to cease charging user fees on SHOP issuers offering plans through an FFE or SBE-FP starting for plan years beginning on and after January 1, 2018.

TABLE 13: Accounting Table

Benefits:				
Qualitative:				
<ul style="list-style-type: none"> • Greater market stability resulting from improvements to the risk adjustment methodology. • Potential increased enrollment in the individual market stemming from lower premiums, 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.^a • More informed Exchange QHP certification decisions. • Increased coverage options for small businesses and employees with less adverse selection. • Cost savings to consumers and issuers due to reduced administrative costs for issuers. • Reduced costs and burden for States with CHIP buy-in plans automatically recognized as recognized as MEC.^b • Potential decreases in premiums associated with States opting to select a new EHB-benchmark plan. • Reduced burden to Exchanges, due to the removal of the requirements that each Exchange must have at least two Navigator entities, and that one of these entities must be a community and consumer-focused nonprofit group, and the removal of the requirement that each Navigator (and each non-Navigator entity subject to §155.215) maintain a physical presence in the Exchange service area. • Reduced costs and burden and increased flexibility to agents and brokers performing direct enrollment and their third party auditors due to the removal of the requirement to obtain HHS approval to perform reviews. • Reduction in administrative costs to issuers due to the removal of the meaningful difference standard, and proposed changes to the SHOPS. • Reduction in costs and burden to issuers by establishing a 15 percent default threshold for rate increase reasonableness review. 				
Costs:	Estimate	Year Dollar	Discount Rate	Period Covered
	- \$ 28 million	2016	7 percent	2018-2022
Annualized Monetized (\$/year)	- \$ 26.75 million	2016	3 percent	2018-2022
Quantitative:				
<ul style="list-style-type: none"> • Costs incurred by issuers and States to comply with provisions in the proposed rule as detailed in the Collection of Information Requirements section, taking into account the reduction in burden and costs for issuers and States due to the elimination of the requirement to submit rate reviews to HHS for student health insurance coverage^b and increase in the rate review threshold and the reduction in burden and costs to States related to the requests for adjustment to the MLR standard in their individual markets. • Reduction in costs to issuers due to changes to the requirements for risk adjustment data validation. • Reduction in potential costs to Exchanges since they will no longer be required to conduct sampling as a verification process for eligibility for employer-based insurance starting plan year 2018, and can instead conduct an alternate process through plan year 2019. • Regulatory familiarization costs. 				
Qualitative:				
<ul style="list-style-type: none"> • Costs due to increases in providing medical services (if health insurance enrollment increases). • Costs to issuers of redesigning SADPs to account for the removal of actuarial value standards for SADPs. 				

<ul style="list-style-type: none"> Potential increases in out of pocket costs associated with States opting to select a new EHB-benchmark plan. 				
Transfers:	Estimate	Year Dollar	Discount Rate	Period Covered
Federal Annualized Monetized (\$/year)	\$ 16.2 million	2017	7 percent	2018-2022
	\$17 million	2017	3 percent	2018-2022
Other Annualized Monetized (\$/year)	\$ 87 million	2017	7 percent	2018-2022
	\$ 87 million	2017	3 percent	2018-2022
Quantitative: <ul style="list-style-type: none"> Decrease in transfers from health insurance issuers to the Federal government of \$2 million related to the decrease in annual cost of risk adjustment user fees for 2019 - 2021(the total risk adjustment user fee amount for 2018 was \$40 million and was previously estimated to remain the same for years 2019-2021). Increased transfers from SBE-FP issuers to the Federal government of \$20 million due to increase in user fee rate from 2.0 set in 2018 to 3.0 percent proposed for 2019. Decrease in user fee transfers from SHOP issuers offering plans through an FFE or SBE-FP to the Federal government of approximately \$6 million in 2019. Reduced transfers from consumers to health insurance issuers in the form of rebates of \$75 million to \$87 million due to proposed amendments to the medical loss ratio requirements.^c 				
Qualitative: <ul style="list-style-type: none"> Lower premium rates in the individual market due to the improved risk profile of the insured, competition, and pooling. A decrease in the premiums and risk adjustment transfers in the small group market as a result of potential State requests to reduce the Statewide average premium for the purposes of the risk adjustment transfer formula in the small group market. Potential increases in premiums associated with adjustments to MLR. Potential decreases in premiums associated with removal of AV standards for SADPs. Potential increases in out of pocket costs associated with removal of AV standards for SADPs. 				

a. Removal of AV standards for SADPs may reduce enrollment due to reductions in coverage and potential higher out-of-pocket costs.

b. The reduction in burden and costs associated with student health insurance and CHIP buy-in plans could result in lower premiums for these groups.

c. For the purpose of calculating total transfers, the upper bound was used.

This RIA expands upon the impact analyses of previous rules and utilizes the Congressional Budget Office's (CBO) analysis of the PPACA's impact on Federal spending, revenue collection, and insurance enrollment. The PPACA ends the transitional reinsurance program and temporary risk corridors program after the benefit year 2016. Therefore, the costs associated with those programs are not included in Tables 14 or 15 for fiscal years 2019-2022. Table 14 summarizes the effects of the risk adjustment program on the Federal budget from fiscal years 2018 through 2022, 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 14. We note that transfers associated with the risk adjustment program 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 13).

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 2018 Payment Notice for the impacts associated with the advance payment of premium tax credits, the premium stabilization programs, and FFE user fee requirements.

TABLE 14: Estimated Federal Government Outlays and Receipts for the Risk Adjustment, Reinsurance, and Risk Corridors Programs from Fiscal Year 2018-2022, in billions of dollars

Year	2018	2019	2020	2021	2022	2018-2022
Risk Adjustment, Reinsurance, and Risk Corridors Program Payments	5	5	5	6	6	27
Risk Adjustment, Reinsurance, and Risk Corridors Program Collections*	5	5	6	6	6	28

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 \$1 million in payments in FY 2018 that are collected in prior fiscal years. CBO does not expect a shortfall in these programs.

Source: Congressional Budget Office. *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017 to 2027* Table 2. September 2017. Available at <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53091-fshic.pdf>.

1. Risk Adjustment

The risk adjustment program is a permanent program created by the PPACA 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 153 in Title 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 through 2018 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 2019 benefit year, we estimate that the total cost for HHS to operate the risk adjustment program on behalf of States for 2019 will be approximately \$38 million, slightly less than in 2018, and that the risk adjustment user fee would be approximately \$1.68 per enrollee per year. This user fee reflects contract costs to support the risk adjustment data validation process in 2019, lower costs related to risk adjustment issuer outreach and education, and lower enrollment in risk adjustment covered QHPs, which results in the same user fee rate as the 2018 benefit year after rounding to the nearest cent.

We believe that our proposal to blend the coefficients calculated from the 2016 benefit year EDGE enrollee-level data with 2014 and 2015 MarketScan® data will provide stability within the risk adjustment program and minimize volatility in changes to risk scores from the 2018 benefit year to the 2019 benefit year due to differences in the datasets' underlying populations.

We are proposing to allow States to request a reduction in the Statewide average premium in the small group market. We expect this proposed policy would reduce premiums and transfers in the small group markets proportional to the percent by which the States choose to reduce the transfers. However, because the risk adjustment program is budget neutral, any State

decision to reduce the Statewide average premium used to calculate risk adjustment transfers will have no net impact on risk adjustment transfers.

2. Risk Adjustment Data Validation

This proposed regulation includes changes to the requirements for risk adjustment data validation that overall would reduce regulatory burden and costs for issuers of risk adjusted plans. HHS believes the proposal to only adjust issuers' risk adjustment risk scores whose data validation error rates materially deviate from the national central tendency of error rates would help market stability by increasing issuers' ability to predict risk adjustment transfers and liquidity needs. We anticipate that, under this proposal, most issuers required to participate in risk adjustment data validation would not have their risk scores adjusted, based on our analysis of error rates in the Medicare risk adjustment data validation program.

The proposal to retroactively adjust transfers for issuers that exited a State market would result in transfer adjustments for a small subset of issuers that previously would not have had their transfers adjusted, but HHS does not expect this policy to increase burden for these issuers, especially in light of the payment adjustment proposal described above.

HHS estimates that not requiring issuers that have 500 or fewer billable member months Statewide to conduct an initial validation audit beginning in the 2017 benefit year would reduce the administrative burden and costs on those issuers. The reduction in burden and costs related to this ICR has been discussed previously in the Collection of Information Requirements section.

Under the proposed change to the sampling methodology, issuers that were the sole issuer in a risk pool would still need to provide a sample for data validation, but the sample would not include enrollees from the risk pool where they were the sole issuer. Therefore, this proposal would not have a significant impact on costs or burden for affected issuers.

We propose to amend §153.630(b)(6) to state that a provider licensed to diagnose mental illness that is prohibited by State privacy laws from furnishing a complete medical record for data validation may furnish a signed mental or behavioral health assessment that providers routinely prepare. For risk adjustment data validation purposes, we assume a mental or behavioral health assessment is signed by a qualified provider who is licensed by the State to diagnose mental illness and, to the extent permissible under governing privacy and confidentiality laws, contains: (i) the enrollee's name; (ii) gender; (iii) date of birth; (iv) current status of all mental or behavioral health diagnoses; and (v) dates of service. The burden associated with submitting medical records for RADV purposes and therefore, this proposal, is currently approved under OMB Control Number 0938–1155: Standards Related to Reinsurance, Risk Corridors, Risk Adjustment, and Payment Appeals.

We propose to amend §153.630(b)(9) to state that, if an issuer of a risk adjustment covered plan (1) fails to engage an initial validation auditor; (2) fails to submit the results of an initial validation audit to HHS; (3) engages in misconduct or substantial non-compliance with the risk adjustment data validation standards and requirements applicable to issuers of risk adjustment covered plans; or (4) intentionally or recklessly misrepresents or falsifies information that it furnishes to HHS, HHS may impose CMPs in accordance with the procedures set forth in §156.805(b) through (e). Because risk adjustment data validation has thus far operated as a pilot program, we cannot estimate the number of issuers that would be subject to CMPs. However, we do not expect that a significant number of issuers would engage in the extreme misconduct required to warrant a CMP under this proposal.

3. Rate Review

In §154.103, we propose to exclude student health insurance coverage from the Federal rate review requirements. This would reduce burden related to rate review submission and review for issuers and States. In addition, providing States with more flexibility regarding timing of submission of rate filing justification, reducing the advance notification requirement for rate increase announcements, timing of posting proposed and final rate filing information, and changing the threshold for reasonableness review to a 15 percent increase rather than a 10 percent increase, would reduce regulatory burden for issuers and States. The reduction in burden and costs related to ICRs have been discussed previously in the Collection of Information Requirements section.

4. Additional Required Benefits (§155.170)

In the preamble to §155.170, we propose to extend the applicability of the policies governing State-required benefits to the proposals described at §156.111 that would provide States with new options for selecting their EHB-benchmark plans beginning for the 2019 plan year. Specifically, under any of the three proposed EHB-benchmark plan selection options, or if the State defaults to its current EHB-benchmark plan, the current policies regarding State-required benefits would continue to apply if the proposals at §156.111 are finalized. Because these policies would continue to be in effect, we do not anticipate any additional burden on States or issuers due to this proposal.

5. Standards for Navigators and certain Non-Navigator Assistance Personnel (§§155.210 and 155.215)

We propose to amend §155.210(c)(2) to remove the requirements that each Exchange must have at least two Navigator entities and that one of these entities must be a community and consumer-focused nonprofit group. We also propose to amend §§155.210(e)(7) and 155.215(h)

to remove the requirements that Navigators and non-Navigator assistance personnel entities subject to those regulations maintain a physical presence in the Exchange service area. The proposed amendments to §155.210(c)(2) would reduce the burden on Exchanges to have at least two separate Navigator entities, and as a result, Exchanges may be able to reduce funding amounts while still meeting program requirements. Removing these requirements would help promote flexibility and autonomy for each Exchange to structure its Navigator program, and to award grant funding to the number and type of entities that would be most effective for that specific Exchange service area. To the extent that Exchanges take advantage of these flexibilities, consumers may have fewer options of Navigator grantees and may not have access to a Navigator grantee or a non-Navigator assistance personnel entity that maintains a physical presence in the Exchange service area. Exchanges continue to have the flexibility to fund more than one Navigator grantee and SBEs continue to have the flexibility to require that Navigators maintain a physical presence in the Exchange service area.

6. Standards for third-party entities to perform audits of agents, brokers, and issuers participating in direct enrollment (§155.221)

The proposed regulations would replace the existing requirement that an HHS-approved third party perform audits of agents and brokers participating in direct enrollment to instead permit a third-party entity to conduct operational readiness reviews for agents, brokers, and issuers participating in direct enrollment. HHS anticipates this approach would reduce the regulatory burden on agents, brokers, and issuers utilizing this section for enhanced direct enrollment oversight. HHS also anticipates that this proposal would reduce the burden on third-party auditors performing reviews under §155.221, as those entities would no longer be required to obtain HHS approval to perform the reviews. Furthermore, we believe this proposal would

expand the available number of qualified third-party auditors by removing any time and operational restrictions imposed by the HHS pre-approval requirement, which would provide more flexibility to agents, brokers, or issuers as they complete operational readiness reviews. Additionally, we believe this proposal would enable more agents, brokers and issuers to demonstrate operational readiness by reducing the burden on HHS for conducting reviews, expediting the ability of these entities to demonstrate readiness, and increasing the feasibility of approval for use of innovative pathways, thereby creating more opportunities for enrollment in QHP coverage for consumers, potentially increasing enrollment. HHS anticipates that some of the burden would be lessened by the fact that many agent, brokers, or issuers would already have the established privacy and security controls, and may have existing relationships with auditors that could be leveraged for these reviews. We would provide additional technical details regarding compliance with the specific requirements under these rules in guidance in the future. It is difficult to estimate a nationwide effect with precision. We seek comment on the impact of this policy.

7. Eligibility Standards (§155.305)

The requirement in §155.305(f)(4)(ii) that the Exchange must send direct notification to the tax filer before denying eligibility for APTC to consumers who fail to file and reconcile went into effect in mid-January 2017; therefore, it did not impact operations for the 2017 open enrollment period, which was nearly over then. At that point in time, for the FFE, the household contacts for non-filers had been notified of their tax filer's non-compliance, and APTC had been discontinued at auto re-enrollment for those who did not file a Federal income tax return according to IRS data or inform the FFE that they had filed a Federal tax return and reconciled past APTC. Requiring the Exchange to deny APTC for failure to file and reconcile even in the

absence of “direct notification . . . to the tax filer” is unlikely to add new burden since Exchanges have not yet implemented §155.305(f)(4)(ii). We do not believe that Exchanges have built an FTI-compliant noticing infrastructure since the publication of the final rule establishing §155.305(f)(4)(ii) that they would need to dismantle if this proposal is finalized. However, if §155.305(f)(4)(ii) remains in effect, Exchanges will incur significant costs, as discussed above, to build the infrastructure necessary to directly notify tax filers about their tax filing status while protecting FTI.

8. Verification Requirements (155.320)

Verification Requirements in this proposed rule would also amend §155.320(d)(4) to allow an Exchange to conduct an HHS-approved alternative process instead of sampling, as provided under paragraph (d)(4)(ii) through benefit year 2019. We believe this would relieve Exchanges from the burden of investing resources to conduct sampling when the FFEs’ study of a sampling-like process found that this method of verification may not be cost-effective for some Exchanges at this time. We estimate the burden associated with sampling based in part on the alternative process used for the FFEs. HHS incurred approximately \$750,000 in costs to design and operationalize this study and the study indicated that \$353,581 of APTC was potentially incorrectly granted to individuals who inaccurately attested to their eligibility for or enrollment in a qualifying eligible employer-sponsored plan. We placed calls to employers to verify 15,125 cases but were only able to verify 1,948 cases. A large number of employers either could not be reached or were unable to verify a consumer’s information, resulting in a verification rate of approximately 13 percent. The sample-size involved in the 2016 study did not represent a statistically significant sample of the target population and did not fulfill all regulatory requirements for sampling under paragraph (d)(4)(i) of §155.320.

Taking additional costs into account—namely, the cost of sending notices to employees as required under paragraph (d)(4)(i)(A), the cost of building the infrastructure and implementing the first year of operationalizing this process, and the cost of expanding the number of cases to a statistically significant sample size of approximately 1 million cases—we estimate that the overall cost of implementing sampling would be approximately \$8 million for the FFE, and between \$2 million and \$7 million for other Exchanges, depending on their enrollment volume and existing infrastructure. Therefore, we estimate that the average per-Exchange cost of implementing sampling that resembles the FFE’s approach would be approximately \$4.5 million for a total cost to State-based Exchanges of \$54 million, when assuming 12 State-based Exchanges (operating in 11 States and the District of Columbia). This cost estimate does not, however, take into account the cost of notifying consumers when the information provided by their employer changes their eligibility determination described under paragraph (d)(4)(i)(E), the cost of providing employees consumer support that may be needed to understand notices and any change in eligibility, or the cost of ending those consumers’ APTCs, when necessary. This estimate also does not account for the unique operating costs of each Exchange, the proposed change to paragraph (d)(4) to allow Exchanges to continue to use an alternate process through benefit year 2019, and the flexibility afforded Exchanges described at §155.315(h) and referenced in §155.320(a)(2).

We believe these changes would lessen the financial and technical burdens on Exchanges under current regulation and allow Exchanges to conduct an alternative process to sampling under paragraph (d)(4) as approaches to sampling are refined and data bases are compiled over time. We seek comment on the reduction in burden associated with extending the option to allow

Exchanges to fulfill verification requirements by conducting an HHS-approved alternative process to sampling through plan year 2019.

9. Special Enrollment Periods (§155.420)

We do not anticipate that the revisions to §155.420 would create any costs or burdens. The proposed revisions in paragraph (b)(2)(i) align regulatory policy for special enrollment periods based on a court order with other similar special enrollment period types, and create operational efficiencies for Exchanges by streamlining effective date options across similar special enrollment period qualifying events related to a qualified individual gaining or becoming a dependent. For example, this revision to the regulation would enable the FFE to use a simpler online, automated application pathway for more special enrollment period-eligible consumers, meaning that fewer consumers will need to use a manual and costly casework process to use their special enrollment period. For limited cases when casework support is required, operations would also be simplified.

Similarly, the revision to paragraph (d)(1)(iii) allows Exchanges to provide similar treatment to all women losing non-MEC pregnancy-related coverage, which enables a more streamlined special enrollment period eligibility process.

Additionally, amending paragraph (a)(5) to exempt qualified individuals from the prior coverage requirement that applies to certain special enrollment periods if, for at least 1 of the 60 days prior to the date of their qualifying event, they lived in a service area where there were no QHPs offered through an Exchange may provide a pathway to coverage for a small group of individuals, and is not anticipated to impact the Exchange risk pool. The Exchange already exempts qualified individuals who may not previously have had access to QHP coverage through an Exchange, including those who were previously living in a foreign country or United States

territory and Indians as defined by section 4 of the Indian Health Care Improvement Act.

Therefore, we do not believe that adding an additional small population to this exemption will create additional costs or burdens.

Finally, because simplified special enrollment period eligibility policy provides improved pathways to continuous coverage for special enrollment period-eligible consumers, we anticipate that the revisions would reduce burden on consumers, have a positive effect on the risk pool, and not result in additional costs or burdens for issuers.

10. Effective dates for terminations (§155.430)

Permitting all enrollee-initiated terminations to become effective on the date of enrollee request or a later date of their choosing and removing the special termination effective date for newly eligible Medicaid/CHIP/basic health plan consumers streamlines termination effective dates for Exchanges and reduces complication and confusion among consumers and issuers. There are no new costs incurred by Exchanges or issuers by aligning these termination dates, as Exchanges and issuers are well acquainted with same-day termination transactions. However, enrollees who receive retroactive coverage under Medicaid may be unable to recoup QHP premiums paid. Nevertheless, operationalizing the aligned termination dates may reduce system errors and related casework, as well as confusion for consumers, issuers, and caseworker and call center staff based on contradictory rules for different scenarios.

11. Eligibility Standards for Exemptions (§155.605)

We do not anticipate that the proposed amendment to §155.605(d) would create additional costs or burdens. The proposed amendment to §155.605(d)(2)(iv) would enable the Exchanges to process the consumer's exemption from the individual shared responsibility provision due to lack of affordable coverage based on projected income, for those not eligible for

employer-sponsored coverage, when there is no bronze plan available by allowing the Exchanges to process the consumer's exemption based on the lowest cost Exchange metal level plan available in the individual market through the Exchange in the State in the rating area in which the individual resides. This proposal would not increase the burden on consumers or Exchanges. Without these revisions, individuals may lack access to qualifying or affordable health coverage, but be unable to qualify for an exemption from the individual shared responsibility provision to purchase qualifying health coverage and the associated financial penalty due to the lack of coverage in their area or the inability to calculate whether coverage is unaffordable. This proposal would also not result in additional costs or burdens for issuers.

12. Small Business Health Options Program (Part 155, subpart H, §155.200, §§156.285 and 156.286, §156.350, §§157.205 and 157.206)

HHS is proposing to grant additional flexibilities, for plan years beginning on or after January 1, 2018, to small employers enrolling in SHOP QHPs and to participating QHP issuers in how they interact with a SHOP. If finalized, these changes would become effective as of the effective date of the final rule. Under this proposed rule, several existing requirements on SHOPS would not apply for plan years beginning on or after January 1, 2018, allowing SBEs the flexibility to operate a SHOP in a way that makes sense for the small businesses in their State, with reduced limitations imposed by Federal regulation. The FF-SHOPS, if this rule is finalized as proposed, would take advantage of the flexibility of the enrollment approach described through this proposed rule and operate in a leaner fashion. Under the proposed approach, SHOPS would no longer be required to enroll small groups in SHOP QHPs through a SHOP Web site. Instead, small employers would enroll through a participating QHP issuer, or a SHOP-registered agent or broker.

HHS believes that the proposed changes would reduce burden on participating QHP issuers, small employers, and agents and brokers for several reasons. Under the proposed approach to SHOP enrollment for plan years beginning on or after January 1, 2018, effective on the effective date of the final rule, if finalized as proposed, participating QHP issuers would enroll small groups through their existing enrollment channels—utilizing their existing technologies and processes. Small groups enrolled in SHOP QHPs for plan years before January 1, 2018 would not be affected by the proposed changes to enrollment through a SHOP until they would be due to renew in a SHOP QHP for the 2018 plan year. While some additional requirements would be imposed onto issuers, if this approach were to become final, HHS anticipates that any additional burden on issuers as a result of the changes proposed in this rule, if finalized, would be negated in an ultimate net reduction in burden as many Federal regulations are being removed and any additional requirements onto issuers mainly consist of practices they currently perform in the private market.

In the 2018 Payment Notice, HHS finalized the removal of a participation provision that had required certain QHP issuers to participate in an FF-SHOP in order to participate in an FFE. As a result, HHS expects that there will be a significant decrease in the number of issuers in the FF-SHOPS in the 2018 plan year and therefore, also expects fewer enrollments in the FF-SHOPS and SBE-FPs utilizing the Federal platform for SHOP. As of January 1, 2017, approximately 7,554 employer groups were enrolled in the FF-SHOPS, covering 38,749 lives. With the anticipated significant decreases in QHP issuer participation and enrollment beginning in 2018, it is not cost effective for the Federal government to continue to maintain certain FF-SHOP functionalities, collect significantly reduced user fees on a monthly basis, maintain the

technologies required to maintain an FF-SHOP Web site and payment platform, generate enrollment and payment transaction files, and perform enrollment reconciliation.

Under the proposed approach, issuers would still be subject to their State requirements, and HHS would minimize Federal requirements related to SHOP plans (that is, notice requirements, etc.) for plan years beginning on or after January 1, 2018. For example, issuers are often required by State law to generate enrollment and payment notices, and would continue to generate any State-required notices under the proposed SHOP enrollment approach. Under the proposed approach, the FF-SHOPs would no longer generate enrollment notices, but the notice requirements for the FF-SHOPs would not necessarily be transferred directly to participating QHP issuers. HHS can imagine a scenario where an issuer might generate an additional notice to a SHOP consumer that they are not required by Federal law to send, but may be required by State law, to send.

Issuers, under the proposed approach would still be required to accept enrollment from employers that offer their employees a choice of plans. HHS can foresee a circumstance where an employer offers its employees a choice of plans, across plan categories, and where the employees choose to enroll in plans offered by multiple issuers. In this circumstance, it would also be possible that an issuer would receive one application for enrollment from a group. Under the proposed approach to SHOP enrollment, the issuer would be required to accept that single enrollment so long as the employer's group has met the minimum participation rate for their State, or is enrolling between November 15 and December 15, when the minimum participation rate rules do not apply. Given the expected decrease in issuer participation in the SHOP beginning in plan year 2018, HHS believes that a circumstance, similar to the one discussed above may occur. In the absence of premium aggregation services, issuers, under the proposed

approach would be working directly with an employer, or their appointed SHOP-registered agent or broker for matters of enrollment and premium billing and payment. Under the proposed regulations, issuers would be required to enroll consumers into plans, even if only one employee of a group would like to enroll. Further, if this proposal were to become final, issuers would also be required to process enrollments into SHOP QHPs, and, handle appeals (other than appeals related to employer eligibility), administer special enrollment periods and terminations. Issuers would still be subject to the market wide effective dates outlined in §147.104(b)(1)(i)(C). While HHS believes that issuers currently perform the majority of these tasks, issuers may experience an increase in burden as it relates to the volume of consumers enrolling in their SHOP QHPs. Overall, HHS believes that under this approach, issuers would see a net cost savings, as their business processes for SHOP enrollments could be more closely aligned with their current business practices for enrollments outside the SHOP, and they would no longer be remitting user fees for FF-SHOP and SBE-FP SHOP enrollments.

As noted, SBEs would be given the flexibility to adopt an enrollment approach through which enrollments occur directly with issuers or SHOP-registered agents or brokers, to continue to operate with the same functionalities as they currently do or to develop new practices as permitted by the proposals in this rule. In any case, SBEs would need to meet only the proposed regulations, therefore minimizing the overall amount of regulatory requirements that SBEs would otherwise need to meet. HHS believes that the proposed new flexibility for SBEs will result in an overall reduction in burden and cost for SBEs because we are providing SBEs with the flexibility to pursue the enrollment approach that best meets their needs, because we are reducing the overall regulatory requirements for the SHOP Exchanges, and for the same reasons

described above regarding why the proposed enrollment approach would reduce burdens on the FF-SHOP and its stakeholders.

Under the proposed approach for plan years beginning on or after January 1, 2018, HHS believes that employers seeking to purchase FF-SHOP coverage would experience a reduction in regulatory burden related to enrollment, despite the fact that they may be required to visit at least two Web sites (the SHOP Web site and the issuer's Web site) prior to completing an enrollment in SHOP coverage as they would be able to enroll in coverage through a SHOP-registered agent or broker or through a participating QHP issuer—using issuers' streamlined enrollment technologies. Employers would also be required, under the proposals described throughout this document to notify their QHP issuer of their eligibility to purchase a SHOP QHP and of their ineligibility, if their eligibility were to be revoked. We believe this would still be less cumbersome than the existing eligibility and enrollment process.

Under the proposed approach, some employers, specifically those who offer their employees a choice of plans, would experience an increase of administrative burden with the removal of a SHOP's premium aggregation services. Without a SHOP's premium aggregation services, employers would have to collect the enrollment and payment information needed from each of the issuers whose plans the employer intends to offer to its employees. In the event employees select plans from multiple insurance companies, the employer would be responsible for distributing the applications for enrollment to the individual issuers, collecting payments from the employees and sending the individual payments to each issuer. Due to the expected decrease in issuer participation in the FF-SHOPs, some SHOP employers will likely only have one issuer offering FF-SHOP plans in their area and would not be able to offer their employees a choice of plans across issuers. In addition, historically, a majority of employers have not offered

employee choice across different issuers. Therefore HHS does not believe the potential increased burden in this area due the proposed removal of premium aggregation services to be significant. Employers would still be able to view a listing of all of the SHOP QHPs available, by plan category and issuer on a SHOP Web site. HHS expects that the actual process of enrolling in SHOP QHPs under this approach would be less burdensome than the existing enrollment approach through a SHOP Web site. As previously mentioned, HHS anticipates significantly lower issuer participation in the SHOP in the 2018 plan year. A decrease in issuer participation unfortunately also results in less choice for consumers. While employers could experience an increase in burden, under the proposed flexibilities for SHOPs, HHS anticipates the benefits of the proposed approach would ultimately outweigh the minimal additional costs employers could face, if these proposals were to be finalized.

Further, because the Federal government would experience a dramatic reduction in the role it plays in operating an FF-SHOP and the contract support that it requires in order to support it. In 2016, the cost of running the FF-SHOP Web site was approximately \$30 million, and HHS expects annual expenditures to drop significantly- by at least 90 percent - within a few years, as it responsibly wind-downs the integration of the FF-SHOPs.

13. User Fees (§156.50)

To support the operation of FFEs, we require in §156.50(c) that a participating issuer offering a plan through an FFE or SBE-FP 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 2019 benefit year, we propose a monthly FFE user fee rate equal to 3.5 percent and for an SBE-

FP equal to 3.0 percent of the monthly premium. This increase in SBE-FP user fee rate from 2.0 percent in 2018 to 3.0 percent in 2019 will increase transfers from SBE-FP issuers to the Federal government by \$20 million. Additionally, we propose to cease charging monthly user fees to SHOP issuers offering plans through an FFE or SBE-FP for plan years beginning on and after January 1, 2018, effective on the effective date of the final rule, if finalized as proposed. This proposal will decrease user fee transfers from SHOP issuers offering plans through an FFE or SBE-FP of approximately \$6 million.

14. Provision of EHB

In §156.111, we propose to provide States with more flexibility by offering States three new methods for selecting their State EHB-benchmark plans. Under this proposal, if the State does not select one of the three methods for changing its EHB-benchmark plan, the State would default to its current EHB-benchmark plan. We recognize that, to the extent that States take advantage of the proposed EHB-benchmark plan selection options at §156.111, States, issuers, and consumers would experience an increase in burden to develop new policies and implement new plan designs. We anticipate that most States would need to invest resources to analyze the three new EHB-benchmark selection options to make an informed selection, even if a State defaults. Several States may select one of the new options, and would need additional resources to facilitate a public notice and comment period; develop and submit the necessary documents specified by HHS (including the requisite actuarial certification) to effectuate the State's selection; and, if making changes to their EHB-benchmark plan for 2019, to instruct their issuers on how to manually change the Add-in file used in the Plans and Benefits Template to align with

the State's EHB-benchmark plan, as discussed in preamble.⁷⁷ Additionally, in States that choose to select their EHB-benchmark plan under any of the three available proposed options, issuers offering plans that provide EHB would incur additional administrative costs associated with designing plans compliant with the State's newly selected EHB-benchmark plan.

Due to the many PPACA policies directly or indirectly tied to EHB, HHS recognizes the impact this proposed policy would have on parties beyond issuers required to provide EHB-compliant plans. For example, the State's new EHB-benchmark selection could impact how HHS reviews and recognizes plans seeking minimal essential coverage designation,⁷⁸ how issuers set their annual limitation on cost-sharing, and how issuers determine which benefits may not be subject to annual and lifetime dollar limits.⁷⁹

It is our aim that the flexibility under the proposed policy would allow for States and issuers to be more innovative in designing benefit structures and affordable health plans that benefit the consumer. However, we realize that this proposed policy would have varying impact on consumers depending on how a State chooses to implement the proposed policy. Consumers enrolled in individual and small group market plans would be impacted by changes to EHB in that their benefits may change and in some cases premiums could increase or decrease depending upon State implementation of the proposed policies. Additionally, in States that use one of the

⁷⁷ For certain States, taking action on the EHB-benchmark plan may require legislature action or other high level state approval.

⁷⁸ Consumers generally must maintain minimum essential coverage or obtain an exemption to avoid the individual shared responsibility payment. As noted in the preamble to §156.602 in this proposed rule, in considering whether to recognize coverage as MEC under the application process provided for in §156.604, HHS generally evaluates whether the coverage complies with substantially all the requirements of title I of the PPACA that apply to non-grandfathered coverage in the individual market, including the EHB requirements.

⁷⁹ The definition of EHB also has an impact on the annual limitation on cost sharing at section 1302(c) of the PPACA (which is incorporated into section 2707(b) of the PHS Act) and the prohibition of annual and lifetime dollar limits at section 2711 of the PHS Act, as added by the PPACA.

proposed methods to select a new EHB-benchmark plan, the new EHB-benchmark plan selection may impact the amount of premium tax credit (PTC) and CSRs for enrollees in the State. For these consumers, subsidies would increase or decrease when compared to their State's current EHB-benchmark plan. PTC is available only for that portion of a plan's premium attributed to EHB. To the extent that a State's EHB-benchmark plan, under the proposal, leads to lower premiums for the second lowest cost silver plan, PTC would be reduced, but not the percent of income a consumer with PTC is expected to contribute to their premium. This effect would represent a transfer from consumers who receive PTC to the Federal government. Individual and small group market enrollees who do not receive PTC would experience lower premiums for less comprehensive coverage that could result in more affordable coverage options but possibly higher out-of-pocket costs for the consumer.

We anticipate that States are more likely to select EHB-benchmark plans under this proposal such that premiums are reduced. The proposal, however, provides some flexibility for States to select EHB-benchmark plans in a manner that would increase premiums, for example by selecting another State's EHB-benchmark plan that provides greater benefits than the State's current EHB-benchmark plan. To the extent that a State's EHB-benchmark plan leads to higher premiums for the second lowest cost silver plan, PTC would be increased.

Consumers who have specific health needs may also be impacted by the proposed policy. In the individual and small group markets, depending on the selection made by the State in which the consumer lives, consumers with less comprehensive plans may no longer have coverage for certain services. In other States, again depending on State choices, consumers may gain coverage for some services.

As explained above, HHS anticipates that modifying §156.111 as proposed would generate additional costs for States, issuers, and certain consumers in the short run. However, although we are uncertain as to how States might take advantage of this flexibility and States are not required to make any changes under this policy, we also believe the additional flexibility in plan and benefit design might produce premium savings, outweighing the potential burdens. The proposed policies offer issuers in States that utilize the proposed flexibility to select a new EHB-benchmark plan the opportunity to lower plan premiums, which would increase affordability of health insurance for consumers in the individual and small group markets who do not receive PTC and do not require the benefits that are no longer considered EHB.

When adjusting coverage of services under the proposed options, we encourage States to consider the spillover effects in addition to the costs and utilization of these services. Spillover effects include increased use of other services, such as increased use of emergency services or increased use of public services provided by the State or other government entities, when a certain service is no longer covered by insurance. Depending on the State population's use of services and health care needs, States may arrive at different conclusions about the effects of adjusting a particular benefit. Because we do not know how States would choose to adjust their benchmark plans, we are not able to predict the effects these modifications may have on costs.

Additionally, we also proposed at §156.115 to allow for benefit substitution to occur within the same EHB category or between EHB categories to offer additional issuer flexibility. Because issuers are already familiar with substituting benefits within benefit categories, we do not believe that broadening the policy to allow benefit substitution between benefit categories would create additional burden for issuers. This proposal would increase the burden on consumers who choose between plans offered in the individual and small group markets as they

would need to spend more time and effort comparing benefits offered by different plans in order to determine what, if any, benefits have been substituted and what plan would best suit their health care and financial needs. We also note that States are generally primarily responsible for enforcement of EHB and continue to have the option to set criteria for benefit substitution. Additionally, by allowing substitution between categories, States may encounter difficulties in ensuring that all categories are filled in such a way that amounts to EHB.

We solicit comments on the impact of the proposed EHB policy and on whether other impacts should be considered.

15. Application to stand-alone dental plans inside the Exchange (§156.150)

In this proposed rule, we are proposing to remove AV requirements for SADP issuers. We estimate that the proposed change in AV could lead to a reduction in premiums for certain SADPs. Issuers may choose to offer more SADPs at varying premiums and levels of coverage. The offering of more SADPs and SADPs with lower premiums may lead to increased enrollment in SADPs. Because certain eligible taxpayers could use premium tax credit to pay for the portion of SADP premiums attributable to EHB, a reduction in premiums would likely reduce the benchmark premium for purposes of the premium tax credit, leading to a small transfer from credit recipients to the government. If enrollment increases due to potentially lower premiums there could be an overall increase in the total premium tax credit payments by the government. The net effect is uncertain. We seek comment on the impact of this proposed change.

16. Qualified health plan certification

For plan years 2019 and later, we propose to further expand the role of States in the QHP certification process for FFEs, including FFEs where the State performs plan management functions. Specifically, we propose to defer to States for additional review areas, including

accreditation requirements at §156.275, compliance reviews at §156.715, minimum geographic area of the plan's service area at §155.1055, and quality improvement strategy reporting at §156.1130, if feasible and appropriate. We also propose to extend, for the 2019 benefit year and beyond, the QHP certification review standards related to network adequacy and essential community providers that we finalized in the Market Stabilization rule. We do not anticipate these proposals would increase burden on States because we believe these reviews are already being performed by States. We anticipate a slight reduction in burden for issuers due to not needing to undergo duplicative reviews and a reduction in costs to the Federal government. We seek comment on whether there are burdens we are not considering.

In §156.298, we propose to remove the meaningful difference standard. If the meaningful difference standard is removed, issuers would have a potential reduction in administrative costs since they would no longer have to implement their internal assessments as to whether their plan offerings meet this standard. Consumers may have more QHPs to select from. However, we do not have evidence from any Exchange that removing the meaningful difference standard would create any new burden on consumers.

We also anticipate that the proposal to remove the meaningful difference standard would reduce the regulatory burden on SBE-FPs. Under §155.200(f)(2)(iv), SBE-FPs are required to establish and oversee requirements for their issuers that are no less stringent than the meaningful difference standard as it applies to issuers participating in the FFEs. Under our proposal, SBE-FPs would no longer need to establish such a standard or oversee it.

17. Provisions Related to Cost Sharing (§156.130)

The PPACA provides for the reduction or elimination of cost sharing for certain eligible individuals enrolled in QHPs offered through the Exchanges. This assistance helps many low-

and moderate-income individuals and families obtain health insurance – for many people, cost sharing is a barrier to obtaining needed health care.⁸⁰

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 PPACA to the estimated 2019 maximum annual limitation on cost sharing for self-only coverage. 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 past Payment Notices.

We also proposed the premium adjustment percentage for the 2019 benefit year. Under §156.130(e), and 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 the percentage (if any) by which the average per enrollee premium for employer-sponsored health insurance coverage for the preceding calendar year exceeds such average per enrollee premium for employer-sponsored health insurance for 2013. The annual premium adjustment percentage sets the rate of increase for three parameters detailed in the PPACA: the annual limitation on cost sharing (defined at §156.130(a)), the required contribution percentage used to determine eligibility for certain exemptions under section 5000A of the Code, and the assessable payments

⁸⁰ 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>.

under sections 4980H(a) and 4980H(b) of the Code. We believe that the proposed 2019 premium adjustment percentage is well within the parameters used in the modeling of the PPACA, and we do not expect that these proposed provisions will alter CBO's March 2016 baseline estimates of the budget impact.

18. Minimum Essential Coverage (§156.602, §156.604)

We propose to designate CHIP buy-in programs that provide identical coverage to the CHIP program under title XXI of the Act in the applicable State as minimum essential coverage. Currently very few States offer CHIP buy-in plans and such plans in two states have applied for and been recognized as minimum essential coverage. This proposed provision would reduce burden on sponsors of such programs that might otherwise have had to electronically submit to HHS information regarding their plans and certify that their plans meet substantially all of the requirements of Title I of the PPACA, as applicable to non-grandfathered, individual coverage (including reviewing and updating documents), make changes to their program to obtain recognition as minimum essential coverage, and provide a notice to enrollees informing them that the plan has been recognized as minimum essential coverage for the purposes of the individual shared responsibility provision. If CHIP buy-in programs that provide greater coverage and government-sponsored buy-in programs, such as Medicaid buy-in programs are categorically recognized as minimum essential coverage, sponsors of such programs would also experience a similar reduction in burden. The sponsor of any type of coverage recognized as minimum essential coverage would continue to be required to provide the annual information reporting to the IRS specified in section 6055 of the Code and furnish statements to individuals enrolled in such coverage to assist them in establishing that they are not subject to the individual shared responsibility provision of section 5000A of the Code.

19. Medical Loss Ratio (Part 158)

We propose to amend §158.221(b) to allow issuers the option to report a single quality improvement activity expense amount equal to 0.8 percent of earned premium in the relevant State and market, in lieu of reporting the actual QIA amounts in five separate categories described in §158.150(b)(2)(i)-(v). Based on MLR data for the 2015 MLR reporting year, HHS estimates that the proposed amendment would decrease rebate payments from issuers to consumers by approximately \$23 million.

We also propose to amend several sections of 45 CFR part 158, subpart C (§§158.301, 158.321-158.322, 158.330, 158.341, 158.350) to modify the process and criteria for the Secretary to determine whether to adjust the 80 percent MLR standard in the individual market in a State. While it is uncertain what specific adjustments States may request, most adjustments previously granted by the Secretary have ranged from 70 to 75 percent. Based on MLR data for the 2015 MLR reporting year, and assuming that 22 States would request an adjustment (including 17 States that previously requested adjustments), HHS estimates that the proposed amendments would decrease rebate payments from issuers to consumers or increase premiums paid by consumers to issuers by approximately \$52 million (assuming a reduction of the 80 percent MLR standard to 75 percent for all 22 States) to \$64 million (assuming a reduction of the MLR standard to 70 percent for all 22 States) annually, for up to 3 years at a time. This represents an estimated 74 percent to 91 percent reduction, respectively, in rebates payable in those 22 States, which together accounted for \$70 million out of the nationwide total \$107 million in rebates that issuers owed to individual market consumers for 2015. The actual reduction in rebates may be lower or higher depending on which States apply for an adjustment, and whether and how much the Secretary may adjust the individual market MLR standard in each State.

20. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on last year's proposed rule will be the number of reviewers of this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed last year's rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons we thought that the number of past commenters would be a fair estimate of the number of reviewers of this rule. We welcome any comments on the approach in estimating the number of entities which will review this proposed rule.

We are required to promulgate a substantial portion of this rule each year under our regulations and we estimate that approximately half of the remaining provisions would cause additional regulatory review burden that stakeholders do not already anticipate. We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule, and therefore for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule, excluding the portion of the rule that we are required to promulgate each year.

Using the wage information from the BLS for medical and health service managers (Code 11-9111), we estimate that the cost of reviewing this rule is \$105.16 per hour, including

overhead and fringe benefits.⁸¹ Assuming an average reading speed, we estimate that it would take approximately 1 hour for the staff to review the relevant portions of this proposed rule that causes unanticipated burden. For each entity that reviews the rule, the estimated cost is \$105.16. Therefore, we estimate that the total cost of reviewing this regulation is approximately \$70,247 (\$105.16 x 668 reviewers).

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.

For the 2019 benefit year, we considered using only the 2016 benefit year enrollee-level EDGE data to recalibrate the risk adjustment model coefficients. However, this could lead to uncertainty in issuers' expectation of risk adjustment transfers due to the sole use of a new dataset for recalibrating the model coefficients. We believe that blending multiple years of data will promote stability for the risk adjustment coefficients year-to-year, particularly for rare conditions with small sample sizes. Therefore, we are proposing to blend coefficients calculated from the 2016 benefit year enrollee-level EDGE data with 2014 and 2015 MarketScan® data. Additionally, given the timing of the proposed rule, we are unable to analyze the enrollee-level EDGE data in time to publish the coefficients calibrated using the EDGE data in the proposed rule. Similar to the 2018 benefit year final risk adjustment coefficients, we considered publishing the 2019 benefit year final risk adjustment coefficients in guidance after the publication of the final rule with more recent MarketScan® data that will become available at the end of this year.

⁸¹ https://www.bls.gov/oes/current/oes_nat.htm.

However, we expect the 2016 benefit year enrollee-level risk adjustment data will be available in time for the final rule. Additionally, we are not proposing to use the 2016 MarketScan® data that will become available at the end of this year for the 2019 benefit year risk adjustment model recalibration. As such, we are proposing to finalize the 2019 benefit year model coefficients blended with 2016 EDGE data, and 2014 and 2015 MarketScan® data in the final rule.

With respect to the risk adjustment data validation program, HHS considered an alternate policy under which HHS would not adjust payment transfers for an issuer that exited a market within a State during or after the benefit year being audited, unless the error rate for the exited issuer was egregiously high relative to the error rates of other issuers in the State and market. We would define the error rate threshold for triggering a payment adjustment as 2 or 3 standard deviations from a benchmark negative error rate. For exited issuers that have error rates above the established threshold, we would make a retroactive adjustment to their final benefit year payment transfer in the same manner as outlined above. While this alternative approach may provide returning issuers in the State and market with more certainty about their risk adjustment transfers for a given benefit year, it does not offer as much protection against gaming as the proposed policy, and could result in exited issuers that do not have egregiously high error rates being overpaid relative to the risk of their enrollee populations.

We considered maintaining the current applicability of rate review, and continuing to review student health insurance coverage rate increases. However, the proposed rule would provide States with greater flexibility to meet the needs of their markets and reduce the burden associated with review of plans that are not part of the single risk pool. As a practical matter, student health insurance coverage has generally been given the same plan design flexibility as plans in the large group market. Just like purchasers of large group plans, purchasers in the

student market are viewed as more sophisticated, with greater leverage and ability to avoid the imposition of unreasonable rate increases. Single risk pool pricing, the primary focus of the rate review program, does not apply to student health insurance coverage.

We considered maintaining the current 30-day notice requirement for States to notify HHS prior to posting proposed and final rate increases. However, such advanced notice may be impractical in some States so we have decreased the notice requirement to 5 business days.

In adding standards for §155.221, HHS considered making no changes to the existing rule and retaining the existing standard for agents and brokers to contract with a third-party entity approved by HHS for conducting audits under the section. We believe, however, that changes to this section are necessary to include issuers and to provide the necessary flexibility in oversight that both protects consumers and encourages enrollment pathway innovation for agents, brokers, and issuers using direct enrollment.

For the proposed amendments to §155.320, we considered developing a comprehensive database using information from employers on the plans they offer to their employees and their family members that could satisfy verification requirements under paragraph (d)(2) for all Exchanges. This approach would be resource-intensive for Exchanges, and would produce a database with limited utility due to data limitations. Developing a database; recruiting and educating employers to participate in voluntarily submitting the data; and providing technical assistance to employers for the first year of implementation on how to input the data is estimated to cost at least \$38 million. Building such a database would also rely on the voluntary participation of substantially all employers. This participation would be onerous for employers. Employers would need to provide individual employee level data regarding plans the employer will offer, information that may not be available in time to populate a comprehensive database

prior to the Exchange's plan year. In addition, since the PPACA does not require employers to provide to the Exchange the relevant information on what coverage they offer, Exchanges and HHS would not receive data from all employers. After weighing our options, we decided that this approach would be overly costly and burdensome, and of limited value due to gaps in the data Exchanges and HHS would be able to collect. We also considered removing the requirement to connect to an HHS-approved data source, and the requirement to use an alternative method if the Exchange does not connect to the required data sources, but were concerned about the potential impact on program integrity.

In developing the proposal related to the SHOP enrollment process, we considered maintaining the status quo, but believe that the increase in flexibility, cost savings and reduction in burden resulting from the proposed enrollment approach, would have a positive impact on small businesses across the country and provide States with needed flexibility.

In developing the proposal for the new EHB-benchmark plan selection options described at §156.111, we considered a variety of alternatives, including maintaining the current EHB-benchmark policy without modification. Although maintaining the current policy would promote stability by preserving the current EHB-benchmarks across all States, we do not believe it would offer the additional flexibility that States have requested in selecting an EHB-benchmark plan to best meet the needs of their consumer population. We also considered whether it was feasible to offer States increased flexibility by allowing them to set a range of acceptable EHB within their State, such that issuers could offer plans within that range with more limited EHB coverage or more robust EHB coverage. However, we determined that this option did not meet statutory requirements. To balance stability, flexibility, and statutory requirements, we instead propose to offer States the expanded EHB-benchmark plan selection options at §156.111 as well as the

option to default to the State's current EHB-benchmark plan. We believe this approach would provide States with the opportunity to take advantage of greater flexibility in selecting an EHB-benchmark plan while also providing those States that value stability with the option to retain their current benchmark plan. We solicit comments on proposed options at §156.111.

With respect to the provision regarding removing the AV requirement for SADPs, we considered making no change or proposing an expansion to the de minimis range to mirror the expanded de minimis range for QHPs (-4/+2 percentage points) or of +/- 3 percentage points. We determined that these alternatives were less desirable because they do not provide issuers with as much flexibility to offer a range of SADPs as the proposed removal of the AV standards for SADPs.

For the QHP certification standard regarding meaningful difference, we considered maintaining the requirement on issuers, but we believe that removing this provision would promote the offering of a variety of affordable QHPs that will meet consumers' needs, would provide issuers with more flexibility, and would remove an unnecessary regulatory requirement.

We considered maintaining the current policy requiring all CHIP buy-in programs that wish to be recognized as minimum essential coverage, to comply with the requirements for recognition as MEC outlined in §156.604. However, this proposed rule would help reduce burden on plan sponsors of such programs, while ensuring the enrollees have a basic standard of coverage that satisfies the individual shared responsibility provision. In the preamble to §156.602, we solicit comments on whether CHIP buy-in programs that are not identical to the State's CHIP program but provide similar or greater coverage for enrollees should also be designated as MEC or whether such programs must submit an application so that HHS can

evaluate any differences with the title XXI program to ensure that the program substantially resembles the title XXI program.

For the proposed amendments to §158.221(b), we considered retaining the current quality improvement activity reporting requirements, since giving issuers the option to report a standardized rate for QIA expenditures may inhibit HHS from being able to analyze trends in issuers' investment in improving the quality of healthcare in the future, and reduce rebates to consumers by allowing issuers to effectively increase their MLRs by 0.8 percent even if those issuers engaged in and spent only trivial amounts on QIA. However, this change would also potentially level the playing field among issuers to a certain extent and lead to more accurate rebate payments, since many issuers likely do engage in QIA but forego reporting that spending because the burden of analyzing, documenting, tracking, allocating, and reporting QIA expenses exceeds the benefits for MLR purposes. Because the proposed approach of giving issuers the option to report a minimal, standardized rate would reduce unwarranted regulatory and economic burdens for issuers that do not want to track and report the exact QIA amounts for their MLR calculation, we believe that the proposed approach would be more effective and objective than the current requirements.

For the proposed amendments to part 158, subpart C, we considered retaining the current requirements for States to request an adjustment to the 80 percent MLR standard in the individual market in a State. However, HHS recognizes that many of the current State application requirements are burdensome and less relevant in the post-2014 reformed environment, and may preclude or discourage States from proposing innovative solutions to help stabilize their individual markets. Therefore, we believe this proposal would reduce regulatory

burdens on States, and provide States with an additional tool to promote stability in their markets.

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 and risk adjustment data validation 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.⁸² We believe that few, if any, insurance companies underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) fall below these size thresholds.

In this proposed rule, we proposed to allow enrollment through a SHOP-registered agent or broker, or through a participating QHP issuer. The SHOPs are generally 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.

⁸² “Table of Small Business Size Standards Matched to North American Industry Classification System Codes”, effective February 26, 2016, U.S. Small Business Administration, available at <https://www.sba.gov/contracting/getting-started-contractor/make-sure-you-meet-sba-size-standards/table-smallbusiness-size-standards>.

Based on data from MLR annual report submissions for the 2015 MLR reporting year, approximately 92 out of over 530 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 50 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. We estimate that 57 of these 92 potentially small entities would experience a decrease in the rebate amount owed to consumers under the proposed amendments to the quality improvement activity reporting provisions in part 158, and 27 of these 57 entities are part of larger holding groups. In addition, we estimate that no small entities would be impacted by the proposed amendments to 45 CFR part 158, subpart C. Therefore, we believe that the provisions of this proposed rule regarding MLR would not affect a substantial number of small entities, and further, the impact of the proposed QIA provisions on small entities would be positive.

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. Currently, that threshold is approximately \$148 million. Although we have not been able to quantify all costs, we expect the combined impact on State, local, or Tribal governments and the private sector to be below the threshold.

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.

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 rule, HHS attempted to balance the States' interests in regulating health insurance issuers with the need to ensure market stability. By doing so, it is HHS's view that we have complied with the requirements of Executive Order 13132.

Because States have flexibility in designing their Exchange and Exchange-related programs, State decisions will ultimately influence both administrative expenses and overall premiums. States are not required to establish an Exchange or risk adjustment program. For States that elected previously to operate an Exchange, or risk adjustment program, much of the initial cost of creating these programs was funded by Exchange Planning and Establishment Grants. After establishment, Exchanges must be financially self-sustaining, with revenue sources at the discretion of the State. Current State Exchanges charge user fees to issuers.

In 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, we propose to provide States with substantially more flexibility in selecting an EHB-benchmark plan, to explore ways to make it easier for States to establish and maintain a State Exchange, to expand the role of States in QHP certification in FFEs, to provide States with substantially more flexibility in how they operate a SHOP, to provide States with the option to request an adjustment in the risk adjustment program for their small group market; and to make it easier for States to apply for and be granted an adjustment to the MLR standard in their State. This rule also proposes to return flexibility to States in their review of rate increases. We propose to give States the choice to review rate increases for student health insurance coverage. We propose to eliminate the requirement that proposed and final rate increases must be posted uniformly, instead allowing States with an Effective Rate Review program to publish proposed and final rate increases on a rolling basis if they so choose. We also propose to reduce the advanced notification that States must give HHS about the posting of rate increases from 30 days to 5 business days. Finally, we propose that States would no longer be required to seek approval if the State-specific threshold for reasonableness review is lower than the Federal default rate review threshold.

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.

I. Reducing Regulation and Controlling Regulatory Costs

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017. Section 2(a) of Executive Order 13771 requires an agency, unless prohibited by law, to identify at least two existing regulations to be repealed when the agency publicly proposes for notice and comment, or otherwise promulgates, a new regulation. In furtherance of this requirement, section 2(c) of Executive Order 13771 requires that the new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations. This proposed rule, if finalized as proposed, is expected to be an EO 13771 deregulatory action.

List of Subjects

45 CFR Part 147

Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Part 153

Administrative practice and procedure, Health care, Health insurance, Health records, Intergovernmental relations, Organization and functions (Government agencies), Reporting and recordkeeping requirements.

45 CFR Part 154

Administrative practice and procedure, Claims, Health care, Health insurance, Penalties, Reporting and recordkeeping requirements.

45 CFR Part 155

Administrative practice and procedure, Advertising, Brokers, Conflict of interests, Consumer protection, Grants administration, Grant programs-health, Health care, Health insurance, Health maintenance organizations (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Intergovernmental relations, Loan programs-health, Medicaid, Organization and functions (Government agencies), Public assistance programs, Reporting and recordkeeping requirements, Technical assistance, Women and youth.

45 CFR Part 156

Administrative practice and procedure, Advertising, Advisory committees, Conflict of interests, Consumer protection, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Loan programs-health, Medicaid, Organization and functions

(Government agencies), Public assistance programs, Reporting and recordkeeping requirements, State and local governments, Sunshine Act, Technical assistance, Women, Youth.

45 CFR Part 157

Employee benefit plans, Health insurance, Health maintenance organizations (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Medicaid, Organization and functions (Government agencies), Public assistance programs, Reporting and recordkeeping requirements, Technical assistance, Women and 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 147, 153, 154, 155, 156, 157 and 158 as set forth below.

**PART 147 – HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP
AND INDIVIDUAL HEALTH INSURANCE MARKETS**

1. 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.

2. Section 147.102 is amended by revising paragraph (c)(3)(iii)(D) to read as follows:

§147.102 Fair health insurance premiums.

* * * * *

(c) * * *

(3) * * *

(iii) * * *

(D) To the extent permitted by applicable state law and, in the case of coverage offered through a SHOP, as permitted by the SHOP, apply this paragraph (c)(3)(iii) uniformly among group health plans enrolling in that product, giving those group health plans the option to pay premiums based on average enrollee premium amounts.

* * * * *

3. Section 147.104 is amended by --

- a. Revising paragraphs (b)(1)(i)(B), (b)(1)(i)(C) and (b)(1)(ii);
- b. Removing paragraph (b)(1)(iii); and
- c. Revising paragraphs (b)(2)(i) introductory text and (ii).

The revisions read as follows:

§147.104 Guaranteed availability of coverage

* * * *

(b) * *

(1) * *

(i) * *

(B) In the case of a group health plan in the small group market that cannot comply with employer contribution or group participation rules for the offering of health insurance coverage, as allowed under applicable State law, and in the case of a QHP offered in the SHOP, as permitted by §156.285(e) or §156.286(e) of this subchapter, a health insurance issuer may restrict the availability of coverage to an annual enrollment period that begins November 15 and extends through December 15 of each calendar year.

(C) With respect to coverage in the small group market, and in the large group market if such coverage is offered through a SHOP in a State, for a plan selection received on the first through the fifteenth day of any month, the coverage effective date must be the first day of the following month. For a plan selection received on the 16th through last day of any month, the coverage effective date must be the first day of the second following month. In either such case, a small employer may instead opt for a later effective date within a quarter for which small group market rates are available.

(ii) Individual market. A health insurance issuer in the individual market must allow an individual to purchase health insurance coverage during the initial and annual open enrollment periods described in §155.410(b) and (e) of this subchapter. Coverage must become effective consistent with the dates described in §155.410(c) and (f) of this subchapter.

(2) * *

(i) A health insurance issuer in the individual market must provide a limited open enrollment period for the triggering events described in §155.420(d) of this subchapter, excluding, with respect to coverage offered outside of an Exchange, the following:

* * * * *

(ii) In applying this paragraph (b)(2), a reference in §155.420 (other than in §155.420(a)(5)) of this subchapter to a “QHP” is deemed to refer to a plan, a reference to “the Exchange” is deemed to refer to the applicable State authority, and a reference to a “qualified individual” is deemed to refer to an individual in the individual market.

* * * * *

PART 153 – STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS, AND RISK ADJUSTMENT UNDER THE AFFORDABLE CARE ACT

4. The authority citation for part 153 continues to read as follows:

Authority: Secs. 1311, 1321, 1341–1343, Pub. L. 111–148, 24 Stat. 119.

5. Section 153.630 is amended by revising paragraphs (b)(6), (8), and (9) to read as follows:

§153.630 Data validation requirements when HHS operates risk adjustment.

* * * * *

(b) * * *

(6) An issuer must provide the initial validation auditor and the second validation auditor with all relevant source enrollment documentation, all claims and encounter data, and medical record documentation from providers of services to each enrollee in the applicable sample without unreasonable delay and in a manner that reasonably assures confidentiality and security in transmission. Notwithstanding any other provision of this section, a qualified provider that is

licensed to diagnose mental illness by the State and that is prohibited from furnishing a complete medical record by applicable Federal or State privacy laws concerning any enrollee's treatment for one or more mental or behavioral health conditions may furnish a signed mental or behavioral health assessment that, to the extent permissible under such laws, should contain: the enrollee's name; gender; date of birth; current status of all mental or behavioral health diagnoses; and dates of service. The mental or behavioral health assessment should be signed by the provider and submitted with an attestation that the provider is prohibited from furnishing a complete medical record by applicable State or Federal privacy laws.

* * * * *

(8) The initial validation auditor must measure and report to the issuer and HHS, in a manner and timeframe specified by HHS, its inter-rater reliability rates among its reviewers. The initial validation auditor must achieve a consistency measure of at least 95 percent for his or her review outcomes, except that for validation of risk adjustment data for the 2015 and 2016 benefit years, the initial validation auditor may meet an inter-rater reliability standard of 85 percent for review outcomes.

(9) HHS may impose civil money penalties in accordance with the procedures set forth in §156.805(b) through (e) of this subchapter if an issuer of a risk adjustment covered plan—

- (i) Fails to engage an initial validation auditor;
- (ii) Fails to submit the results of an initial validation audit to HHS;
- (iii) Engages in misconduct or substantial non-compliance with the risk adjustment data validation standards and requirements applicable to issuers of risk adjustment covered plans; or
- (iv) Intentionally or recklessly misrepresents or falsifies information that it furnishes to HHS.

* * * * *

PART 154 – HEALTH INSURANCE ISSUER RATE INCREASES: DISCLOSURE AND REVIEW REQUIREMENTS

6. The authority citation for part 154 continues to read as follows:

Authority: Section 2794 of the Public Health Service Act (42 U.S.C. 300gg-94).

7. Section 154.103 is amended by revising paragraph (b) to read as follows:

§154.103 Applicability.

* * * * *

(b) Exceptions. The requirements of this part do not apply to—

- (1) Grandfathered health plan coverage as defined in §147.140 of this subchapter;
- (2) Excepted benefits as described in section 2791(c) of the PHS Act; and
- (3) For plan years beginning on or after January 1, 2019, student health insurance coverage as defined in §147.145 of this subchapter.

8. Revise §154.200 to read as follows:

§154.200 Rate increases subject to review.

(a) A rate increase filed in a State, or effective in a State that does not require a rate increase to be filed, is subject to review if:

- (1) The rate increase is 15 percent or more applicable to a 12-month period that begins on January 1, as calculated under paragraph (b) of this section; or
- (2) The rate increase meets or exceeds a State-specific threshold applicable to a 12-month period that begins on January 1, as calculated under paragraph (b) of this section, determined by the Secretary. A State-specific threshold shall be based on factors impacting rate increases in a State to the extent that the data relating to such State-specific factors are available by August 1 of

the preceding year. States interested in proposing a State-specific threshold greater than the Federal default stated in paragraph (a)(1) of this section are required to submit a proposal for approval of such threshold to the Secretary by August 1 of the preceding year.

(b) A rate increase meets or exceeds the applicable threshold set forth in paragraph (a) of this section if 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.

(c) If a rate increase that does not otherwise meet or exceed the threshold under paragraph (b) of this section meets or exceeds the threshold when combined with a previous increase or increases during the 12-month period preceding the date on which the rate increase would become effective, then the rate increase must be considered to meet or exceed the threshold and is subject to review under §154.210, and such review shall include a review of the aggregate rate increases during the applicable 12-month period.

9. Section 154.215 is amended by revising paragraph (h)(2) to read as follows:

§154.215 Submission of rate filing justification.

* * * * *

(h) * * *

(2) CMS will make available to the public on its Web site 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's Freedom of Information Act regulations, 45 CFR 5.31(d).

* * * * *

10. Section 154.301 is amended by revising paragraph (b)(2), and removing paragraph (b)(3) to read as follows:

§154.301 CMS's determinations of Effective Rate Review Programs.

* * * * *

(b)* * *

(2) If a State intends to make the information in paragraph (b)(1)(i) of this section available to the public prior to the date specified by the Secretary, or if it intends to make the information in paragraph (b)(1)(ii) of this section available to the public prior to the first day of the annual open enrollment period in the individual market for the applicable calendar year, the State must notify CMS in writing, no later than five (5) business days prior to the date it intends to make the information public, of its intent to do so and the date it intends to make the information public.

* * * * *

PART 155 – EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

11. 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).

12. Section 155.106 is amended by revising paragraph (c) introductory text to read as follows:

§155.106 Election to operate an Exchange after 2014.

* * * * *

(c) Process for State Exchanges that seek to utilize the Federal platform for select functions. States may seek approval to operate a State Exchange utilizing the Federal platform for only the individual market. A State seeking approval to operate a State Exchange utilizing the Federal platform for the individual market to support select functions through a Federal platform agreement under §155.200(f) must:

* * * * *

13. Section 155.200 is amended by removing and reserving paragraphs (f)(2)(ii) through (iv); and revising paragraph (f)(4) introductory text to read as follows;

§155.200 Functions of an Exchange.

* * * * *

(f) * * *

(2) * * *

(ii) [Reserved]

(iii) [Reserved]

(iv) [Reserved]

* * * * *

(4) A State Exchange on the Federal platform that utilizes the Federal platform for SHOP functions, for plan years beginning on or after January 1, 2018, must require its QHP issuers to make any changes to rates in accordance with the timeline applicable in a Federally-facilitated SHOP under §155.706(b)(6)(i)(A). A State Exchange on the Federal platform that utilizes the Federal platform for SHOP functions, as set forth in paragraphs (f)(4)(i) through (vii) of this section, for plan years beginning prior to January 1, 2018, must—

* * * * *

14. Section 155.210 is amended by revising paragraphs (c)(2) introductory text and (e)(7) to read as follows:

§155.210 Navigator program standards.

* * * * *

(c) * * *

(2) The Exchange must include an entity from at least one of the following categories for receipt of a Navigator grant:

* * * * *

(e) * * *

(7) In a Federally-facilitated Exchange, no individual or entity shall be ineligible to operate as a Navigator solely because its principal place of business is outside of the Exchange service area;

* * * * *

15. Section 155.215 is amended by revising paragraph (h) 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.

* * * * *

(h) In a Federally-facilitated Exchange, no individual or entity shall be ineligible to operate as a non-Navigator entity or as non-Navigator assistance personnel solely because its principal place of business is outside of the Exchange service area.

* * * * *

16. Section 155.221 is revised to read as follows:

§155.221 Standards for third-parties to perform audits of agents, brokers, and issuers participating in direct enrollment.

(a) An agent, broker, or issuer participating in direct enrollment must engage a third-party entity to conduct an annual review to demonstrate operational readiness in accordance with §155.220(c)(3)(i)(K) and with §156.1230(b)(2) of this subchapter. The third-party entity will be a downstream or delegated entity of the agent, broker or issuer that participates or wishes to participate in direct enrollment.

(b) An agent, broker, or issuer participating in direct enrollment must satisfy the requirement to demonstrate operational readiness under paragraph (a) of this section by engaging a third-party entity that meets each of the following standards:

(1) Has experience conducting audits or similar services, including experience with relevant privacy and security standards;

(2) Adheres to HHS specifications for content, format, privacy, and security in the conduct of an operational readiness review, which includes ensuring that agents, brokers, and issuers are in compliance with the applicable privacy and security standards and other applicable requirements;

(3) Collects, stores, and shares with HHS all data related to the third-party entity's audit of agents, brokers, and issuers in a manner, format, and frequency specified by HHS until 10 years from the date of creation, and complies with the privacy and security standards HHS adopts for agents, brokers, and issuers as required in accordance with §155.260;

(4) Discloses to HHS any financial relationships between the entity and individuals who own or are employed by an agent, broker, or issuer for which it is conducting an operational readiness review.

(5) Complies with all applicable Federal and State requirements;

(6) Ensures, on an annual basis, that appropriate staff successfully complete operational readiness review training as established by HHS prior to conducting audits under paragraph (a) of this section;

(7) Permits access by the Secretary and the Office of the Inspector General (OIG) or their designees in connection with their right to evaluate through audit, inspection, or other means, to the third-party entity's books, contracts, computers, or other electronic systems, relating to the third-party entity's audits of agent's, broker's, or issuer's obligations in accordance with Federal standards under paragraph (a) of this section until 10 years from the date of creation; and

(8) Complies with other minimum business criteria as specified in guidance by HHS.

(c) An agent, broker or issuer may engage multiple third-party entities to conduct the audit under paragraph (a) of this section and each third-party entity must satisfy the standards outlined under paragraph (b) of this section.

17. Section 155.305 is amended by revising paragraph (f)(4) to read as follows:

§155.305 Eligibility standards.

* * * *

(f) * *

(4) Compliance with filing requirement. The Exchange may not determine a tax filer eligible for APTC if HHS notifies the Exchange as part of the process described in §155.320(c)(3) that APTC were made on behalf of the tax filer or either spouse if the tax filer is

a married couple for a year for which tax data would be utilized for verification of household income and family size in accordance with §155.320(c)(1)(i), and the tax filer or his or her spouse did not comply with the requirement to file an income tax return for that year as required by 26 U.S.C. 6011, 6012, and implementing regulations and reconcile the advance payments of the premium tax credit for that period.

* * * * *

18. Section 155.320 is amended by—

- a. Revising paragraphs (c)(3)(iii) introductory text, and paragraph (c)(3)(iii)(A);
- b. Adding paragraphs (c)(3)(iii)(D) through (F);
- c. Revising paragraph (c)(3)(vi)(C), (D), (F) and (G); and
- d. Revising paragraph (d)(4) introductory text.

The revisions and additions read as follows:

§155.320 Verification process related to eligibility for insurance affordability programs.

* * * * *

(c) * * *

(3) * * *

(iii) Verification process for changes in household income. (A) Except as specified in paragraph (c)(3)(iii)(B), (C), and (D) of this section, if an applicant's attestation, in accordance with paragraph (c)(3)(ii)(B) of this section, indicates that a tax filer's annual household income has increased or is reasonably expected to increase from the data described in paragraph (c)(3)(ii)(A) of this section for the benefit year for which the applicant(s) in the tax filer's family are requesting coverage and the Exchange has not verified the applicant's MAGI-based income through the process specified in paragraph (c)(2)(ii) of this section to be within the applicable

Medicaid or CHIP MAGI-based income standard, the Exchange must accept the applicant's attestation regarding a tax filer's annual household income without further verification.

* * * * *

(D) If an applicant's attestation to projected annual household income, as described in paragraph (c)(3)(ii)(B) of this section, is greater than or equal to 100 percent but not more than 400 percent of the FPL for the benefit year for which coverage is requested and is more than a reasonable threshold above the annual household income computed in accordance with paragraph (c)(3)(ii)(A) of this section, the data described in paragraph (c)(3)(ii)(A) of this section indicates that projected annual household income is under 100 percent FPL, and the Exchange has not verified the applicant's MAGI-based income through the process specified in paragraph (c)(2)(ii) of this section to be within the applicable Medicaid or CHIP MAGI-based income standard, the Exchange must proceed in accordance with §155.315(f)(1) through (4). For the purposes of this paragraph, a reasonable threshold is established by the Exchange in guidance and approved by HHS, but must not be less than 10 percent, and can also include a threshold dollar amount. Applicants that would otherwise be eligible for APTC based on §155.305(f)(2) are not subject to the verification described in this paragraph.

(E) If, at the conclusion of the period specified in §155.315(f)(2)(ii), the Exchange remains unable to verify the applicant's attestation, the Exchange must determine the applicant's eligibility based on the information described in paragraph (c)(3)(ii)(A) of this section, notify the applicant of such determination in accordance with the notice requirements specified in §155.310(g), and implement such determination in accordance with the effective dates specified in §155.330(f).

(F) If, at the conclusion of the period specified in §155.315(f)(2)(ii), the Exchange remains unable to verify the applicant's attestation and the information described in paragraph (c)(3)(ii)(A) of this section is unavailable, the Exchange must determine the tax filer ineligible for advance payments of the premium tax credit and cost-sharing reductions, notify the applicant of such determination in accordance with the notice requirements specified in §155.310(g), and discontinue any advance payments of the premium tax credit and cost-sharing reductions in accordance with the effective dates specified in §155.330(f).

* * * * *

(vi) * * *

(C) Increases in annual household income. If an applicant's attestation, in accordance with paragraph (c)(3)(ii)(B) of this section, indicates that a tax filer's annual household income has increased or is reasonably expected to increase from the data described in paragraph (c)(3)(vi)(A) of this section to the benefit year for which the applicant(s) in the tax filer's family are requesting coverage and the Exchange has not verified the applicant's MAGI-based income through the process specified in paragraph (c)(2)(ii) of this section to be within the applicable Medicaid or CHIP MAGI-based income standard, the Exchange must accept the applicant's attestation for the tax filer's family without further verification, unless:

(1) The Exchange finds that an applicant's attestation of a tax filer's annual household income is not reasonably compatible with other information provided by the application filer, or

(2) The data described in paragraph (c)(3)(vi)(A) of this section indicates that projected annual household income is under 100 percent FPL and the applicant's attestation to projected household income, as described in paragraph (c)(3)(ii)(B) of this section, is greater than or equal to 100 percent but not more than 400 percent of the FPL for the benefit year for which coverage

is requested and is more than a reasonable threshold above the annual household income as computed using data sources described in paragraph (c)(3)(vi)(A) of this section, in which case the Exchange must follow the procedures specified in §155.315(f)(1) through (4). The reasonable threshold used under this paragraph must be equal to the reasonable threshold established in accordance with paragraph (c)(3)(iii)(D) of this section.

(D) Decreases in annual household income and situations in which electronic data is unavailable. If electronic data are unavailable or an 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 as computed using data sources described in paragraphs (c)(3)(vi)(A) of this section, the Exchange must follow the procedures specified in §155.315(f)(1) through (4). The reasonable threshold used under this paragraph must be equal to the reasonable threshold established in accordance with paragraph (c)(3)(vi) of this section.

* * * * *

(F) If, at the conclusion of the period specified in §155.315(f)(2)(ii), the Exchange remains unable to verify the applicant's attestation, the Exchange must determine the applicant's eligibility based on the information described in paragraph (c)(3)(ii)(A) of this section, notify the applicant of such determination in accordance with the notice requirements specified in §155.310(g), and implement such determination in accordance with the effective dates specified in §155.330(f).

(G) If, at the conclusion of the period specified in §155.315(f)(2)(ii), the Exchange remains unable to verify the applicant's attestation for the tax filer and the information described in paragraph (c)(3)(ii)(A) of this section is unavailable, the Exchange must determine the tax

filer ineligible for advance payments of the premium tax credit and cost-sharing reductions, notify the applicant of such determination in accordance with the notice requirement specified in §155.310(g), and discontinue any advance payments of the premium tax credit and cost-sharing reductions in accordance with the effective dates specified in §155.330(f).

* * * * *

(d) * * *

(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 through 2019, 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.

* * * * *

19. Section 155.420 is amended by:

- a. Revising paragraphs (a)(4)(iii), (a)(5) and (b)(2)(i);
- b. Removing paragraph (b)(2)(v);
- c. Redesignating paragraph (b)(2)(vi) as paragraph (b)(2)(v);
- d. Revising paragraph (d)(1)(iii); and

e. Revising paragraph (d)(10)(i).

The revisions read as follows:

§155.420 Special enrollment periods.

(a) * * *

(4) * * *

(iii) For the other triggering events specified in paragraph (d) of this section, except for paragraphs (d)(2)(i), (d)(4), (d)(6)(i) and (ii) for becoming newly eligible for CSRs, (d)(8), (d)(9), (d)(10) and (d)(12) of this section:

(A) If an enrollee qualifies for a special enrollment period, the Exchange must allow the enrollee and his or her dependents to change to another QHP within the same level of coverage (or one metal level higher or lower, if no such QHP is available), as outlined in §156.140(b) of this subchapter; or

(B) If a dependent qualifies for a special enrollment period, and an enrollee is adding the dependent to his or her QHP, the Exchange must allow the enrollee to add the dependent to his or her current QHP; or, if the QHP's business rules do not allow the dependent to enroll, the Exchange must allow the enrollee and his or her dependents to change to another QHP within the same level of coverage (or one metal level higher or lower, if no such QHP is available), as outlined in §156.140(b) of this subchapter, or enroll the new qualified individual in a separate QHP.

(5) Prior coverage requirement. Qualified individuals who are required to demonstrate coverage in the 60 days prior to a qualifying event can either demonstrate that they had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of the qualifying event; lived in a foreign country or in a United States

territory for 1 or more days during the 60 days preceding the date of the qualifying event; are an Indian as defined by section 4 of the Indian Health Care Improvement Act; or lived in a service area for 1 or more days during the 60 days preceding the date of the qualifying event where no qualified health plan was offered through the Exchange.

(b) * * *

(2) * * *

(i) In the case of birth, adoption, placement for adoption, placement in foster care, or child support or other court order as described in paragraph (d)(2)(i) of this section, the Exchange must ensure that coverage is effective for a qualified individual or enrollee on the date of birth, adoption, placement for adoption, placement in foster care, or effective date of court order; or it may permit the qualified individual or enrollee to elect a coverage effective date of the first of the month following plan selection; or in accordance with paragraph (b)(1) of this section. If the Exchange permits the qualified individual or enrollee to elect a coverage effective date of either the first of the month following the date of plan selection or in accordance with paragraph (b)(1) of this section, the Exchange must ensure coverage is effective on the date duly selected by the qualified individual or enrollee.

* * * * *

(d) * * *

(1) * * *

(iii) Loses pregnancy-related coverage described under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX), of the Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)) or loses access to health care services through coverage provided to a pregnant woman's unborn child, based on the definition of a child in 42 CFR 457.10. The date of the loss of coverage is the last

day the qualified individual would have pregnancy-related coverage or access to health care services through the unborn child coverage; or

* * * *

(10) * *

(i) Is a victim of domestic abuse or spousal abandonment as defined by 26 CFR 1.36B-2 or a dependent or unmarried victim within a household, is enrolled in minimum essential coverage, and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment; or

* * * *

20. Section 155.430 is amended by:

- a. Revising paragraph (d)(1);
- b. Removing paragraphs (d)(2)(i) through (iv);
- c. Adding new paragraph (d)(2)(i); and
- d. Redesignating paragraph (d)(2)(v) as (d)(2)(ii).

The revisions and additions read as follows:

§155.430 Termination of Exchange enrollment or coverage.

(d) * *

(1) For purposes of this section, changes in eligibility for advance payments of the premium tax credit and cost sharing reductions, including terminations, must adhere to the effective dates specified in §155.330(f).

(2) * *

(i) On the date on which the termination is requested by the enrollee or on another prospective date selected by the enrollee; or

* * * * *

21. Section 155.500 is amended by revising the definitions of “Appeal request” and “Appeals entity” to read as follows:

§155.500 Definitions.

* * * * *

Appeal request means a clear expression, either orally or in writing, by an applicant, enrollee, employer, or small business employer or employee to have any eligibility determination or redetermination contained in a notice issued in accordance with §155.310(g), §155.330(e)(1)(ii), §155.335(h)(1)(ii), §155.610(i), §155.715(e) or (f), or §155.716(e) reviewed by an appeals entity.

Appeals entity means a body designated to hear appeals of eligibility determinations or redeterminations contained in notices issued in accordance with §155.310(g), §155.330(e)(1)(ii), §155.335(h)(1)(ii), §155.610(i), §155.715(e) and (f), or §155.716(e).

* * * * *

22. Section 155.605 is amended by revising paragraph (d)(2)(iv) to read as follows:

§155.605 Eligibility standards for exemptions.

* * * * *

(d) * * *

(2) * * *

(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. If there is not a bronze level plan offered through the Exchange in the individual's rating area, the Exchange must use the annual premium for the lowest cost Exchange metal level plan available in the individual market through the Exchange in the State in the rating area in which the individual resides to determine whether coverage exceeds the affordability threshold specified in section 5000A(e)(1) of the Code; and

* * * * *

23. Section 155.610 is amended by revising paragraph (h)(2) to read as follows:

§155.610 Eligibility process for exemptions.

* * * * *

(h) * * *

(2) The Exchange will only accept an application for an exemption described in §155.605(d)(1) during one of the 3 calendar years after the month or months during which the applicant attests that the hardship occurred.

24. Section 155.700 is amended by revising paragraph (a) to read as follows:

§155.700 Standards for the establishment of a SHOP.

(a) General requirement. (1) For plan years beginning before January 1, 2018, an Exchange must provide for the establishment of a SHOP that meets the requirements of this subpart and is designed to assist qualified employers and facilitate the enrollment of qualified employees into qualified health plans.

(2) For plan years beginning on or after January 1, 2018, an Exchange must provide for the establishment of a SHOP that meets the requirements of this subpart and is designed to assist qualified employers in facilitating the enrollment of their employees in qualified health plans.

* * * *

25. Section 155.705 is amended by revising the section heading and adding paragraph (e) to read as follows:

§155.705 Functions of a SHOP for plan years beginning prior to January 1, 2018.

* * * *

(e) Applicability date. The provisions of this section apply for plan years beginning prior to January 1, 2018. Section 155.706 is applicable for plan years beginning on or after January 1, 2018.

26. Section 155.706 is added to read as follows:

§155.706 Functions of a SHOP for plan years beginning on or after January 1, 2018.

(a) Exchange functions that apply to SHOP. The SHOP must carry out all the required functions of an Exchange described in this subpart and in subparts C, E, K, and M of this part, except:

- (1) Requirements related to individual eligibility determinations in subpart D of this part;
 - (2) Requirements related to enrollment of qualified individuals described in subpart E of this part;
 - (3) The requirement to issue certificates of exemption in accordance with §155.200(b);
- and
- (4) Requirements related to the payment of premiums by individuals, Indian tribes, tribal organizations and urban Indian organizations under §155.240.

(b) Unique functions of a SHOP. The SHOP must also provide the following unique functions:

(1) Enrollment and eligibility functions. The SHOP must adhere to the requirements outlined in subpart H.

(2) Employer choice requirements. The SHOP must allow a qualified employer to select a level of coverage as described in section 1302(d)(1) of the Affordable Care Act, in which all QHPs within that level are made available to the qualified employees of the employer.

(3) SHOP options with respect to employer choice requirements. (i) For plan years beginning on or after January 1, 2018, SHOP:

(A) Must allow an employer to make available to qualified employees all QHPs at the level of coverage selected by the employer as described in paragraph (b)(2) of this section, and

(B) May allow an employer to make one or more QHPs available to qualified employees by a method other than the method described in paragraph (b)(2) of this section.

(ii) For plan years beginning on or after January 1, 2018, a Federally-facilitated SHOP will provide a qualified employer a choice of two methods to make QHPs available to qualified employees:

(A) The employer may choose a level of coverage as described in paragraph (b)(2) of this section, or

(B) The employer may choose a single QHP.

(iii) For plan years beginning on or after January 1, 2018, a SHOP may, and a Federally-facilitated SHOP will provide a qualified employer a choice of two methods to make stand-alone dental plans available to qualified employees:

(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 the SHOP at a level of coverage as described in §156.150(b)(2) of this subchapter.

(iv) A SHOP may also provide a qualified employer with a choice of a third method to make QHPs available to qualified employees by offering its qualified employees a choice of all QHPs offered through the 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. A State with a Federally-facilitated SHOP may recommend that the Federally-facilitated SHOP not make this additional option available in that State, by submitting a letter to HHS in advance of the annual QHP certification application deadline, by a date to be established by HHS. The State's letter must describe and justify the State's recommendation, based on the anticipated impact this additional option would have on the small group market and consumers.

(v) A SHOP may also provide a qualified employer with a choice of a third method to make stand-alone dental plans available to qualified employees by offering its qualified employees a choice of all stand-alone dental plans offered through the SHOP by a single issuer across all available levels of coverage, as described in §156.150(b)(2) of this subchapter, if such levels are available. If levels of coverage are not available, a SHOP may make a choice of all stand-alone dental plans available. A State with a Federally-facilitated SHOP may recommend that the Federally-facilitated SHOP not make this additional option available in that State, by submitting a letter to HHS in advance of the annual QHP certification application deadline, by a date to be established by HHS. The State's letter must describe and justify the State's recommendation, based on the anticipated impact this additional option would have on the small group market and consumers.

(vi) States operating 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, except that a State with a State-based Exchange utilizing the Federal platform for SHOP enrollment functions may decide against offering the employer choice models specified in paragraphs (b)(3)(iv) and (b)(3)(v) of this section in that State, provided that the State notifies HHS of that decision in advance of the annual QHP certification application deadline, by a date to be established by HHS.

(4) The SHOP may, upon an election by a qualified employer, enter into an agreement with a qualified employer to facilitate the administration of continuation coverage by collecting premiums for continuation coverage enrolled in through the SHOP directly from a person enrolled in continuation coverage through the SHOP consistent with applicable law and the terms of the group health plan, and remitting premium payments for this coverage to QHP issuers.

(5) QHP Certification. With respect to certification of QHPs in the small group market, the SHOP must ensure each QHP meets the requirements specified in §156.285 of this subchapter.

(6) Rates and rate changes. The SHOP must—

(i) Require all QHP issuers to make any change to rates at a uniform time that is no more frequently than quarterly.

(A) In a Federally-facilitated SHOP, rates may be updated quarterly with effective dates of January 1, April 1, July 1, or October 1 of each calendar year. The updated rates must be submitted to HHS at least 60 days in advance of the effective date of the rates.

(B) [Reserved]

(ii) Prohibit all QHP issuers from varying rates for a qualified employer during the employer's plan year.

(7) QHP availability in merged markets. If a State merges the individual market and the small group market risk pools in accordance with section 1312(c)(3) of the Affordable Care Act, the SHOP may permit employer groups to enroll in any QHP meeting level of coverage requirements described in section 1302(d) of the Affordable Care Act.

(8) QHP availability in unmerged markets. If a State does not merge the individual and small group market risk pools, the SHOP must permit employer groups to enroll only in QHPs in the small group market.

(9) SHOP expansion to large group market. If a State elects to expand the SHOP to the large group market, a SHOP must allow issuers of health insurance coverage in the large group market in the State to offer QHPs in such market through a SHOP beginning in 2017 provided that a large employer meets the qualified employer requirements other than that it be a small employer.

(10) Participation rules. Subject to §147.104 of this subchapter, the SHOP may authorize a uniform group participation rate for the offering of health insurance coverage in the SHOP, which must be a single, uniform rate that applies to all groups and issuers in the SHOP. If the SHOP authorizes a minimum participation rate, such rate must be based on the rate of employee participation in the SHOP, not on the rate of employee participation in any particular QHP or QHPs of any particular issuer.

(i) Subject to §147.104 of this subchapter, a Federally-facilitated SHOP must use a minimum participation rate of 70 percent, calculated as the number of full-time employees accepting coverage offered by a qualified employer plus the number of full-time employees who,

at the time the employer submits the SHOP group enrollment, are enrolled in coverage through another group health plan, governmental coverage (such as Medicare, Medicaid, or TRICARE), coverage sold through the individual market, or in other minimum essential coverage, divided by the number of full-time employees offered coverage.

(ii) Notwithstanding paragraphs (b)(10)(i) of this section, a Federally-facilitated SHOP may utilize a different minimum participation rate in a State if there is evidence that a State law sets a minimum participation rate or that a higher or lower minimum participation rate is customarily used by the majority of QHP issuers in that State for products in the State's small group market outside the SHOP.

(11) Premium calculator. In the SHOP, the premium calculator described in §155.205(b)(6) must facilitate the comparison of available QHPs.

(c) Coordination with individual market Exchange for eligibility determinations. A SHOP that collects employee eligibility or enrollment data must provide data related to eligibility and enrollment of a qualified employee to the individual market Exchange that corresponds to the service area of the SHOP, unless the SHOP is operated pursuant to §155.100(a)(2).

(d) Duties of Navigators in the SHOP. In States that have elected to operate only a SHOP pursuant to §155.100(a)(2), at State option and if State law permits the Navigator duties described in §155.210(e)(3) and (4) may be fulfilled through referrals to agents and brokers.

(e) Applicability date. The provisions of this section apply for plan years beginning on or after January 1, 2018.

27. Section 155.715 is amended by revising the section heading and adding paragraph (h) to read as follows:

§155.715 Eligibility determination process for SHOP for plan years beginning prior to January 1, 2018.

* * * * *

(h) Applicability date. The provisions of this section apply for plan years beginning prior to January 1, 2018. §155.716 is applicable for plan years beginning on or after January 1, 2018.

28. Section 155.716 is added to read as follows:

§155.716 Eligibility determination process for SHOP for plan years beginning on or after January 1, 2018.

(a) General requirement. The SHOP must determine whether an employer requesting a determination of eligibility to participate in a SHOP is eligible in accordance with the requirements of §155.710.

(b) Applications. The SHOP must accept a SHOP single employer application form from employers, in accordance with the relevant standards of §155.730.

(c) Verification of eligibility. For the purpose of verifying employer eligibility, the SHOP—

(1) May establish, in addition to or in lieu of reliance on the application, additional methods to verify the information provided by the applicant on the applicable application;

(2) Must collect only the minimum information necessary for verification of eligibility in accordance with the eligibility standards described in §155.710; and

(3) May not perform individual market Exchange eligibility determinations or verifications described in subpart D of this part.

(d) Eligibility adjustment period. When the information submitted on the SHOP single employer application is inconsistent with information collected from third-party data sources

through the verification process described in paragraph (c)(1) of this section or otherwise received by the SHOP, the SHOP must—

(1) Make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors;

(2) Notify the employer of the inconsistency;

(3) Provide the employer with a period of 30 days from the date on which the notice described in paragraph (d)(2) of this section is sent to the employer to either present satisfactory documentary evidence to support the employer's application, or resolve the inconsistency; and

(4) If, after the 30-day period described in paragraph (d)(2) of this section, the SHOP has not received satisfactory documentary evidence, the SHOP must—

(i) Notify the employer of its denial or termination of eligibility in accordance with paragraph (e) of this section and of the employer's right to appeal such determination; and

(ii) If the employer was enrolled pending the confirmation or verification of eligibility information, discontinue the employer's participation in the SHOP at the end of the month following the month in which the notice is sent.

(e) Notification of employer eligibility. The SHOP must provide an employer requesting eligibility to purchase coverage through the SHOP with a notice of approval or denial or termination of eligibility and the employer's right to appeal such eligibility determination.

(f) Validity of Eligibility Determination. An employer's determination of eligibility to participate in SHOP remains valid until the employer makes a change that could end its eligibility under §155.710(b) or withdraws from participation in the SHOP.

(g) Applicability date. The provisions of this section apply for plan years beginning on or after January 1, 2018.

29. Section 155.720 is amended by revising the section heading and adding paragraph (j) to read as follows:

§155.720 Enrollment of employees into QHPs under SHOP for plan years beginning prior to January 1, 2018.

* * * * *

(j) Applicability date. The provisions of this section apply for plan years beginning prior to January 1, 2018. Section 155.721 is applicable for plan years beginning on or after January 1, 2018.

30. Section 155.721 is added to read as follows:

§155.721 Record retention and IRS Reporting for plan years beginning on or after January 1, 2018.

(a) Records. The SHOP must receive and maintain for at least 10 years records of qualified employers participating in the SHOP.

(b) Reporting requirement for tax administration purposes. The SHOP must, at the request of the IRS, report information to the IRS about employer eligibility to participate in SHOP coverage.

(c) Applicability date. The provisions of this section apply for plan years beginning on or after January 1, 2018.

31. Section 155.725 is amended by revising the section heading and adding paragraph (l) to read as follows:

§155.725 Enrollment periods under SHOP for plan years beginning prior to January 1, 2018.

* * * * *

(l) Applicability date. The provisions of this section apply for plan years beginning prior to January 1, 2018. Section 155.726 is applicable for plan years beginning on or after January 1, 2018.

32. Section 155.726 is added to read as follows:

§155.726 Enrollment periods under SHOP for plan years beginning on or after January 1, 2018.

(a) General requirements. The SHOP must ensure that issuers offering QHPs through the SHOP adhere to applicable enrollment periods, including special enrollment periods.

(b) Rolling enrollment in the SHOP. The SHOP must permit a qualified employer to purchase coverage for its small group at any point during the year. The employer's plan year must consist of the 12-month period beginning with the qualified employer's effective date of coverage, unless the plan is issued in a State that has elected to merge its individual and small group risk pools under section 1312(c)(3) of the Affordable Care Act, in which case the plan year will end on December 31 of the calendar year in which coverage first became effective.

(c)(1) Special enrollment periods. The SHOP must ensure that issuers offering QHPs through the SHOP provide special enrollment periods consistent with the section, during which certain qualified employees or dependents of qualified employees may enroll in QHPs and enrollees may change QHPs.

(2) The SHOP must ensure that issuers offering QHPs through a SHOP provide a special enrollment period for a qualified employee or a dependent of a qualified employee who;

(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), (9), (10), (11), or (12);

(ii) Loses eligibility for coverage under a Medicaid plan under title XIX of the Social Security Act or a State child health plan under title XXI of the Social Security Act; or

(iii) Becomes eligible for assistance, with respect to coverage under a SHOP, under such Medicaid plan or a State child health plan (including any waiver or demonstration project conducted under or in relation to such a plan).

(3) A qualified employee or dependent of a qualified employee who experiences a qualifying event described in paragraph (j)(2) of this section has:

(i) Thirty (30) days from the date of a triggering event described in paragraph (c)(2)(i) of this section to select a QHP through the SHOP; and

(ii) Sixty (60) days from the date of a triggering event described in paragraph (c)(2)(ii) or (iii) of this section to select a QHP through the SHOP;

(4) A dependent of a qualified employee is not eligible for a special enrollment period if the employer does not extend the offer of coverage to dependents.

(5) The effective dates of coverage for special enrollment periods are determined using the provisions of §155.420(b).

(6) Loss of minimum essential coverage is determined using the provisions of §155.420(e).

(d) Limitation. Qualified employees will not be able to enroll unless the employer group meets any applicable minimum participation rate implemented under §155.706(b)(10).

(e) Applicability date. The provisions of this section apply for plan years beginning on or after January 1, 2018.

33. Section 155.730 is amended by revising the section heading and adding paragraph (h) to read as follows:

§155.730 Application standards for SHOP for plan year beginning prior to January 1, 2018.

* * * * *

(h) Applicability date. The provisions of this section apply for plan years beginning prior to January 1, 2018. Section 155.731 is applicable for plan years beginning on or after January 1, 2018.

34. Section 155.731 is added to read as follows:

§155.731 Application standards for SHOP for plan years beginning on or after January 1, 2018.

(a) General requirements. Application forms used by the SHOP must meet the requirements set forth in this section.

(b) Single employer application. The SHOP must use a single application to determine employer eligibility. Such application must collect the following—

- (1) Employer name and address of employer's locations;
- (2) Information sufficient to confirm the employer is a small employer;
- (3) Employer Identification Number (EIN); and
- (4) Information sufficient to confirm that the employer is offering, at a minimum, all full-time employees coverage in a QHP through a SHOP.

(c) Model application. The SHOP may use the model single employer application provided by HHS.

(d) Alternative employer application. The SHOP may use an alternative application if such application is approved by HHS and collects the information described in paragraph (b).

(e) Filing. The SHOP must:

(1) Accept applications from SHOP application filers; and

(2) Provide the tools to file an employer eligibility application via an Internet Web site.

(f) Additional safeguards. (1) The SHOP may not provide to the employer any information collected on an employee application with respect to spouses or dependents other than the name, address, and birth date of the spouse or dependent.

(2) The SHOP is not permitted to collect information on the single employer or on an employee application unless that information is necessary to determine SHOP eligibility or effectuate enrollment through the SHOP.

(g) Applicability date. The provisions of this section apply for plan years beginning on or after January 1, 2018.

35. Section 155.735 is amended by revising the section heading and adding paragraph (h) to read as follows:

§155.735 Termination of SHOP enrollment or coverage for plan years beginning prior to January 1, 2018.

* * * * *

(h) Applicability date. The provisions of this section apply for plan years beginning before January 1, 2018.

36. Section 155.740 is amended by revising the section heading and adding paragraph (p) to read as follows:

§155.740 SHOP employer and employee eligibility appeals requirements for plan years beginning prior to January 1, 2018.

* * * * *

(p) Applicability date. The provisions of this section apply for plan years beginning prior to January 1, 2018. Section 155.741 is applicable for plan years beginning on or after January 1, 2018.

37. Section 155.741 is added to subpart H to read as follows:

§155.741 SHOP employer and employee eligibility appeals requirements for plan year beginning on or after January 1, 2018.

(a) Definitions. The definitions in §§155.20, 155.300, and 155.500 apply to this section.

(b) General requirements. (1) A State, establishing an Exchange that provides for the establishment of a SHOP pursuant to §155.100 must provide an eligibility appeals process for the SHOP. Where a State has not established an Exchange that provides for the establishment of a SHOP pursuant to §155.100, HHS will provide an eligibility appeals process for the SHOP that meets the requirements of this section and the requirements in paragraph (b)(2) of this section.

(2) The appeals entity must conduct appeals in accordance with the requirements established in this section and §§155.505(e) through (h) and 155.510(a)(1) and (2) and (c).

(c) Employer right to appeal. An employer may appeal—

(1) A notice of denial or termination of eligibility under §155.716(e); or

(2) A failure by the SHOP to provide a timely eligibility determination or a timely notice of an eligibility determination in accordance with §155.716(e).

(d) Appeals notice requirement. Notices of the right to appeal a denial of eligibility under §155.716(e) must be written and include—

(1) The reason for the denial or termination of eligibility, including a citation to the applicable regulations; and

(2) The procedure by which the employer may request an appeal of the denial or termination of eligibility.

(e) Appeal request. The SHOP and appeals entity must—

(1) Allow an employer to request an appeal within 90 days from the date of the notice of denial or termination of eligibility to—

(i) The SHOP or the appeals entity; or

(ii) HHS, if no State Exchange that provides for establishment of a SHOP has been established;

(2) Accept appeal requests submitted through any of the methods described in §155.520(a)(1);

(3) Comply with the requirements of §155.520(a)(2) and (3); and

(4) Consider an appeal request valid if it is submitted in accordance with paragraph (e)(1) of this section.

(f) Notice of appeal request. (1) Upon receipt of a valid appeal request, the appeals entity must—

(i) Send timely acknowledgement to the employer of the receipt of the appeal request, including—

(A) An explanation of the appeals process; and

(B) Instructions for submitting additional evidence for consideration by the appeals entity.

(ii) Promptly notify the SHOP of the appeal, if the appeal request was not initially made to the SHOP.

(2) Upon receipt of an appeal request that is not valid because it fails to meet the requirements of this section, the appeals entity must—

(i) Promptly and without undue delay, send written notice to the employer that is appealing that—

(A) The appeal request has not been accepted,

(B) The nature of the defect in the appeal request; and

(C) An explanation that the employer may cure the defect and resubmit the appeal request if it meets the timeliness requirements of paragraph (e) of this section, or within a reasonable timeframe established by the appeals entity.

(ii) Treat as valid an amended appeal request that meets the requirements of this section.

(g) Transmittal and receipt of records. (1) Upon receipt of a valid appeal request under this section, or upon receipt of the notice under paragraph (f)(2) of this section, the SHOP must promptly transmit, via secure electronic interface, to the appeals entity—

(i) The appeal request, if the appeal request was initially made to the SHOP; and

(ii) The eligibility record of the employer that is appealing.

(2) The appeals entity must promptly confirm receipt of records transmitted pursuant to paragraph (g)(1) of this section to the SHOP that transmitted the records.

(h) Dismissal of appeal. The appeals entity—

(1) Must dismiss an appeal if the employer that is appealing—

(i) Withdraws the request in accordance with the standards set forth in §155.530(a)(1); or

(ii) Fails to submit an appeal request meeting the standards specified in paragraph (e) of this section.

(2) Must provide timely notice to the employer that is appealing of the dismissal of the appeal request, including the reason for dismissal, and must notify the SHOP of the dismissal.

(3) May vacate a dismissal if the employer makes a written request within 30 days of the date of the notice of dismissal showing good cause why the dismissal should be vacated.

(i) Procedural rights of the employer. The appeals entity must provide the employer the opportunity to submit relevant evidence for review of the eligibility determination.

(j) Adjudication of SHOP appeals. SHOP appeals must—

(1) Comply with the standards set forth in §155.555(i)(1) and (3); and

(2) Consider the information used to determine the employer's eligibility as well as any additional relevant evidence submitted during the course of the appeal by the employer or employee.

(k) Appeal decisions. Appeal decisions must—

(1) Be based solely on—

(i) The evidence referenced in paragraph (j)(2) of this section;

(ii) The eligibility requirements for the SHOP under §155.710(b), as applicable.

(2) Comply with the standards set forth in §155.545(a)(2) through (5)

(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 the employer is found ineligible under the decision, then the appeal decision is effective as of the date of the notice of the appeal decision.

(l) Notice of appeal decision. The appeals entity must issue written notice of the appeal decision to the employer and to the SHOP within 90 days of the date the appeal request is received.

(m) Implementation of SHOP appeal decisions. The SHOP must promptly implement the appeal decision upon receiving the notice under paragraph (l) of this section.

(n) Appeal record. Subject to the requirements of §155.550, the appeal record must be accessible to the employer in a convenient format and at a convenient time.

(o) Applicability date. The provisions of this section apply for plan years beginning on or after January 1, 2018.

PART 156 – HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

38. 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).

39. Section 156.100 is amended by revising the section heading and the introductory text and by adding paragraph (d) to read as follows:

§156.100 State selection of benchmark plan for plan years beginning prior to January 1, 2019.

For plan years beginning before January 1, 2019, each State may identify a single EHB-benchmark plan according to the selection criteria described below:

* * * * *

(d) Applicability date: For plan years beginning on or after January 1, 2019, §156.111 applies in place of this section.

40. Section 156.111 is added to Subpart B to read as follows:

§156.111 State selection of EHB-benchmark plan for plan years beginning on or after January 1, 2019.

(a) Subject to paragraphs (b), (c), (d) and (e) of this section, for plan years beginning on or after January 1, 2019, a State may change its EHB-benchmark plan by:

(1) Selecting the EHB-benchmark plan that another State used for the 2017 plan year under §156.100 and §156.110 of this subpart;

(2) Replacing one or more categories of EHBs under §156.110(a) of this subpart under its EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another State used for the 2017 plan year under §156.100 and §156.110 of this subpart; or

(3) Otherwise selecting a set of benefits that would become the State's EHB-benchmark plan, provided that the new EHB-benchmark plan does not exceed the generosity of the most generous among a set of comparison plans, including:

(i) The State's EHB-benchmark plan used for the 2017 plan year, and
(ii) Any of the State's base-benchmark plan options for the 2017 plan year described in §156.100(a)(1) of this subpart, supplemented as necessary under §156.110 of this subpart.

(b) A State's EHB-benchmark plan must:

(1) EHB coverage. Provide an appropriate balance of coverage for the categories of benefits at §156.110(a) of this subpart.

(2) Scope of benefits. (i) Be equal in scope of benefits to what is provided under a typical employer plan, defined as:

(A) An employer plan within a product (as these terms are defined in §144.103 of this subchapter) with substantial enrollment in the product of at least 5,000 enrollees sold in the small group or large group market, in one or more States; or

(B) A self-insured group health plan with substantial enrollment of at least 5,000 enrollees in one or more States;

(ii) Not have benefits unduly weighted towards any of the categories of benefits at §156.110(a) of this subpart; and

(iii) Provide benefits for diverse segments of the population, including women, children, persons with disabilities, and other groups.

(c) The State must provide reasonable public notice and an opportunity for public comment on the State's selection of an EHB-benchmark plan.

(d) A State must notify HHS of the selection of a new EHB-benchmark plan by a date to be determined by HHS for each applicable plan year.

(1) If the State does not make a selection by the annual selection date, the State's EHB-benchmark plan for the applicable plan year would be that State's EHB-benchmark plan applicable for the prior year.

(2) [Reserved]

(e) A State changing its EHB-benchmark plan under this section must submit documents in a format and manner specified by HHS by a date determined by HHS. These must include:

(1) A document confirming that the State’s EHB-benchmark plan definition complies with the requirements under paragraphs (a), (b) and (c) of this section, including information on which selection option under paragraph (a) of this section the State is using, and whether the State is using another State’s EHB-benchmark plan;

(2) If the State is selecting its EHB-benchmark plan using the options in paragraph (a)(2) or (3) of this section, an actuarial certification and an associated actuarial report from an actuary, who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies that affirms:

(i) That the State’s EHB-benchmark plan definition is equal in scope to benefits provided under a typical employer plan; and

(ii) If the State is selecting its EHB-benchmark plan using the option in paragraph (a)(3) of this section, that the new EHB-benchmark plan does not exceed the generosity of the most generous among the plans listed in paragraph (a)(3)(i) and (ii) of this section;

(3) The State’s EHB-benchmark plan document that reflects the benefits and limitations, including medical management requirements, a schedule of benefits and, if the State is selecting its EHB-benchmark plan using the option in paragraph (a)(3) of this section, a formulary drug list in a format and manner specified by HHS; and

(4) Other documentation specified by HHS, which is necessary to operationalize the State’s EHB-benchmark plan.

41. Section 156.115 is amended by revising paragraph (b)(1)(ii) to read as follows:

§156.115 Provision of EHB.

* * * *

(b) * *

(1) * * *

(ii) Is substituted within the same essential health benefit category or between essential health benefit categories, as long as the plan with substitutions still provides benefits that are substantially equal to the EHB-benchmark plan, provides an appropriate balance among the EHB categories such that benefits are not unduly weighted towards any category, and provides benefits for diverse segments of the population; and

* * * * *

42. Section 156.150 is amended by removing and reserving paragraph (b) to read as follows:

§156.150 Application to stand-alone dental plans inside the Exchange.

* * * * *

(b) [Reserved]

* * * * *

43. Section 156.200 is amended by revising paragraph (b)(2) to read as follows:

§156.200 QHP issuer participation standards.

* * * * *

(b) * * *

(2) Comply with Exchange processes, procedures, and requirements set forth in accordance with subpart K of part 155 and, in the small group market, §155.705 and §155.706 of this subchapter;

* * * * *

44. Section 156.285 is amended by revising the section heading and adding paragraph (f) to read as follows:

§156.285 Additional standards specific to SHOP for plan years beginning prior to January 1, 2018.

* * * * *

(f) Applicability date. The provisions of this section apply for plan years beginning prior to January 1, 2018. Additional standards specific to SHOP for plan years beginning on or after January 1, 2018 are in §156.286.

45. Section 156.286 is added to read as follows:

§156.286 Additional standards specific to SHOP for plan years beginning on or after January 1, 2018.

(a) SHOP rating and premium payment requirements. QHP issuers offering a QHP through a SHOP must:

(1) Accept payment from a qualified employer or an enrollee, or a SHOP on behalf of a qualified employer or enrollee

(2) Adhere to the SHOP timeline for rate setting as established in §155.706(b)(6) of this subchapter;

(3) Charge the same contract rate for a plan year; and

(4) Adhere to the premium rating standards described in §147.102 of this subchapter regardless of whether the QHP being sold through the SHOP is sold in the small group market or the large group market.

(b) Enrollment periods and processes for the SHOP. QHP issuers offering a QHP through the SHOP must adhere to enrollment periods and processes established by the SHOP, consistent with §155.726 of this subchapter, and establish a uniform enrollment timeline and process for enrolling qualified employers and employer group members.

(c) Enrollment process for the SHOP. A QHP issuer offering a QHP through the SHOP must:

(1) Provide new enrollees with the enrollment information package as described in §156.265(e); and

(2) Enroll all qualified employees consistent with the plan year of the applicable qualified employer.

(d) Participation rules. QHP issuers offering a QHP through the SHOP may impose group participation rules for the offering of health insurance coverage in connection with a QHP only if and to the extent authorized by the SHOP in accordance with §155.706 of this subchapter.

(e) Employer choice. QHP issuers offering a QHP through the SHOP must accept enrollments from groups in accordance with the employer choice policies applicable to the SHOP under §155.706(b)(3) of this subchapter.

(f) Identification of SHOP enrollments. QHP issuers offering a QHP through the SHOP must use a uniform enrollment form, maintain processes sufficient to identify whether a group market enrollment is an enrollment through the SHOP, and maintain records of SHOP enrollments for a period of 10 years following the enrollment.

(g) Applicability date. The provisions of this section apply for plan years beginning on or after January 1, 2018.

§156.298 [Removed]

46. Section 156.298 is removed.

47. Section 156.340 is amended by revising paragraph (a)(2) to read as follows:

§156.340 Standards for downstream and delegated entities.

(a) * * *

(2) Exchange processes, procedures, and standards in accordance with subparts H and K of part 155 and, in the small group market, §155.705 and §155.706 of this subchapter;

* * * *

48. Section 156.350 is amended by revising paragraphs (a)(1) and (a)(2) to read as follows:

§156.350 Eligibility and enrollment standards for Qualified Health Plan issuers on State-based Exchanges on the Federal platform.

(a) * * *

(1) Section 156.285(a)(4)(ii) regarding the premiums for plans offered on the SHOP, for plan years beginning prior to January 1, 2018;

(2) Section 156.285(c)(5) and (c)(8)(iii) regarding the enrollment process for SHOP, for plan years beginning prior to January 1, 2018; and

* * * *

49. Section 156.602 is amended by redesignating paragraph (e) as paragraph (f) and adding new paragraph (e) to read as follows:

§156.602 Other coverage that qualifies as minimum essential coverage.

* * * *

(e) CHIP buy-in programs. Coverage under a Children's Health Insurance Program (CHIP) buy-in program that provides identical coverage to that State's CHIP program under title XXI of the Social Security Act.

* * * *

50. Section 156.1230 is amended by revising paragraph (b)(2) to read as follows:

§156.1230 Direct enrollment with the QHP issuer in a manner considered to be through the Exchange.

* * * *

(b) * * *

(2) The QHP issuer must engage a third party entity in accordance with §155.221 of this subchapter to demonstrate operational readiness and compliance with applicable requirements prior to the QHP issuer's Internet Web site being used to complete a QHP selection.

* * * *

PART 157—EMPLOYER INTERACTIONS WITH EXCHANGES AND SHOP PARTICIPATION

51. The authority citation for part 157 continues to read as follows:

Authority: Title I of the Affordable Care Act, Sections 1311, 1312, 1321, 1411, 1412, Pub. L. 111-148, 124 Stat. 199.

52. Section 157.205 is amended by revising the section heading and adding paragraph (h) to read as follows:

§157.205 Qualified employer participation process in a SHOP for plan years beginning prior to January 1, 2018.

* * * *

(h) Applicability date. The provisions of this section apply for plan years beginning prior to January 1, 2018. Section 157.206 is applicable for plan years beginning on or after January 1, 2018.

53. Section 157.206 is added to read as follows:

§157.206 Qualified employer participation process in a SHOP for plan years beginning on or after January 1, 2018.

(a) General requirements. When joining the SHOP, a qualified employer must comply with the requirements, processes, and timelines set forth by this part and must remain in compliance for the duration of the employer's participation in the SHOP.

(b) Selecting QHPs. During an election period, a qualified employer may make coverage in a QHP available through the SHOP in accordance with the processes developed by the SHOP in accordance with §155.706 of this subchapter.

(c) Information dissemination to employees. A qualified employer participating in the SHOP must disseminate information to its qualified employees about the process to enroll in a QHP through the SHOP.

(d) Employees hired outside of the initial or annual open enrollment period. Qualified employers must provide employees hired outside of the initial or annual open enrollment period with information about the enrollment process.

(e) Participation in the SHOP and termination of coverage or enrollment through the SHOP. (1) Changes affecting participation. Employers must submit a new single employer application to the SHOP or withdraw from participating in the SHOP if the employer makes a change that could end its eligibility under §155.710 of this subchapter.

(2) If an employer receives a determination of ineligibility to participate in the SHOP or the SHOP terminates its eligibility to participate in the SHOP, the employer must notify the issuer or issuers of QHPs in which their group members are enrolled in coverage of its ineligibility or termination of eligibility within 5 business days of the end of any applicable appeal process under §155.741, which could include when the time to file an appeal lapses

without an appeal being filed, when the appeal is rejected or dismissed, or when the appeal process concludes with an adjudication by the appeals entity, as applicable.

(3) Employers must promptly notify the issuer or issuers of QHPs in which their group members are enrolled in coverage if it wishes to terminate coverage or enrollment through the SHOP.

(f) Applicability date. The provisions of this section apply for plan years beginning on or after January 1, 2018.

PART 158—ISSUER USE OF PREMIUM REVENUE: REPORTING AND REBATE REQUIREMENTS

54. 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.

55. Section 158.170 is amended by revising paragraph (b) introductory text to read as follows:

§158.170 Allocation of expenses.

* * * * *

(b) Description of the methods used to allocate expenses. The report required in §158.110 must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses (unless the report utilizes the percentage of premium option described in §158.221(b)(8), in which case the allocation method description should state so), Federal and State taxes and licensing or regulatory fees, and other non-claims costs, to each health insurance market in each State. A detailed description of each expense

element must be provided, including how each specific expense meets the criteria for the type of expense in which it is categorized, as well as the method by which it was aggregated.

* * * * *

56. Section 158.221 is amended by adding paragraph (b)(8) to read as follows:

§158.221 Formula for calculating an issuer's medical loss ratio.

* * * * *

(b) * * *

(8) Beginning with the 2017 MLR reporting year, an issuer has the option of reporting an amount equal to 0.8 percent of earned premium in the relevant State and market in lieu of reporting the issuer's actual expenditures for activities that improve health care quality, as defined in §§158.150 and 158.151.

* * * * *

57. Section 158.301 is revised to read as follows:

§158.301 Standard for adjustment to the medical loss ratio.

The Secretary may adjust the MLR standard that must be met by issuers offering coverage in the individual market in a State, as defined in section 2791 of the PHS Act, for a given MLR reporting year if, in the Secretary's discretion, the Secretary determines that there is a reasonable likelihood that an adjustment to the 80 percent MLR standard of section 2718(b)(1)(A)(ii) of the Public Health Service Act will help stabilize the individual market in that State.

58. Section 158.321 is revised to read as follows:

§158.321 Information regarding the State's individual health insurance market.

(a) Subject to §158.320, the State must provide, for each issuer who actively offers coverage in the individual market in the State, the following information, in accordance with paragraph (b) of this section, for the preceding calendar year and, at the State's option, for the current year:

- (1) Total earned premium and incurred claims;
- (2) Total number of enrollees (life-years and covered lives);
- (3) Total agents' and brokers' commission expenses;
- (4) Net underwriting gain;
- (5) Risk-based capital level; and
- (6) Whether the issuer has provided notice to the State's insurance commissioner,

superintendent, or comparable State authority that the issuer will cease or begin offering individual market coverage on the Exchange, certain geographic areas, or the entire individual market in the State.

(b) The information required in paragraphs (a)(1) through (4) and (6) of this section must be provided separately for the issuer's individual market plans grouped by the following categories, as applicable: on-Exchange, off-Exchange, grandfathered health plans as defined in §147.140 of this subchapter, coverage that meets the criteria for transitional policies outlined in applicable guidance, and non-grandfathered single risk pool coverage. The information required in paragraph (a)(1) through (5) of this section must be provided at the issuer level.

(c) The State must also provide information regarding whether any issuer other than those described in paragraph (a) of this section has provided notice to the State's insurance commissioner, superintendent, or comparable State authority that the issuer will cease or begin

offering individual market coverage on the Exchange, certain geographic areas, or the entire individual market in the State.

59. Section 158.322 is revised to read as follows:

§158.322 Proposal for adjusted medical loss ratio.

A State must provide its own proposal as to the adjustment it seeks to the MLR standard. This proposal must include an explanation of how an adjustment to the MLR standard for the State's individual market will help stabilize the State's individual market.

60. Section 158.330 is revised to read as follows:

§158.330 Criteria for assessing request for adjustment to the medical loss ratio.

The Secretary may consider the following criteria in assessing whether an adjustment to the 80 percent MLR standard, as calculated in accordance with this subpart, would be reasonably likely to help stabilize the individual market in a State that has requested such adjustment:

(a) The number and financial performance (based on data provided by a State under §158.321) of issuers actively offering individual health insurance coverage on- and off-Exchange, grandfathered health plans as defined in §147.140 of this subchapter, coverage that meets the criteria for transitional policies outlined in applicable guidance, and non-grandfathered single risk pool coverage; the number of issuers reasonably likely to cease or begin offering individual market coverage in the State; and the likelihood that an adjustment to the 80 percent MLR standard could help increase competition in the individual market in the State, including in underserved areas.

(b) Whether an adjustment to the 80 percent MLR standard for the individual market may improve consumers' access to agents and brokers.

(c) The capacity of any new issuers or issuers remaining in the individual market to write additional business in the event one or more issuers were to cease offering individual market coverage on the Exchange, in certain geographic areas, or in the entire individual market in the State.

(d) The impact on premiums charged, and on benefits and cost sharing provided, to consumers by issuers remaining in or entering the individual market in the event one or more issuers were to cease or begin offering individual market coverage on the Exchange, in certain geographic areas, or in the entire individual market in the State.

(e) Any other relevant information submitted by the State's insurance commissioner, superintendent, or comparable official in the State's request.

61. Section 158.341 is revised to read as follows:

§158.341 Treatment as a public document.

A State's request for an adjustment to the MLR standard, and all information submitted as part of its request, will be treated as a public document. Instructions for how to access documents related to a State's request for an adjustment on the MLR standard will be made available on the Secretary's Web site.

62. Section 158.350 is revised to read as follows:

§158.350 Subsequent requests for adjustment to the medical loss ratio.

A State that has made a previous request for an adjustment to the MLR standard must, in addition to the other information required by this subpart, submit information as to what steps the State has taken since its prior requests, if any, to improve the stability of the State's individual market.

CMS-9930-P

Dated: October 12, 2017.

Seema Verma,
Administrator,
Centers for Medicare & Medicaid Services.

Dated: October 23, 2017.

Eric D. Hargan,
Acting Secretary,
Department of Health and Human Services.

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