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Part III

Department of Health and Human Services

45 CFR Parts 144, 146, 147, 148, *et al.*
Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 144, 146, 147, 148, 153, 154, 155, 156, 157, and 158

[CMS–9934–P]

RIN 0938–AS95

Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018

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 program; cost-sharing parameters and cost-sharing reductions; and user fees for Federally-facilitated Exchanges and State-based Exchanges on the Federal platform. It also provides additional guidance relating to standardized options; qualified health plans; consumer assistance tools; network adequacy; the Small Business Health Options Program; stand-alone dental plans; fair health insurance premiums; guaranteed renewability; the medical loss ratio program; eligibility and enrollment; appeals; and other related topics.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on October 6, 2016.

ADDRESSES: In commenting, please refer to file code CMS–9934–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–9934–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–9934–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period: a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.) b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

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

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

FOR FURTHER INFORMATION CONTACT: Jeff Wu, (301) 492–4305, Lindsey Murtagh, (301) 492–4106, or Michelle Koltov, (301) 492–4225 for general information.

Lisa Cuozzo, (410) 786–1746, for matters related to fair health insurance premiums, guaranteed renewability, and single risk pool.

Michael Cohen, (301) 492–4277, for matters related to the Pre-Existing Condition Insurance Plan Program.

Kelly Drury, (410) 786–0558, or Krutika Amin, (301) 492–5153, for matters related to risk adjustment.

Adrianne Patterson, (410) 786–0686, for matters related to sequestration, risk adjustment data validation discrepancies, and administrative appeals.

Emily Ames, (301) 492–4246, for matters related to language access.

Dana Krohn, (301) 492–4412, for matters related to periodic data matching, redeterminations of advance payments of the premium tax credit, and appeals.

Ryan Mooney, (301) 492–4405, for matters related to premium payment, billing, and terminations due to fraud.

Christelle Jang, (410) 786–8438, for matters related to the Small Business Health Options Program (SHOP).

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

Leigha Basini, (301) 492–4380, for matters related to mid-year withdrawals, and other standards for QHP issuers.

Ielnaz Kashefipour, (301) 492–4376, for matters related to standardized options.

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

Cindy Chiou, (301) 492–5142, for matters related to QHP issuer oversight and direct enrollment.

Allison Yadsko, (410) 786–1740, for matters related to levels of coverage and actuarial value.

Pat Meisol, (410) 786–1917, for matters related to cost-sharing reductions, reconciliation of the cost-sharing reduction portion of advance payments discrepancies, and the premium adjustment percentage.

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

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following 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.

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Acronyms and Abbreviations

Affordable Care Act The collective term for the Patient Protection and Affordable Care Act (Pub. L. 111–148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), as amended
APTC Advance payments of the premium tax credit
AV Actuarial value
CBO Congressional Budget Office
CFR Code of Federal Regulations
CHIP Children's Health Insurance Program
CMP Civil money penalties
CMS Centers for Medicare & Medicaid Services
CPI Consumer price index
ECP Essential community provider
ED Enrollment duration
EDGE External data gathering environment
EHB Essential health benefits
ESRD End Stage Renal Disease
FDA Food and Drug Administration
FFE Federally-facilitated Exchange
FF–SHOP Federally-facilitated Small Business Health Options Program
FPL Federal poverty level
FR Federal Register
FTE Full-time equivalent
HCC Hierarchical condition category
HDHP High deductible health plan
HHS United States Department of Health and Human Services
HIPAA Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)
HMO Health maintenance organization
IRS Internal Revenue Service
LEP Limited English proficient/proficiency
MLR Medical loss ratio
NAIC National Association of Insurance Commissioners
NDC National Drug Code
NHEA National Health Expenditure Accounts
OMB Office of Management and Budget
PCIP Pre-Existing Condition Insurance Plan
PHS Act Public Health Service Act
PI Personal income
PMPM Per member per month
PPO Preferred provider organization
QHP Qualified health plan
QIA Quality improvement activities
RXC Prescription Drug Categories
SADP Stand-alone dental plan
SBC Summary of benefits and coverage
SBE–FP State-based Exchange on the Federal platform
SHOP Small Business Health Options Program
The Code Internal Revenue Code of 1986 (26 U.S.C. 1, *et seq.*)
USP United States Pharmacopeia

I. Executive Summary

The Affordable Care Act enacted a set of reforms that are making high quality health insurance coverage and care more affordable and accessible to millions of Americans. These reforms include the creation of competitive marketplaces called Affordable Insurance Exchanges, or ''Exchanges'' (in this proposed rule, we also call an Exchange a Health Insurance Marketplace℠,[1] or Marketplace℠), through which qualified individuals and qualified employers can purchase health insurance coverage. In addition, many individuals who enroll in qualified health plans (QHPs) through individual market Exchanges are eligible to claim a premium tax credit to make health insurance premiums more affordable, and reductions in cost-sharing payments to reduce out-of-pocket expenses for health care services. These Affordable Care Act reforms also include the risk adjustment program and rules that are intended to mitigate the potential impact of adverse selection and stabilize the price of health insurance in the individual and small group markets. In previous rulemaking, we have outlined the major provisions and parameters related to many Affordable Care Act programs.

In this proposed rule, to further promote stable premiums in the individual and small group markets, we propose several updates to the risk adjustment methodology based on our experience with the program to date that are intended to refine the methodology's ability to estimate risk. In particular, we propose updates to better estimate the risk associated with enrollees who are not enrolled for a full 12 months, to use prescription drug data to update the predictive ability of our risk adjustment models, and to establish transfers that will better account for the risk of high-cost enrollees. We propose a number of policies relating to the use of external data gathering environment (EDGE) server data for recalibration of our risk adjustment models, and the use of more recent data for future calibrations. We also propose several amendments to the risk adjustment data validation process, including proposals relating to the review of prescription drug data and the establishment of a discrepancy identification and administrative appeals process.

In addition to provisions aimed at stabilizing premiums, we propose several provisions related to cost-sharing parameters. First, we propose the premium adjustment percentage for 2018, which is used to set the rate of increase for several parameters detailed in the Affordable Care Act, including the maximum annual limitation on cost sharing for 2018. We also propose the maximum annual limitations on cost sharing for the 2018 benefit year for cost-sharing reduction plan variations. This proposed rule also proposes standards for stand-alone dental plans (SADPs) related to the annual limitation on cost sharing.

We also propose a number of amendments that we believe would help promote consumer choice in health

[1] Health Insurance Marketplace℠ and Marketplace℠ are service marks of the U.S. Department of Health & Human Services.

plans. These include a proposal specifying that at least one QHP in the silver coverage level and at least one QHP in the gold coverage level must be offered throughout each service area in which a QHP issuer offers coverage through the Exchange; and a proposal to permit a broader de minimis range for the actuarial value of bronze plans to permit greater flexibility in benefit design and to accommodate proposed updates to the 2018 Actuarial Value (AV) Calculator.

Our proposal requiring QHP issuers on an Exchange to participate in the Exchange for a full plan year (unless a basis for suppression applies) as a QHP certification requirement would help ensure that individuals enrolling through special enrollment periods and newly qualified employees have access to a range of plans that is generally comparable to the range of plans that can be accessed by those who enroll during an open enrollment period. We also seek comment on whether to remove a requirement tying participation in the individual market Federally-facilitated Exchanges to participation in the Federally-facilitated Small Business Health Options Programs.

We also propose to expand the medical loss ratio (MLR) provision allowing issuers to defer reporting of policies newly issued with a full 12 months of experience (rather than policies newly issued and with less than 12 months of experience) in that MLR reporting year, and to limit the total rebate liability payable with respect to a given calendar year. We propose several changes to our guaranteed renewability regulations that would address instances where issuers may inadvertently trigger a 5-year prohibition on re-entering an applicable market. In these select instances, we believe it is appropriate to allow issuers to remain in the applicable market, and believe allowing so will improve the availability of choice for consumers. We also propose a change to our age rating rules for children.

In this proposed rule, we propose several provisions regarding when and how consumers may choose and enroll in plans. This rule includes proposals relating to codifying several special enrollment periods that are already available to consumers in order to ensure the rules are clear and to limit abuse; the enrollment processes in the Small Business Health Options Program (SHOP); and binder payment deadlines. We also propose several amendments related to insurance affordability programs, including regarding eligibility determinations, and periodic data matching.

We are proposing a number of amendments to assist consumers in selecting and enrolling in QHPs and insurance affordability programs. In the HHS Notice of Benefit and Payment Parameters for 2017 Final Rule (2017 Payment Notice), we established standardized options, which we will display on *HealthCare.gov* in a manner that distinguishes them from other QHPs, and a categorization of network depth. We believe both policies will make it easier for consumers to select health plans through *HealthCare.gov*. In this proposed rule, we expand upon both policies. For standardized options, we propose four bronze standardized options (including one health savings account-eligible high deductible health plan), and three standardized options at each of the silver, silver cost-sharing reduction variations, and gold metal levels. We propose to select one standardized option at each metal level and one at each cost-sharing reduction plan variation level for use in each State. We hope that by increasing the scope of potential standardized designs, we will better accommodate State cost-sharing laws. We also propose to make differential display of standardized options available in State-based Exchanges on the Federal platform (SBE–FPs) at the State's option, as well as to require differential display of standardized options by QHP issuers and web-brokers using a direct enrollment pathway to facilitate enrollment through a Federally-facilitated Exchange (FFE) or SBE–FP. Additionally, we propose a number of standards and consumer protections that would apply to a web-broker or issuer using the direct enrollment pathway. We propose to augment our network adequacy display policy to account for QHPs that are part of an integrated delivery system. We also make proposals relating to the essential community provider requirements and propose amendments to the standards regarding providing taglines in non-English languages indicating the availability of language services.

We seek comment on potential ways to further support the transition of former Pre-Existing Condition Insurance Plan (PCIP) Program enrollees into the Exchange to ensure that they do not experience a lapse in coverage.

We also propose several amendments that would strengthen Exchanges' oversight capabilities. These include proposals requiring issuers attempting to rescind coverage purchased through the Exchange to show that the rescission is appropriate; and making explicit HHS's authority to impose civil money penalties (CMPs) in situations where QHP issuers are non-responsive or uncooperative with compliance reviews. We also propose an avenue through which issuers can appeal a non-certification or decertification.

Finally, in this proposed rule, we propose minor adjustments to our rules governing the single risk pool, SHOP, user fees, and notices, including notices related to SHOP, decertification, and appeals.

II. Background

A. Legislative and Regulatory Overview

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

The Affordable Care Act reorganizes, amends, and adds to the provisions of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets.

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

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

Section 2702 of the PHS Act, as added by the Affordable Care Act, requires health insurance issuers that offer health insurance coverage in the group or individual market in a State to offer coverage to and accept every employer and individual in the State that applies for such coverage, unless an exception applies.[2]

[2] Before enactment of the Affordable Care Act, the Health Insurance Portability and Accountability Act of 1996 amended the PHS Act (formerly section

Section 2703 of the PHS Act, as added by the Affordable Care Act, and former section 2712 and section 2742 of the PHS Act, as added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), require health insurance issuers that offer health insurance coverage in the group or individual market to renew or continue in force such coverage at the option of the plan sponsor or individual unless an exception applies.

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

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

Section 1101 of the Affordable Care Act required the Secretary to establish a temporary high-risk health insurance pool program to provide health insurance coverage from the establishment of the program until January 1, 2014 for eligible individuals, namely U.S. residents who are U.S. citizens or lawfully present in the U.S.; did not have other health insurance coverage in the 6 months preceding enactment; and have a pre-existing condition. Section 1101 also requires that the Secretary develop procedures to provide for the transition of eligible individuals enrolled in this health insurance coverage into qualified health plans offered through an Exchange to avoid a lapse in coverage.

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

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

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

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

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

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

Section 1311(c)(6)(C) of the Affordable Care Act states that the Secretary is to provide for special enrollment periods specified in section 9801 of the Internal Revenue Code of 1986 (the Code) and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Social Security Act (the Act).

Section 1312(e) of the Affordable Care Act directs the Secretary to establish procedures under which a State may permit agents and brokers to enroll qualified individuals and qualified employers in QHPs through an Exchange, and to assist individuals in applying for financial assistance for QHPs sold through an Exchange.

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

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

When operating a Federally-facilitated Exchange under section 1321(c)(1) of the Affordable Care Act, HHS has the

2711) to generally require guaranteed availability of coverage for employers in the small group market.

[3] The implementing regulations in part 154 limit the scope of the requirements under section 2794 of the PHS Act to health insurance issuers offering health insurance coverage in the individual market or small group market.

[4] If a State elects this option, the rating rules in section 2701 of the PHS Act and its implementing regulations will apply to all coverage offered in such State's large group market under section 2701(a)(5) of the PHS Act.

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

Section 1321(c)(2) of the Affordable Care Act authorizes the Secretary to enforce the Exchange standards using 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 with respect to health insurance issuers when a State fails to substantially enforce these provisions.

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

Section 1343 of the Affordable Care Act establishes a risk adjustment program in which States, or HHS on behalf of States, collects charges from health insurance issuers that attract lower-risk populations in order to use those funds to provide payments to health insurance issuers that attract higher-risk populations, such as those with chronic conditions, thereby reducing incentives for issuers to avoid higher-risk enrollees.

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

1. Premium Stabilization Programs

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

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

In the November 26, 2014 **Federal Register** (79 FR 70673), we published a proposed rule outlining the benefit and payment parameters for the 2016 benefit year to expand the provisions related to the premium stabilization programs, setting forth certain oversight provisions and establishing the payment parameters in those programs (proposed 2016 Payment Notice). We published the 2016 Payment Notice final rule in the February 27, 2015 **Federal Register** (80 FR 10749).

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).

2. Program Integrity

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

3. Exchanges

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

We established standards for SHOP in the 2014 Payment Notice and in the Amendments to the HHS Notice of Benefit and Payment Parameters for 2014 interim final rule, published in the March 11, 2013 **Federal Register** (78 FR 15541). We also set forth standards related to Exchange user fees in the 2014 Payment Notice.

In the 2017 Payment Notice we established additional Exchange standards, including requirements for State Exchanges using the Federal platform and standardized options.

In an interim final rule with comment published in the May 11, 2016 **Federal Register** (81 FR 29146) we amended the parameters of certain special enrollment periods.

4. Essential Health Benefits and Actuarial Value

On December 16, 2011, HHS released a bulletin [5] (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

[5] Essential Health Benefits Bulletin. (Dec. 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. Feb. 24, 2012. Available at: *https://www.cms.gov/CCIIO/Resources/Files/Downloads/Av-csr-bulletin.pdf*.

Accreditation Final Rule, which was published in the February 25, 2013 **Federal Register** (78 FR 12833) (EHB Rule).

5. Market Rules

A proposed rule relating to the 2014 health insurance market rules was published in the November 26, 2012 **Federal Register** (77 FR 70584). A final rule implementing the health insurance market rules was published in the February 27, 2013 **Federal Register** (78 FR 13406) (2014 Market Rules).

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

6. Rate Review

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

7. Medical Loss Ratio

We published a request for comment on section 2718 of the PHS Act in the April 14, 2010 **Federal Register** (75 FR 19297), and published an interim final rule relating to the MLR program on December 1, 2010 (75 FR 74863). A final rule was published in the December 7, 2011 **Federal Register** (76 FR 76573). An interim final rule 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).

8. Pre-Existing Condition Insurance Plan Program

We published an interim final rule in the July 30, 2010 **Federal Register** (75 FR 45013) setting forth implementing regulations for the Pre-Existing Condition Insurance Plan Program. An amendment to this interim final rule was published in the August 30, 2012 **Federal Register** (77 FR 52614). We published an interim final rule in the May 22, 2013 **Federal Register** (78 FR 30218).

B. Stakeholder Consultation and Input

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

On March 31, 2016, we hosted a public conference to discuss the potential improvements to the Federally certified HHS-operated risk adjustment methodology. Prior to the conference, we published the ''March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting: Discussion Paper'' (''White Paper''),[7] on which we received public comment. These comments are available at: *https://www.regtap.info/uploads/library/RA_Onsite_Discussion_Paper_Comments_5CR_080916.pdf.*

We considered all public input we received as we developed the policies in this proposed rule.

C. Structure of Proposed Rule

The regulations outlined in this proposed rule would be codified in 45 CFR parts 144, 146, 147, 148, 153, 154, 155, 156, 157 and 158.

The proposed regulations in parts 144 and 154 would make conforming revisions to the regulatory definitions of ''plan'' and ''product.''

The proposed regulations in parts 146, 147 and 148 would address two scenarios in which the discontinuation of all coverage currently offered by an issuer within a market and State will not be treated as a market withdrawal for purposes of the guaranteed renewability requirements. The proposed regulations in part 147 would also create multiple child age bands for rating purposes, and would amend the provision regarding limited open enrollment periods (also known as special enrollment periods) in the individual market to reflect the proposed amendments regarding special enrollment periods in the Exchanges.

The discussion in part 152 seeks comment on potential approaches to ensure the successful transition of former Pre-Existing Condition Insurance Plan (PCIP) Program enrollees to the Exchange without a lapse in coverage, under the PCIP statute.

The proposed regulations in part 153 include the risk adjustment user fee for 2018 and outline a number of proposed modifications to the HHS risk adjustment methodology, including modifications to: (1) Address partial year enrollment; (2) use prescription drug data to predict actuarial risk; and (3) alter the methodology to better account for high-cost enrollees. We also propose to use EDGE server data to recalibrate the risk adjustment models, and propose revisions to the risk adjustment data validation process.

The proposed regulations in part 155 include several amendments regarding standardized options, including the 2018 cost-sharing structures for standardized options. Other proposals in part 155 are related to the eligibility and verification processes for insurance affordability programs. We propose to amend rules related to enrollment of qualified individuals into QHPs and make various proposals related to the SHOPs. We propose to amend the regulations requiring Exchanges, QHP issuers, and web-brokers to provide taglines in non-English languages. We propose the required contribution percentage for 2018. We propose a new policy regarding appealing denials of QHP certification. We also propose amendments to the standards applicable in State Exchanges using the Federal platform for SHOP functions in parts 155 and 156. We also propose amendments to the regulations applicable to qualified employers in the SHOPs in part 157.

The proposed regulations in part 156 set forth proposals related to cost-sharing parameters, 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 2018. We also propose the user fee rate applicable in the FFEs and SBE–FPs. The proposed regulations also include an amendment providing for calibration of the single risk pool index rate. We also propose changes regarding AV, levels of coverage, and essential community provider requirements.

The proposed amendments to the regulations in part 158 propose

[7] Available at: *https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf.*

revisions related to deferral of reporting of experience for newer business, as well as revisions related to limiting the total rebate liability payable with respect to a given calendar year.

III. Provisions of the Proposed HHS Notice of Benefit and Payment Parameters for 2018

A. Part 144—Requirements Relating to Health Insurance Coverage

1. Definitions (§ 144.103)

We propose to revise the regulatory definitions of ''plan'' and ''product'' in § 144.103. Specifically, we propose to remove language from each definition that would restrict a plan or product from being considered the same plan or product when it is no longer offered by the same issuer, but is still offered by a different issuer in the same controlled group. We also propose to add a second sentence to clarify that, in the case of a product that has been modified, transferred, or replaced, the product will be considered to be the same product when it meets the standards for uniform modification of coverage at § 146.152(f), § 147.106(e), or § 148.122(g), as applicable. For further discussion of the provisions of this proposed rule related to the transfer or replacement of all products in a market in a State, please see the preamble to § 147.106. Finally, for purposes of clarity, we propose to include examples of product network types in the definition of ''product'' in § 144.103, including health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization, point of service, and indemnity.

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

1. Guaranteed Renewability of Coverage for Employers in the Group Market (§ 146.152)

For a discussion of the provisions of this proposed rule related to part 146, please see the preamble to § 147.106.

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

1. Fair Health Insurance Premiums (§ 147.102)

Section 2701 of the PHS Act, as implemented at 45 CFR 147.102(a)(3), permits premium rates to vary based on age within a ratio of 3 to 1 for adults. Section 147.102(d) provides for uniform age bands, including a single age band for individuals age 0 through 20. In the proposed 2017 Payment Notice (80 FR 75496), we stated that we recognized that the Federal child age band and factor may need to be updated to better reflect the health risk of children. While average health care costs vary by the age of the child, in general, claim costs are highest for children age 0 through 4, followed by individuals age 15 through 20. Children age 5 through 14 generally have lower claim costs. Having one age band for individuals age 0 through 20, together with the current child age factor, may result in significant premium increases for an individual when reaching age 21. In general, the premium at age 21 is 57% higher than the premium at age 20. Therefore, we sought comment regarding age rating for children to inform our reconsideration of the child age rating factor in the Federal uniform age curve.[8]

Most comments submitted to HHS in response to the proposed 2017 Payment Notice supported continuing to spread the cost of newborns across a broader age band, and supported a more gradual transition in premiums up to age 21. Some stakeholders also indicated that the default child age factor of 0.635 should be higher, stating that the relatively low child age factor currently leads to insufficient premiums for children. We conducted an analysis of total annual cost from a national commercial database that incorporates 2015 claims data from the individual and small group markets. Based on this analysis, we propose to amend § 147.102(d) to create multiple child age bands and propose a corresponding increase in the overall child age factor.

We propose one age band for individuals age 0 through 14 and then single-year age bands for individuals age 15 through 20, effective for plan years or policy years beginning on or after January 1, 2018. Establishing single-year age bands beginning at age 15 would be likely to result in small annual increases in premiums for children age 15 to 20, which would help mitigate large premium increases attributable to age due to the transition from a child to an adult age rating. However, we solicit comments on alternative approaches that would achieve these objectives.

We recognize that age rating factors have a significant impact on issuers' approach to developing health insurance rates and therefore also propose age rating factors for the default Federal standard child age curve. These factors, listed in Table 1, correspond to the proposed change to child age bands. We solicit comments on these child age rating factors and whether they should be implemented at one time or phased in over a 3-year period. As stated in the preamble to the 2014 Market Rules (78 FR at 13413), we intend to revise the default Federal standard age curve periodically in guidance, but no more frequently than annually, to reflect market patterns in the individual and small group markets. We propose to reflect this approach by amending § 147.102(e). We intend to monitor the effect of these new age bands and rating factors, if finalized, to determine whether further refinements are needed.

TABLE 1—CMS STANDARD AGE CURVE FOR CHILDREN

Age	Current premium ratio	Proposed premium ratio
0–14	0.635	0.765
15	0.635	0.833
16	0.635	0.859
17	0.635	0.885
18	0.635	0.913
19	0.635	0.941
20	0.635	0.970

2. Guaranteed Availability of Coverage (§ 147.104)

For a discussion of the provisions of this proposed rule related to limited open enrollment periods (also known as special enrollment periods) in § 147.104, please see the preamble to § 155.420.

The guaranteed availability requirement in section 2702 of the PHS Act generally requires each health insurance issuer that offers health insurance coverage in the group or individual market in a State to accept every employer or individual in the State that applies for such coverage. However, in the case of an issuer that offers coverage through a network plan, the issuer may limit its offer of coverage to individuals in the individual market who live or reside in the service area of such network plan, and to employers in the small group or large group market with employees who live, work, or reside in the service area of such network plan.[9]

[8] Under 45 CFR 147.102(e), each State may establish a uniform age rating curve in the individual or small group market, or both markets, for rating purposes. If a State does not establish a uniform age rating curve or provide information on such age curve in accordance with § 147.103, a default uniform age rating curve specified in guidance by the Secretary will apply in that State that takes into account the rating variation permitted for age under State law.

[9] In the 2014 Market Rules, we codified in regulation the ability of an issuer of a network plan to limit the availability to individuals who live or reside in the service area, noting that ''[w]hile PHS Act section 2702(c)(1)(A) does not explicitly include a corresponding exception allowing issuers to limit the sale of individual market coverage to individuals who live or reside in the individual market plan's service area, failing to recognize such an exception would eliminate an issuer's ability to

This protection under Federal law does not require that the employer have a principal business address within the issuer's service area.[10] In the 2017 Payment Notice, we amended § 147.102 to ensure that a network plan could be appropriately rated for sale to an employer with employees in multiple geographical rating areas, consistent with both the rating rules and the guaranteed availability requirements.

We understand that some issuers have unique network sharing agreements with other affiliated issuers through which an employer's employees may access in-network coverage outside the service area of the primary issuer, using the provider network of the affiliated issuers. Under the terms of these agreements, the affiliated issuers require the employer itself to be located in the issuer's service area in order to be eligible to purchase coverage, and the issuers agree not to offer products to an employer whose business headquarters is outside of the primary issuer's service area. For example, affiliated issuers A and B have service areas A and B, respectively. Under the terms of the agreements, an employer with business headquarters in service area A could purchase coverage from issuer A to cover its employees in both service areas A and B, but that employer could not purchase coverage from issuer B.

We understand these issuers believe issuer B satisfies the guaranteed availability requirements because the employer is guaranteed coverage from issuer A, and its employees in service area B can have access to the coverage under the plan issued by issuer A using issuer B's network. These issuers explain that this system promotes simplicity for employers, who can purchase a single plan from one of the locally affiliated issuers serving the employer's area to cover their employees in multiple service areas.

We seek comment on whether and how restricting an employer's ability to purchase coverage from an issuer, when the offering of such coverage would not exceed the scope of the issuer's license from the applicable State authority, may limit employers' options.

We also seek comments on these and other similar arrangements and whether or how they could be structured, consistent with State licensure requirements, to satisfy the guaranteed availability right of employers to purchase all products that are approved for sale from an issuer when the employer has employees who live, work, or reside within the issuer's service area.

3. Guaranteed Renewability of Coverage (§ 147.106)

a. Market Withdrawal Exception to Guaranteed Renewability Requirements

PHS Act section 2703(c)(2)(B) provides that a health insurance issuer that elects to discontinue all health insurance coverage in the individual or group market in a State is prohibited from re-entering the applicable market for at least 5 years. The 5-year ban on market re-entry is codified at § 147.106(d)(2). However, we recognize that interpreting certain issuer transactions or reorganizations to be withdrawals from the market, triggering the 5-year ban on market re-entry, may have unintended effects and may not be necessary to ensure the continuity of coverage for consumers, which is a primary focus of the protections in the guaranteed renewability statute.

For example, as part of a corporate reorganization, an issuer could transfer all of its products to another related issuer, where the products otherwise would be considered the same products based on the uniform modification standards at § 147.106(e). More specifically, an issuer with multiple lines of business, such as a Medicaid managed care line and a commercial line, could decide to create a subsidiary and transfer its commercial line of business to the subsidiary. In such cases, enrollees in the commercial products maintain continuity of coverage when their plans and products are not changed beyond what is permitted by the scope of the uniform modification provisions. We also note that several States evaluate transactions at the holding company level and have informed HHS that a transaction of the type described in this example would not trigger the 5-year ban on market re-entry and corresponding notice requirement under State law.

We recognize that interpreting such a transfer to constitute a market withdrawal could have the unintended consequences of potentially raising conflicts with State approaches and unnecessarily limiting issuer corporate structuring transactions. Therefore, to align with State approaches to corporate structuring or other transactions within a controlled group of issuers, and to avoid unintended market bans where continuity of coverage is effectively provided, we propose to amend § 147.106(e)(3)(i) to provide that, for purposes of guaranteed renewability, a product will be considered to be the same product when offered by a different issuer within an issuer's controlled group, provided it otherwise meets the standards for uniform modification of coverage.[11]

For this purpose, we propose to use a definition based on the Internal Revenue Service (IRS) definition of controlled group that applies for purposes of determining whether a group of two or more persons is treated as a single covered entity under the health insurance providers fee under section 9010 of the Affordable Care Act and 26 CFR 57.2(c). Specifically, for purposes of guaranteed renewability, we propose that ''controlled group'' means a group of two or more persons that is treated as a single employer under section 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code of 1986, as amended. We propose that definition for consistency with other Affordable Care Act provisions, including sections 9008 and 9010, which pertain to the branded prescription drug fee and health insurance providers fee, respectively, and are familiar to health insurance issuers. We note that the definition of issuer group under 45 CFR 156.20 is also familiar to issuers and we are considering whether to use a similar definition for purposes of these regulations. That section provides that the term issuer group means all entities treated under subsection (a) or (b) of section 52 of the Code as a member of the same controlled group of corporations as (or under common control with) a health insurance issuer, or issuers affiliated by the common use of a nationally licensed service mark. We solicit comment on whether this or another definition would be appropriate.

As a result of this proposal, issuers transferring products to another issuer in their controlled group that otherwise remain within the scope of a uniform modification would not be required to

define a service area for its individual market business within a State. Moreover, references to persons with individual market coverage in paragraph (c)(1) and subparagraph (c)(1)(B) of PHS Act section 2702 suggest that such persons with individual market coverage also were intended to be described in paragraph (c)(1)(A).''

[10] However, this provision does not require an issuer to offer coverage to an employer whose place of business is located outside the State in which the issuer is licensed to do business. Further, this provision does not require an issuer to offer coverage to an employer if doing so would exceed the scope of the issuer's State licensure (for example, the issuer's product is not approved for sale to an employer where the situs of the contract is outside the issuer's service area).

[11] As we explained in an FAQ related to Market Reforms, *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/qa_hmr.html*, enrollees in a grandfathered product can maintain that coverage if that coverage continues to be offered and the coverage does not make a change that would cause the product to cease to be grandfathered as provided for in regulations. See 26 CFR 54.9815–1251(g)(1); 29 CFR 2590.715–1251(g)(1); and 45 CFR 147.140(g)(1).

send discontinuation notices under paragraph (c)(1) or (d)(1), as applicable. However, because this interpretation considers the transferred product to be the same as the product previously offered, the issuer of the coverage at the time notice must be provided (whether the current issuer or the acquiring issuer) would be required to provide a renewal notice in accordance with the timeframe specified in the regulation. We also propose that States that interpret or apply market withdrawal provisions differently under State law would not be prohibited by this interpretation from considering products transferred to a different issuer within a controlled group to be a new product and the scenario a market withdrawal. We propose to make conforming amendments at §§ 146.152(f)(3)(i) and 148.122(g)(3)(i). Because, under this interpretation, the products would be considered the same products for purposes of continuity of coverage for the enrollees, we also propose that the products be considered the same products for purposes of the Federal rate review requirements, to the extent applicable, and therefore we propose conforming amendments as described in the preamble to § 154.102. For States where HHS is responsible for enforcement of the guaranteed renewability provisions of the PHS Act, we propose to adopt this interpretation and not consider the transfer of products to a different issuer within a controlled group to be a market withdrawal when the conditions in this proposed rule are met, where permitted under applicable State law.

There is a second situation where we have determined that it may not be appropriate to interpret an issuer's actions to constitute a market withdrawal resulting in a 5-year ban on market re-entry. When an issuer discontinues offering all of its products and seeks to offer new products within the same market, if the changes made to the new products exceed the scope of a uniform modification of coverage, we have considered such an action to be a market withdrawal, subject to the 5-year ban on market re-entry.[12] In such a scenario an issuer might, for example, offer only products A, B, and C one year, but then offer only products D, E, and F the next year, where products D, E and F differ from products A, B and C in ways that do not meet the criteria for uniform modification of coverage. This scenario is different from the first scenario mentioned above because the new products are offered by the same issuer that previously offered the discontinued products. State regulators and other interested parties have indicated that this scenario is not viewed by some States as a market withdrawal under State law, as long as the issuer continues to provide a product in the same market in which it previously offered the discontinued products.[13] As noted above, we believe ensuring continuity of coverage for consumers is a primary focus of the protections in the guaranteed renewability statute. Unlike the circumstances described in the prior scenario, where the enrollee has continuity of the product, but with a related issuer, in the situation described here, enrollees would have continuity with the same issuer, but would not have the protection of the limitations imposed by the uniform modification provision. Notwithstanding our prior interpretation described in the Uniform Modification and Plan/Product Withdrawal FAQ,[14] we recognize that the statute could be interpreted to mean that, as long as an issuer has a product available in the applicable market (even if that issuer discontinues all of its previously offered products), it has not withdrawn from the applicable market. Adopting this interpretation may be in the best interest of consumers, as imposing the 5-year ban on market re-entry in these circumstances could diminish consumer choice and market competition.

We note that, under our current interpretation requiring that the issuer leave at least one product in place that meets uniform modification standards to avoid the 5-year market ban on re-entry, the issuer would remain subject to Federal rate review under section 2794 with respect to at least one product. Under the new interpretation, an issuer would be able to avoid Federal rate review altogether without triggering the 5-year ban by sufficiently altering all of its existing products. To prevent issuers from avoiding Federal rate review requirements in this manner, we propose to permit issuers to replace their entire portfolio of products without triggering the 5-year ban under the market withdrawal provision when an issuer replaces its entire portfolio of products in a market with products that are different in ways that are not within the scope of uniform modifications, provided the issuer reasonably identifies which newly offered product (or products) replace which discontinued product (or products) and subjects the new product (or products) to the Federal rate review process under part 154 (to the extent otherwise applicable to coverage of the same type and in the same market (for example, the Federal rate review process does not apply in the U.S. territories)) as if it were the same product as the discontinued product it replaces.[15] An issuer's identification of which new product replaces which discontinued product would be considered reasonable if it reflects the issuer's expectations regarding significant transfer of enrollment from one product to the other (for example, because the products have been cross-walked for auto-reenrollment). We also propose that States that interpret or apply market withdrawal provisions differently under State law would not be prohibited from continuing to consider the scenario described here as a market withdrawal. For States where HHS is responsible for enforcement of the guaranteed renewability provisions of the PHS Act, we propose to adopt this interpretation and not consider this scenario to constitute a market withdrawal when the conditions outlined in this proposed rule are met, where permitted under applicable State law.

We note that in the second scenario, consumers generally will still get the protection required under the product discontinuance provision under guaranteed renewability, including a special enrollment period for loss of minimum essential coverage to select another product made available by the same or a different issuer, and a notice from the issuer of the product discontinuance at least 90 days in advance of the termination of coverage.[16]

To reflect our proposed interpretations in these two scenarios,

[12] Uniform Modification and Plan/Product Withdrawal FAQ (Jun. 15, 2015), available at *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/uniform-mod-and-plan-wd-FAQ–06–15–2015.pdf.*

[13] We also note that, in the context of reenrollment through an Exchange in coverage under a different product, we stated that, under certain limited circumstances, enrollments completed under the hierarchy specified in 45 CFR 155.335(j) will be considered to be a renewal of the enrollee's coverage.

[14] Uniform Modification and Plan/Product Withdrawal FAQ (Jun. 15, 2015). Available at *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/uniform-mod-and-plan-wd-FAQ–06–15–2015.pdf.*

[15] Under this interpretation, issuers of health insurance products offered in the U.S. territories would be able to replace their products in those markets without subjecting the new products to the Federal rate review process and without triggering the 5-year ban.

[16] As noted earlier, under certain limited circumstances, enrollments through an Exchange into a different product that are completed under the hierarchy specified in 45 CFR 155.335(j) will be considered to be a renewal of the enrollee's coverage. In such cases, a special enrollment period is not available, and a renewal notice is sent.

we propose to add a new paragraph (d)(3) to § 147.106 to provide that an issuer has not discontinued offering all health insurance coverage in a market if a member of the issuer's controlled group continues to offer and make available for enrollment at least one product of the original issuer that is considered to be the same product (as proposed to be amended in § 144.103 of this proposed rule), meaning that any change to the product is within the scope of a uniform modification of coverage under § 147.106(e), or if the issuer continues to offer and make available a product in the applicable market in a State and subjects the new product to the rate review requirements under part 154 of this title (to the extent otherwise applicable to coverage of the same type and in the same market) as if that part applied to that product, and reasonably identifies a discontinued product that corresponds to the new product for purposes of such rate review. We also propose to make conforming amendments to §§ 146.152(d)(3) and 148.122(e)(4).

We solicit comment on all aspects of these proposals.

b. Guaranteed Renewability in the Individual Market and Medicare Eligibility

The guaranteed renewability provision at § 147.106(h)(2) states that Medicare eligibility or entitlement is not a basis for nonrenewal or termination of an individual's health insurance coverage in the individual market. The anti-duplication provision at section 1882(d)(3) of the Act prohibits the sale or issuance of an individual health insurance policy to an individual entitled to benefits under Part A or enrolled under Part B of Medicare [17] with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under Medicare or Medicaid, but does not expressly prohibit the renewal of individual health insurance coverage to someone who becomes entitled to benefits under Part A or enrolls under Part B while enrolled in the individual market coverage. There also is no prohibition on issuers covering Medicare beneficiaries under group health insurance policies.

Under 45 CFR 147.106, in certain circumstances, issuers can satisfy their guaranteed renewability obligations by, at the end of a policy year, reenrolling Medicare beneficiaries who were enrolled in individual market health insurance coverage when they obtained Medicare coverage into a different plan within the same individual health insurance product, or into a different plan within a different individual health insurance product issued by the same issuer of the beneficiary's existing individual market coverage. This may occur, for example, when an issuer makes revisions to a product that exceed the scope of uniform modification of coverage, thus replacing the existing product with a new product. Under our proposal earlier in this section of the preamble, issuers also could satisfy their guaranteed renewability obligations by reenrolling Medicare beneficiaries into individual market health insurance coverage that is considered the same product but that is issued by a different issuer within the issuer's controlled group. We solicit comments on whether the guaranteed renewability statute and the anti-duplication provision at section 1882(d)(3) of the Act should together be interpreted to require or prohibit renewal of a Medicare beneficiary's individual market coverage, if the issuer has knowledge that the renewed coverage would duplicate the Medicare beneficiary's benefits: (1) In a plan under the same contract of insurance; (2) under a plan that was modified but is considered under the guaranteed renewability provisions to be the same plan but that would require a new contract; (3) under a different plan within the same product; (4) under a different product with the same issuer; or, as discussed earlier in this preamble; (5) under the same product offered by a different issuer within the issuer's controlled group. We are particularly interested in information about how requiring or prohibiting renewal in these circumstances could affect individuals' decisions to enroll in the Medicare program, their premiums and out-of-pocket costs if they were insured in the Medicare program versus the individual market, and the effect on Medicare's and the insurance plans' risk pools.

We have become aware of an issue that has arisen with respect to coordination of benefits between Medicare and individual health insurance coverage. Since Medicare Secondary Payer rules do not apply to health coverage in the individual health insurance market, Medicare always pays primary to individual health insurance coverage. Some issuers have a provision in their individual health insurance policies indicating that the coverage will pay secondary to Medicare not only for individuals who are currently covered by Medicare but also for those who could obtain Medicare coverage (such as those individuals who must pay for Part A coverage) but who are not currently covered. We solicit comments on the effects of such provisions on consumers, their premiums, and out-of-pocket costs, how these provisions could affect individuals' decisions to enroll in the Medicare program or individual market coverage, and the effects these provisions and those decisions could have on the Medicare and individual market risk pools, as well as whether this is a permissible coordination of benefits provision with respect to the individuals who could but do not have Medicare coverage. Given that the Medicare Secondary Payer rules have different provisions for End Stage Renal Disease (ESRD) beneficiaries, we also welcome comments on whether a legal basis exists to treat coordination of benefit provisions that relate to coverage in the individual market for Medicare beneficiaries differently for Medicare beneficiaries who are entitled to benefits under Medicare Part A and eligible to enroll under Part B under the ESRD provisions at 42 U.S.C. 426–1.

D. Part 148—Requirements for the Individual Health Insurance Market

1. Guaranteed Renewability of Individual Health Insurance Coverage (§ 148.122)

For a discussion of the provisions of this proposed rule related to part 148, please see the preamble to § 147.106.

E. Part 152—Pre-Existing Condition Insurance Plan Program

1. Pre-Existing Condition Insurance Plan Program (§ 152.45)

Section 1101 of the Affordable Care Act directed HHS to establish a temporary Federal high risk pool program in 2010 to provide health insurance coverage to individuals who were U.S. citizens or nationals or lawfully present in the United States, did not have other health insurance coverage in the 6 months preceding enactment, and had a pre-existing condition. Section 1101(g)(3)(B) directed HHS to develop procedures to provide for the transition of eligible individuals enrolled in health insurance coverage offered through the high risk pool HHS established into qualified health plans offered through an Exchange. Those procedures should, in particular, ensure that there is no lapse in coverage with respect to the individual and may extend coverage after the termination of the risk pool involved, if the Secretary determines necessary to avoid such a lapse.

[17] For information on when individuals are entitled to, eligible for, or able to enroll in Medicare, see *https://www.cms.gov/medicare/eligibility-and-enrollment/origmedicarepartabeligenrol/index.html.*

Starting in 2010, shortly after the Affordable Care Act was enacted, HHS established and began operating the risk pool program required under section 1101, which it called the Pre-Existing Condition Insurance Plan (PCIP) Program, to provide health insurance coverage to eligible individuals, as defined in the Affordable Care Act. Beginning in 2013, HHS worked to enroll these individuals in QHPs through the Exchanges. However, for a variety of reasons, individuals from the high-risk pool established under section 1101 may find it difficult to obtain and maintain coverage in QHPs without a lapse in coverage.

We are therefore seeking information regarding whether and how the remaining funds provided under section 1101 might be used to ensure the successful transition of former PCIP enrollees to the Exchange without a lapse in coverage, consistent with section 1101(g)(3)(B) and its objective of ensuring that high-risk individuals with preexisting conditions are able to transition successfully into the new Exchanges without a lapse in coverage. We seek information, in particular, on the best ways to identify former PCIP enrollees in a QHP of an issuer that has participated in the Exchange from 2014 to 2017, available methods for determining their claims costs, and the necessity of taking steps to ensure that they do not experience a lapse in coverage. If it is not possible to identify former PCIP enrollees, HHS also seeks information about other appropriate measures to assess the size and impact of former PCIP enrollment on existing issuers.

F. Part 153—Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment Under the Affordable Care Act

1. Sequestration

In accordance with the OMB Report to Congress on the Joint Committee Reductions for Fiscal Year 2017,[18] both the transitional reinsurance program and risk adjustment program are subject to the fiscal year 2017 sequestration. The Federal government's 2017 fiscal year will begin on October 1, 2016. The reinsurance program will be sequestered at a rate of 6.9 percent for payments made from fiscal year 2017 resources (that is, funds collected during the 2017 fiscal year). To meet the sequestration requirement for the risk adjustment program for fiscal year 2017, HHS will sequester risk adjustment payments made using fiscal year 2017 resources in all States where HHS operates risk adjustment, at a sequestration rate of 7.1 percent. HHS estimates that increasing the sequestration rate for all risk adjustment payments made in fiscal year 2017 to all issuers in the States where HHS operates risk adjustment by 0.16 percent will permit HHS to meet the required national risk adjustment program sequestration percentage of 6.9 percent noted in the OMB Report to Congress.

HHS, in coordination with the OMB, has determined that, under section 256(k)(6) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, and the underlying authority for these programs, the funds that are sequestered in fiscal year 2017 from the reinsurance and risk adjustment programs will become available for payment to issuers in fiscal year 2018 without further Congressional action. If the Congress does not enact deficit reduction provisions that replace the Joint Committee reductions, these programs would be sequestered in future fiscal years, and any sequestered funding would become available in the fiscal year following that in which it was sequestered.

2. Definition of Large Employer for the Risk Adjustment and Risk Corridors Programs (§ 153.20)

We propose deleting the definition of ''large employer'' set forth in § 153.20, which defines a large employer as having the meaning given to the term at 45 CFR 155.20.[19] HHS provided notice of our intent to propose these changes in a public FAQ[20] which clarified how an issuer should count an employer's employees to determine whether an employer is a small employer or large employer for purposes of the risk adjustment and risk corridors programs.

In that FAQ, we clarified that for the risk adjustment program, the issuer should use the employee counting method used to determine group size under State law, unless that counting method does not account for employees that are not full-time. If the State counting method does not take non-full-time employees into account, then the issuer should use the counting method under section 4980H(c)(2) of the Code.[21] The FAQ also noted that under section 1304(b)(4)(D) of the Affordable Care Act and § 155.710(d), when a small employer participating in a SHOP ceases to be a small employer solely by reason of an increase in the number of its employees, it will continue to be treated as a small employer for purposes of SHOP participation for as long as it continues to purchase coverage through the SHOP, and the issuer should treat such an employer as a small employer for purposes of risk adjustment. We note that nothing in this proposal supersedes or conflicts with the option under section 1312(f)(2)(B)(i) of the Affordable Care Act, which would allow large employers to participate in a SHOP, at the option of a State.

In the FAQ, HHS also clarified that for the risk corridors program, the issuer should use the employee counting method used to determine group size under State law (see § 153.510(f)). However, under section 1304(b)(4)(D) of the Affordable Care Act and § 155.710(d), when a small employer participating in a SHOP ceases to be a small employer solely by reason of an increase in the number of its employees, it will continue to be treated as a small employer for purposes of SHOP participation for as long as it continues to purchase coverage through the SHOP, and the issuer should treat such an employer as a small employer for purposes of risk corridors.

We seek comment on this proposal.

3. Provisions and Parameters for the Permanent Risk Adjustment Program

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

[18] OMB Report to the Congress on the Joint Committee Reductions for Fiscal Year 2017 (Feb. 9, 2016). Available at: *https://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/sequestration/jc_sequestration_report_2017_house.pdf*.

[19] 45 CFR 155.20 defines a large employer, in connection with a group health plan with respect to a calendar year and a plan year, as an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a large employer is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year. A State may elect to define large employer by substituting ''101 employees'' for ''51 employees.'' The number of employees must be determined using the method set forth in section 4980H(c)(2) of the Code.

[20] FAQs #15450 and #15449, published on April 12, 2016 available at: *https://www.regtap.info/faq_viewu.php?id=15450* and *https://www.regtap.info/faq_viewu.php?id=15449*.

[21] See 79 FR 8544.

the Secretary to operate an Exchange may establish a risk adjustment program, or have HHS do so on its behalf.

On March 31, 2016, HHS convened a public conference to discuss potential updates to the HHS risk adjustment methodology for the 2018 benefit year and beyond. Prior to the conference, we also issued a White Paper that was available for public comment.[22] The conference and White Paper focused on what we have learned from the 2014 benefit year of the risk adjustment program, and specific areas of potential refinements to the methodology, including prescription drug modeling, addressing partial year enrollment, future recalibrations using risk adjustment data, and a discussion of the risk adjustment transfer formula. We received numerous thoughtful and substantive comments to the White Paper and at the conference, which directly informed the policy proposals in this Payment Notice.

a. Risk Adjustment Applied to Plans in the Individual and Small Group Markets (§ 153.20)

Section 1312(c) of the Affordable Care Act directs issuers to use a single risk pool for a market—the individual or small group market—when developing rates and premiums. Section 1312(c)(3) of the Affordable Care Act gives States the option to merge the individual and small group market into a single risk pool. To align risk pools for the risk adjustment program and rate development, we stated in the 2014 Payment Notice that we would merge markets when operating risk adjustment on behalf of a State if the State elects to do the same for single risk pool purposes.[23] When the individual and small group markets are merged, we stated that the State average premium would be the average premium of all applicable individual and small group market plans in the applicable risk pool, and calculations under the transfer equation would occur across all plans in the applicable risk pool in the individual and small group markets.

Under the section 1312(c)(3) definition of a merged market and its implementing regulations at §§ 156.80 and 147.104, issuers in a merged individual and small group market must offer the same plans at the same rates to all applicants in the merged market, must offer coverage on a calendar year basis, and may not make quarterly rate adjustments to rates for small group market plans. Some States with markets that are not merged under the Federal merged market provisions require issuers to use a combined individual and small group experience to establish a market-adjusted index rate, but separate the markets for applying plan adjustment factors and for other purposes. This allows small group issuers to make quarterly rate changes that would not otherwise be allowable under the definition at section 1312(c)(3).

Because States that use a combined individual and small group experience to establish a market-adjusted index rate operate in large part as a merged market for purposes of rate setting, we believe they should be risk adjusted as merged markets if the State so elects. Risk adjustment directly impacts rate setting, and as such, should reflect the markets in which States allow issuers to set premiums. Beginning for 2017 benefit year risk adjustment, when HHS will operate risk adjustment on behalf of all States, we propose to expand our interpretation of merged market for purposes of HHS risk adjustment as described in the 2014 Payment Notice to include States that meet the definition of merged market at section 1312(c)(3), as well as States that use a combined individual and small group experience to establish a market-adjusted index rate. HHS will communicate with States that use a combined individual and small group experience to establish a market-adjusted index rate to determine whether they elect to be treated as a merged market for purposes of HHS risk adjustment. We seek comment on this proposal.

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

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

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

For the 2018 benefit year risk adjustment model, HHS will continue to incorporate the methodological improvements finalized in the 2017 Payment Notice, such as incorporating preventive services in our simulation of plan liability and using more granular trend rates that better reflect the growth in specialty drug expenditures and drugs generally as compared to medical and surgical expenditures. Consistent with our discussion in the White Paper, we are proposing a number of updates to the risk adjustment model, including: (1) Adjustment factors for partial year enrollment; (2) prescription drug utilization factors; and (3) modifying transfers to account for high-cost enrollees. We also propose to recalibrate our risk adjustment models using the most recent available data following the publication of the final Payment Notice for the applicable benefit year, and seek comments on other considerations to improve the model's risk prediction in future rulemaking.

i. Partial Year Enrollment

After the 2014 benefit year of risk adjustment, we received feedback indicating that some issuers experienced higher than expected claims costs for partial year enrollees. We sought comment in the 2017 Payment Notice on how the risk adjustment methodology could be adjusted to more directly reflect the experience of partial year enrollees, and we received comments generally supporting an adjustment addressing partial year enrollees in the risk adjustment model. We also received feedback to the White Paper that some believe the methodology does not fully capture the risk associated with enrollees with chronic conditions who may not have accumulated diagnoses in their partial year of enrollment.

In general, we believe that individual and small group health plans are risk adjusted accurately under the HHS risk

[22] March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting: Discussion Paper (Mar. 24, 2016). Available at *https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf*.

[23] See 78 FR at 15419.

adjustment methodology. In light of our experience with the 2014 benefit year, we have observed that risk adjustment may not fully account for when a plan's enrollees differ substantially from the market average with respect to characteristics that are not adjusted for in the risk adjustment model. For example, if a plan has an enrollee population with enrollment duration that differs from the market average, and the risk associated with the enrollment duration is not fully captured through other aspects of the methodology, then for that plan, partial year enrollment may not be fully accounted for in the HHS risk adjustment methodology. As we noted in the White Paper, if the risk adjustment methodology does not fully capture risk for partial year enrollment, and if the plan had lower than average enrollment duration, the plan's risk score might be lower than it might have been otherwise.[24]

As we discussed in the White Paper, we reviewed the predicted expenditures, actual expenditures, and predictive ratios (that is, the ratios of predicted to actual weighted mean plan liability expenditures) by enrollment duration groups (for each: 1 Month, 2 months, and so on up to 12 months) annualized for 2014 MarketScan® adults in our risk adjustment concurrent modeling sample. We found that actuarial risk for all adult enrollees with short enrollment periods tends to be slightly under predicted, and for adult enrollees with full enrollment periods (12 months) tends to be over predicted in our methodology. One potential explanation for these results is that because risk adjustment is calculated on a per member per month basis, the model predicts costs for chronic conditions, which are often spread more evenly over time, better than costs for sudden acute events, which are often concentrated in a small number of months, when the enrollment is only for part of the year.

We discussed various approaches to address this issue in the White Paper, including the use of additional factors and the use of wholly separate models that account for duration of enrollment and metal level.

There was a broadly held preference among commenters to the White Paper for adding enrollment duration (for each: 1 Month, 2 months, and so on up to 11 months [25]) binary indicator variables as additional risk factors, as opposed to separate models based on enrollment duration. After reviewing this feedback, we announced on June 8, 2016, that we intended to propose that, beginning for the 2017 benefit year, the risk adjustment model include adjustment factors for partial year enrollees in risk adjustment covered plans.[26]

Based on analysis we performed on the MarketScan® data, the use of additional risk factors by number of enrollment months that decrease monotonically as the number of months of enrollment increases (with 12 months being the reference group) appears to best address partial year enrollment in the risk adjustment model in the short term, starting in 2017. We also believe that our proposal to add prescription drug utilization in the risk adjustment model will capture additional costs for partial year enrollees beginning in the 2018 benefit year (see discussion below).

We are proposing to recalibrate the 2017 risk adjustment adult model to reflect the incorporation of partial year enrollment duration (ED) factors. Those factors are labeled ''ED_01 . . . ED_11'' in the list of factors for the 2017 risk adjustment adult model at the bottom of Table 3 below.[27] We are proposing to incorporate partial year ED factors in the risk adjustment model methodology for the reasons discussed above, starting with the 2017 benefit year. We are proposing to amend our regulations at § 153.320(a)(1) to allow for HHS to make this update for the 2017 benefit year. Currently, this provision states that a risk adjustment methodology must be Federally certified, and one way a risk adjustment methodology may become Federally certified is to be developed by HHS and published in the annual HHS notice of benefit and payment parameters for the applicable benefit year. We propose to change this provision to state that the methodology may be developed by HHS and published in rulemaking in advance of the benefit year. While HHS would generally make changes to the risk adjustment methodology in the annual HHS notice of benefit and payment parameters for the applicable benefit year, under this rule, in cases where we have identified a change that we can implement prior to the benefit year, and where we can provide issuers with sufficient notice and detail on the proposed change so that issuers may reasonably account for the change, HHS would have the authority to implement the change prior to the beginning of the applicable benefit year in other rulemaking. For our proposed change to address partial year enrollment, we notified issuers of our intent to propose this change in prior guidance, and provided significant detail on the policy.[28] We seek comment on this approach.

We are also proposing to incorporate partial year enrollment duration factors in the 2018 risk adjustment adult model. Those factors are labeled ''ED_01, . . . ED_11'' in the list of factors for the 2018 risk adjustment adult model near the bottom of Table 4. We seek comment on recalibrating the adult models for the 2017 and 2018 benefit years to address partial year enrollment.

We are not making this change in the child and infant models as those models are based on a smaller dataset that does not provide adequate representation of partial year enrollment in these populations. We will reassess both the proposed partial year enrollment adjustment methodology, and whether we can make this adjustment in the child and infant models in the future. We also intend to continue to explore approaches under which we would use separate models for enrollees with different enrollment durations, rather than including partial year enrollment factors in the risk adjustment model, and may implement such an approach in future years. While we do not believe, based on the current data available and the analyses we have been able to perform, that using separate models for each enrollment duration is currently feasible, we believe that using separate models may better capture how the pattern of costs associated with particular diagnoses varies across enrollees with different enrollment durations, particularly for sudden acute events.

ii. Prescription Drug Hybrid Model

As discussed in the White Paper, HHS has been considering whether to propose the incorporation of prescription drug utilization indicators into the HHS risk adjustment model, beginning for the 2018 benefit year, to create a ''hybrid'' drug-diagnosis risk adjustment model. We are aware that there are advantages and disadvantages to including prescription drug utilization indicators in the HHS risk adjustment model and we seek comment on our proposal.

[24] White Paper at p. 36. Available at: *https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf.*

[25] Twelve months is the reference group and therefore is not included.

[26] Available at: *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/RA-OnsiteQA-060816.pdf.*

[27] This table replaces Table 1 published at 81 FR 12220–12223 as the final adult model for the 2017 benefit year.

[28] See *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/RA-OnsiteQA-060816.pdf.*

Many commenters to the White Paper stated that drug information can effectively indicate health risk in cases where diagnoses may be missing. For example, diagnoses may be missing if clinicians fail to enter the condition on a patient's chart, or if there is stigma associated with certain health conditions that leads providers not to record these diagnoses on claims, or if the enrollee simply does not visit a physician during the term of his or her enrollment. However, even in these cases, prescriptions may be filled, providing information on health status.

Drug utilization patterns can also provide information on the severity of the illness. The hierarchical condition categories (HCCs) already capture information about illness severity from diagnoses, but drugs can potentially measure the severity of illness within a given HCC. A patient may receive first, second, or third lines of treatment involving different medications that indicate increasing levels of severity.

Additionally, commenters have noted that drug data can be available sooner and more easily than diagnoses from medical claims. In addition, commenters have noted that because prescription drug data is standardized, it is particularly useful for calibrating and measuring health risk because the prescription drug data will have less variability in coding.

Incorporating prescription drug utilization into the risk adjustment model will help reflect costs incurred by plans for medications for their enrollees in plans' risk scores.

Adding drug data to a diagnosis-based model also introduces operational complexities. Clinical indications for drugs can change quickly, which requires frequent updates to the model calibration and possibly to the therapeutic classification groupings as well. Because the model is calibrated before the start of the benefit year, it may be difficult to assess all updates or upcoming utilization pattern changes. Additional data requirements increase the administrative burden associated with calibrating and applying the model. Issuers of risk adjustment covered plans would be required to report prescription drug utilization as well as diagnoses, and audit and verification of the reported data would be necessary.

We have also indicated our concern that incorporating prescription drug utilization in the model may provide an incentive to overprescribe medications. Drug models may be particularly susceptible to this sort of behavior when there are inexpensive drugs included in therapeutic classes that are statistically linked to high total medical expenditures; in these situations, a small cost to the insurance plan (reimbursement for the drug) can bring a relatively large increase in revenue through the risk adjustment program.

In analyzing if and how to propose to use drug data in the risk adjustment model, we sought to strike a reasonable balance between increasing predictive accuracy and reducing incentives for overprescription. One way we sought to do so was by focusing on drugs for which guidelines on when they should be prescribed are clear. However, substantial uncertainty or disagreement across providers exists over the circumstances in which drugs should be prescribed.

In addition, incorporating drug utilization makes risk adjustment sensitive to variations in drug utilization patterns that exist for reasons other than enrollee health status. Health plans with lower prescribing rates, for example health plans primarily covering individuals in rural areas with low access to pharmacies, would incorrectly appear to have healthier populations, and would pay higher risk charges or receive lower risk payments. Other things being equal, drug utilization is expected to be lower in plans with higher cost sharing (such as bronze or silver plans) and with aggressive drug utilization management, such as prior authorization, step therapy, quantity limits, restrictive formularies, and more stringent requirements to qualify for coverage of expensive drugs.

Furthermore, the lack of clear, one-to-one associations between most drug classes and diagnoses makes development of a ''hybrid'' drug-diagnosis risk adjustment model that incorporates and integrates drug and diagnosis risk markers challenging.

Few drug classes are indicated for only one medical condition. Many drug classes are widely prescribed ''off label'' for indications that are not U.S. Food and Drug Administration (FDA)-approved. Utilization of such drug classes can have very different implications for health care expenditures depending on the reasons for which they are prescribed. Presence of a drug class may not discriminate between high and low cost individuals if it is used for both high and low cost conditions. Some drug classes may be used both for diagnoses that have been included in the HHS–HCC model, as well as for diagnoses that have been intentionally excluded, making it problematic to maintain this distinction in a hybrid drug-diagnosis risk adjustment model. Specific drugs within a drug class may have varying indications; the utilization of such drug classes may not unambiguously indicate the presence of a specific diagnosis.

Acknowledging all of the above considerations, we indicated in the June 8, 2016, guidance noted above that we intend to propose to incorporate a small number of prescription drug classes as predictors in the HHS risk adjustment methodology for the 2018 benefit year to impute missing diagnoses and to indicate severity of illness.[29] We propose to incorporate a small number of prescription drugs in the risk adjustment model for the 2018 benefit year. We are proposing this change to the model with substantial attention to the concerns presented above in determining which drug groups to include and exclude, and the proposed model type used for each drug-diagnosis pair. To ensure this change to the model does not inadvertently increase the perverse incentives described above, we will monitor and evaluate the impact of incorporating prescription drugs in the model on utilization patterns. Using the enrollee-level data that we are proposing to collect in § 153.610, in addition to other relevant data sources, we would seek to evaluate whether incorporation of drugs in the model affects the utilization of drugs included in the model. Based on our evaluation, we would add or remove drug diagnosis pairs to or from the model for future benefit years through notice and comment rulemaking. We seek comment on this proposal.

To develop hybrid drug-diagnosis risk adjustment models, we need a manageable number of clinically and empirically cohesive drug classes. We created several Prescription Drug Categories (RXCs) to select and group the drugs to be included in a hybrid diagnoses-and-drugs risk adjustment model.

Each prescription drug is assigned a National Drug Code (NDC) maintained by the FDA. There are over 190,000 NDCs, which include prescription drugs as well as over-the-counter medications. NDC codes are reported in prescription drug claims data. Due to the large number of individual NDCs, it is necessary to use a therapeutic classification system that classifies individual NDCs into aggregated categories of related drugs used for similar therapeutic purposes, or having similar pharmacological properties.

In the White Paper, we had initially based the RXCs on the American Hospital Formulary Service

[29] Available at: *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/RA-OnsiteQA-060816.pdf.*

Pharmacologic-Therapeutic Classification©, which is published by the Board of the American Society of Health-System Pharmacists®. We chose at that point to use the American Hospital Formulary Service classification because it is widely used, widely available, comprehensive, and regularly updated. Because the American Hospital Formulary Service classification and mappings from NDCs are proprietary, however, we determined that using the United States Pharmacopeia (USP) classification would be better suited for use with HHS risk adjustment to maintain consistency with the essential health benefits requirements and for public access and transparency. The USP classification also provides chemical ingredient level identifications for drug classifications; that is, unlike American Hospital Formulary Service, USP includes comparable levels of detail to identify and group drugs used for only one diagnosis with other drugs used for multiple diagnosis codes. NDC codes are classified into 153 USP therapeutic classes. Drawing on the principles and criteria described below, we selected appropriate USP therapeutic classes and combined and edited those classes in order to create ''payment'' RXCs, each of which is closely associated with a specific HCC or group of HCCs that are potentially suitable for inclusion in a payment risk adjustment model. Most USP classes are somewhat heterogeneous. To designate a class of drugs to serve as an indicator that a medical diagnosis is present, we needed to comprehensively review the drugs in each USP class to select only those that are closely associated with the diagnosis.

The development of a hybrid HHS–HCC risk adjustment model requires selecting drug-diagnosis pairs (RXC–HCC pairs) to include in the model. Similar to our approach in the 2014 Payment Notice when initially determining the HCCs to be included in the HHS risk adjustment models, we used a set of principles to guide our decision making. Development of the RXC–HCC pairs was an iterative process that required recurring consultations with a panel of clinician consultants.

Principle 1—RXC categories should be clinically meaningful. Each RXC is composed of a set of NDCs. These codes should all relate to a reasonably well-specified pharmacologic, therapeutic or chemical characteristic that defines the category. RXCs must be sufficiently clinically specific to minimize opportunities for discretionary coding. Clinical meaningfulness improves the face validity of the classification system to clinicians and the model's interpretability.

Principle 2—RXCs should predict total medical and drug expenditures. NDCs in the same RXC should be reasonably homogeneous with respect to their effect on current year costs.

Principle 3—RXCs that will affect payments should have adequate sample sizes to permit accurate and stable estimates of expenditures. RXCs used in establishing payments should have adequate sample sizes in available datasets. For example, it is difficult to reliably determine the expected cost of extremely rare categories.

Principle 4—In creating an individual's clinical profile, hierarchies should be used to characterize the person's illness level within each RXC where appropriate, while the effects of unrelated prescriptions accumulate. Because each new medical event adds to an individual's total disease burden, unrelated prescriptions in different RXCs should increase predicted costs of care. However, the most severe manifestation of a given disease process principally defines its impact on costs. Therefore, related RXCs should be treated hierarchically, with those associated with more severe manifestations of a condition dominating (and eliminating the effect of) less serious ones.

Principle 5—Providers should not be penalized for prescribing additional NDCs (monotonicity). This principle has two consequences for modeling: (1) No RXC should carry a negative payment weight; and (2) an RXC that is higher-ranked in a drug hierarchy (causing lower-rank drugs in the same hierarchy to be excluded) should have at least as large a payment weight as lower-ranked RXCs in the same hierarchy.

Principle 6—The classification should assign NDCs to only one RXC (mutually exclusive classification). Because each NDC can map to more than one RXC, the classification should map NDCs to the primary RXC based on considerations such as route of administration, intended application of the product, ingredient list identifier, label, dosage form, and strength of the drug.

Principle 7—Discretionary and non-credible drug categories should be excluded from payment models. RXCs that are particularly subject to intentional or unintentional discretionary prescribing variation or inappropriate prescribing by health plans or providers, or that are not clinically or empirically credible as cost predictors, should not be included. Excluding these RXCs reduces the sensitivity of the model to prescribing variation, prescribing proliferation, and gaming.

We used clinical and statistical assessments to appropriately balance all seven principles. In designing the RXCs, principles 5 (monotonicity) and 6 (mutually exclusive classification), were generally followed. Clinical meaningfulness (principle 1) is often best served by creating a very large number of detailed clinical groupings. However, a large number of groupings conflicts with adequate sample sizes for each category (principle 3). We approached the balancing of our principles by designing a drug classification system using empirical evidence on frequencies and predictive power; clinical judgment on relatedness, specificity, and severity of RXCs; and professional judgment on incentives and likely provider responses to the classification system. The RXC risk adjustment model balances these competing goals to achieve prescription drug-based classes for use in risk adjustment.

In addition to following the set of principles described above, we carefully considered selection of high-cost drugs, to avoid overly reducing the incentives for issuers to strive for efficiency in prescription drug utilization. We also carefully considered selection of drugs in areas exhibiting a rapid rate of technological change, as a drug class that is associated with a specific, costly diagnosis in one year may no longer be commonly used for that condition the next, in which case the cost predictions based on previous years of data would be inaccurate.

Based on these considerations, we propose a small number of drug-diagnosis pairs for the proposed hybrid model. We selected RXCs to impute diagnoses and to indicate the severity of diagnoses otherwise indicated through medical coding. We worked with clinician consultants to tailor the RXCs used for imputation based on their expertise in treatment patterns as well as statistical indicators such as positive predictive value. Clinicians also informed our determination of RXCs for use as severity-only indicators in the model. For the severity-only RXCs, the presence of a prescription in the drug class signals a more severe case of the related diagnosis, which is likely to incur greater medical expenditures relative to someone with the same diagnosis, but not the drug. Severity-only RXCs are not specified in the model to impute the associated diagnosis when an HCC is not present. We are proposing limiting the number of prescription drug classes included as predictors to only those drug classes

where the risk of unintended effects on provider prescribing behavior is low; as described above, we intend to monitor prescription drug utilization for unintended effects and may remove drug classes based on such evidence in future rulemaking.

Table 2 shows the list of RXC–HCC pairs that we propose to include in the initial hybrid model. Each pair is designated as either an imputation/severity or a severity-only relationship. For each pair, Table 2 shows the coefficient for the diagnosis (HCC), the drug utilization (RXC), and both.

The drug-diagnosis pairs can include more than one HCC. For example, the list includes a diabetes drug-diagnosis relationship that includes three HCCs (diabetes with acute complication, diabetes with chronic complication, and diabetes without complication) which are grouped together in the model estimation. This RXC can be interpreted as an indication that the individual should have a diagnosis of one of these three diabetes HCCs. In addition, an RXC can be linked in the model to more than one HCC, and vice-versa. For example, RXC 8 (Immune suppressants and immunomodulators) has an imputation/severity relationship with HCC 056 (Rheumatoid arthritis and specified autoimmune disorders), and also has a severity-only relationship with HCC 048 (Inflammatory bowel disease).

While ten of the RXC–HCC pairs have three levels of incremental predicted costs (diagnosis only, prescription drug only, both diagnosis and prescription drug), indicating that they can be used to impute a particular condition, the model also includes two RXC–HCC pairs that will be used for severity only—that is, they will predict incremental costs for enrollees with the diagnosis only, and with both the diagnosis and the prescription drug. There are no additional costs predicted for an enrollee taking the drug who lacks the associated diagnosis. Table 2 lists the RXC–HCC pairs we are proposing to incorporate in the adult models for the 2018 benefit year. Table 4 incorporates the full set of HCCs and RXC–HCCs and their associated coefficients that we are proposing to implement in the 2018 adult models.

TABLE 2—DRUG-DIAGNOSIS (RXC–HCC) PAIRS CHOSEN FOR THE HYBRID RISK ADJUSTMENT MODELS

RXC	RXC Label	HCC	HCC Label	Proposed RXC use
1	Hepatitis C Antivirals	037C, 036, 035, 034	Chronic Hepatitis C, Cirrhosis of Liver, End-Stage Liver Disease, and Liver Transplant Status/Complications.	imputation/severity.
2	HIV/AIDS Antivirals	001	HIV/AIDS	imputation/severity.
3	Antiarrhythmics	142	Specified Heart Arrhythmias	imputation/severity.
4	End Stage Renal Disease (ESRD) 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.
5	Anti-inflammatories for inflammatory bowel disease (IBD).	048, 041	Inflammatory Bowel Disease, Intestine Transplant Status/Complications.	imputation/severity.
6a	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.
6b	Insulin	019, 020, 021, 018	Diabetes with Acute Complications; Diabetes with Chronic Complications; Diabetes without Complication, Pancreas Transplant Status/Complications.	imputation/severity.
7	Multiple Sclerosis Agents	118	Multiple Sclerosis	imputation/severity.
8	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.
9	Cystic Fibrosis Agents	159, 158	Cystic Fibrosis, Lung Transplant Status/Complications.	imputation/severity.
10	Ammonia Detoxicants	036, 035, 034	Cirrhosis of Liver, End-Stage Liver Disease, Liver Transplant Status/Complications.	severity-only.
11	Diuretics, Loop and Select Potassium-Sparing.	130, 129, 128	Congestive Heart Failure, Heart Transplant, Heart Assistive Device/Artificial Heart.	severity-only.

We propose to incorporate the RXC–HCC pairs—some of which are used to impute a diagnosis and calibrate the severity of the condition, and others of which are used only as an indication of severity—into the adult risk adjustment model, beginning in the 2018 benefit year. We intend to evaluate the effects of this change to determine whether to continue, broaden, or reduce this set of factors in the HHS risk adjustment models. We seek comment on this approach, including comments on the list of RXC–HCC pairs.

iii. High-Cost Risk Pooling

The HHS risk adjustment model reflects the average cost for individuals with a given set of demographic characteristics and diagnoses. Our experience with the 2014 benefit year risk adjustment demonstrated the model may underpredict costs for extremely high-cost enrollees since predicted plan liabilities reflect the average costs for individuals with the set of demographic characteristics and diagnoses included in the model. As a consequence, even with risk adjustment in place, issuers may retain an incentive to engage in risk selection in order to avoid these very high-cost enrollees (called ''high-cost enrollees'' throughout this proposal). Recent research has shown that adjusting for high-cost enrollees in a risk adjustment model benefits the model fit and predictive ability for the remaining risk population.[30] To mitigate any residual incentive for risk selection

[30] Schillo, S., G. Lux, J. Wassem and F. Buchner (2016) ''High Cost Pool or High Cost Groups—How to Handle Highest Cost Cases in a Risk Adjustment Mechanism?'' Health Policy (120): 141–147.

to avoid high-cost enrollees, and to ensure that the actuarial risk of a plan with high-cost enrollees is better reflected in the risk adjustment transfers to issuers with high actuarial risk, we propose to alter the risk adjustment methodology to better account for high-cost enrollees so that transfers resulting from the risk adjustment methodology from high actuarial risk plans to low actuarial risk plans better reflect the actuarial risk of risk adjustment covered plans in a market, across all States. We also seek to offset the need for issuers to build large risk premiums into their rates to account for these cases by giving issuers greater predictability on expenditures.

To account for the incorporation of high-cost risk in the risk adjustment model, we propose to adjust the risk adjustment model for high-cost enrollees 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. Secondly, to account for the issuers' actuarial risk for costs associated with the high-cost enrollees, we would apply an adjustment for each issuer of a risk adjustment covered plan to account for a percentage of all high-cost enrollees' costs above the threshold. We would 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 the high-cost enrollees would receive an adjustment to account for actuarial risk 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 above the threshold. HHS would then calculate an adjustment as a percent of the issuer's total premiums in the respective market, which would be applied to the total transfer amount in that market, maintaining the balance of payments and charges within the risk adjustment program. We are proposing a uniform percentage of premium adjustment across all States for the individual (including catastrophic and non-catastrophic plans and merged market plans) and small group markets. We believe pooling across all States for purposes of calculating this adjustment would be most effective in reducing the impact of high-cost enrollees to better reflect actuarial risk, and seek comment on this proposal. Creating a uniform pool of high-cost enrollees, by risk pool or market, could result in some States or geographic areas subsidizing issuers with high-cost enrollees in other States or geographic areas, as we discussed at the conference and commenters to the White Paper noted. We believe pooling high-cost enrollees across all States on whose behalf we are operating the risk adjustment program could prevent certain States with high-cost enrollees from bearing a disproportionate amount of unpredictable risk.

In the White Paper we discussed a threshold of $1 million and a coinsurance rate of 80 percent (where the issuer would be liable for 20 percent of costs above $1 million for an enrollee). Commenters expressed concerns about the potential for issuers to ''game'' this policy by shifting costs to the risk adjustment program, and not pay sufficient attention to cost containment for costs above the threshold. While we believe these inordinately high costs reflect random risk selection for certain issuers, we are sensitive to these concerns, particularly in the first year of this adjustment in the risk adjustment model. Therefore, beginning for the 2018 benefit year, we are proposing a threshold of $2 million and a coinsurance rate of 60 percent (where the issuer would be liable for 40 percent of costs above $2 million). Beginning with the 2018 benefit year recalibration, we would also incorporate these parameters in our recalibration of the model by truncating at 40 percent of costs above $2 million in our dataset used to simulate plan liability. Doing so will produce more accurate predictive coefficients that reflect the impact of the high-cost enrollee pool. To help mitigate concerns raised, while still helping protect issuers from the unpredictable risk of exceptionally high costs, we have designed this proposal based on what we discussed at the conference and comments received on the White Paper.

As discussed above, beginning for the 2018 benefit year, we propose to adjust issuers' risk adjustment transfers by a percent of premium amount that would be determined based on the aggregate costs of the high-cost risk pool above $2 million at 60 percent coinsurance in the benefit year. This adjustment to the transfer formula would be made for all issuers of risk adjustment covered plans in the individual (including catastrophic and non-catastrophic plans and merged market plans), or small group market, across all States, based on total premiums in the respective market. We would create two high-cost risk pools across all States: One for the individual market (including catastrophic, non-catastrophic, and merged market plans), and one for the small group market. To calculate the adjustments, risk adjustment covered plans would be assessed an adjustment to fund the applicable pools and we would perform additional data quality metrics to determine an issuer's eligibility for high-cost risk pool adjustments, even if the issuer failed the data quality analysis for a risk adjustment transfer and was assessed a default charge under § 153.740(b) on that basis. At the proposed threshold and coinsurance, we expect total adjustments as a result of this policy nationally to be very small as a percent of premiums (less than one tenth of one percent of total premiums for either market). We believe the inclusion of this policy, in combination with the transfers attributable to the plan liability risk scores, will allow us to better assess total actuarial risk for each risk adjustment eligible plan, and thereby to ensure that risk adjustment is appropriately compensating issuers. We seek comment on this proposal. We also seek comment on whether to cap the adjustments if they exceed a certain amount.

iv. Other Considerations

We had previously reported that based on the commercial MarketScan® data, the HHS risk adjustment models slightly underpredict risk for low-cost enrollees, and slightly overpredict risk for enrollees with high expenditures.[31] We have received feedback that HHS should adjust the risk adjustment models for the underprediction of risk for low cost enrollees, and the overprediction of risk for enrollees with high expenditures, which affects the plan liability risk scores of plans that enroll more healthy individuals or plans that enroll more individuals with the most extreme chronic health conditions. We are considering the implementation of the following policies, beginning with the 2018 benefit year, in order to improve model performance for these subpopulations, and seek comment on these approaches. We are considering use of a constrained regression approach, under which we would estimate the adult risk adjustment model using only the age-sex variables. We would then re-estimate the model using the full set of HCCs, while constraining the value of the age-sex coefficients to be same as those from the first estimation. We believe that this two-step estimation approach would result in age-sex coefficients of greater magnitude, potentially helping us

[31] Available at: *https://www.cms.gov/mmrr/Downloads/MMRR2014_004_03_a03.pdf.*

predict the risk of the healthiest subpopulations more accurately. Similarly, we are considering approaches in which our first estimation of the model would include additional independent variables intended to account for potential non-linearities in risk for the highest-risk subpopulations, and then removing those additional variables in the second estimation. We are considering creating separate models for enrollees with and without HCCs to derive two separate sets of age-sex coefficients. We believe such an approach could also help improve the models' predictive ratios for the healthiest subpopulations, though this model would have a separate set of age-sex coefficients for individuals with no HCCs and the individuals with HCCs. Finally, we are evaluating an approach in which we would directly adjust plan liability risk scores outside of the model for these subpopulations. For example, we could potentially make an adjustment to the plan liability risk scores calculated through the HHS risk adjustment models that would adjust for such an underprediction or overprediction in actuarial risk by directly increasing low plan liability risk scores and directly reducing high plan liability risk scores in order to better match the relative risks of these subpopulations. We note that while we believe modifications of this type could improve the model's performance along this specific dimension, there is a risk that such modifications could unintentionally worsen model performance along other dimensions on which the model currently performs well. For this reason, we are continuing to evaluate the effect of these types of modifications on all aspects of the model's performance before choosing to implement such an approach, and would not implement these types of modifications if we determined that doing so would have material unintended consequences for the model's performance along other dimensions. We seek comment on methods discussed above as well as other methods to improve the predictive ratios of the HHS risk adjustment models.

In addition, we have received feedback regarding our transfer methodology in community rated States. In the 2014 Payment Notice, we stated that billable members exclude children who do not count towards family rates. In the second Program Integrity Rule, we clarified the modification to the transfer formula to accommodate community rated States that utilize family tiering rating factors. In the case of family tiering States, billable members are based on the number of children that implicitly count towards the premium under a State's family rating factors. We have received feedback that there may be alternative methodologies for calculating billable member months in family tiering States, such as by adjusting for the expected actual number of members on the policy, not the number of members that implicitly count towards the premium. We seek comment on whether our methodology for calculating billable member months in family tiering States should be altered, and how.

v. Data Timing for Risk Adjustment Recalibrations

We have used the three most recent years of MarketScan® data to recalibrate the 2016 and 2017 benefit year risk adjustment models. This approach has allowed for using the blended, or averaged, coefficients from three years of separately solved models, which promotes stability for the risk adjustment coefficients year-to-year, particularly for conditions with small sample sizes. This approach in previous years has also required that we finalize coefficients based on data that does not become available until after the publication of the proposed Payment Notice. We received several comments to the 2017 Payment Notice proposed rule requesting that the Payment Notice schedule be moved up to accommodate substantive comments and to permit issuers more time between the publication of the Payment Notice and the commencement of issuers' certification activities. In order to accommodate commenters' request for an earlier Payment Notice schedule, we would not be able to incorporate an additional recent year of data. We also received many comments on how to best address the data lag for HHS risk adjustment and better reflect new treatments that may be associated with high-cost conditions. We had discussed in the White Paper the use of only 2014 MarketScan® data for the 2018 benefit year recalibration; using blended, three year data coefficients would mitigate any introductions of new costs for particular conditions by two years of older data. However, commenters to the White Paper supported continuing to use a 3-year blend for 2018 benefit year recalibration. We are proposing to continue to use the 3-year blend for 2018 benefit year recalibration.

We noted at the conference that we were considering releasing more recent, updated final coefficients closer to the respective risk adjustment benefit year using more recent data available in guidance after the risk adjustment methodology for the corresponding benefit year has been finalized in the applicable Payment Notice. Commenters supported releasing coefficients closer to the benefit year that reflect the most recent data. We are proposing to amend our regulations at § 153.320(b)(1)(i) to allow for HHS to provide draft coefficients in an annual Payment Notice, as well as the intended datasets to be used to calculate final coefficients and the date by which the final coefficients will be released in guidance. We are considering using 2015, 2016, and 2017 MarketScan® data for 2018 risk adjustment, publishing the final, blended coefficients in the early spring of 2019, prior to final 2018 benefit year risk adjustment calculations. We have previously finalized the risk adjustment methodology, including the final coefficients prior to rate setting and benefits being provided to members. We seek comment on this proposal, specifically the timing of the release of final coefficients and whether such a practice would affect issuer expectations with respect to the methodology to be applied.

We also seek comment on the timing of the publication of the final coefficients, providing a few options to reduce the data lag as much as possible. As the first option, we could release final coefficients for the 2018 benefit year risk adjustment model in the spring of 2017 that would reflect the incorporation of 2015 MarketScan® data, after it becomes available, blended with 2013 and 2014 MarketScan®. On the other hand, we could release final coefficients for the 2018 benefit year risk adjustment model in the spring of 2019, prior to the April 30, 2019, data submission deadline for the 2018 benefit year that would reflect 2015, 2016, and 2017 blended MarketScan® data. We could also provide interim coefficients in the spring of 2018 using 2014, 2015 and 2016 blended MarketScan® data, in addition to the interim coefficients that would be published in the 2018 Payment Notice final rule using 2013 and 2014 data. As noted above, we would continue to finalize the risk adjustment methodology for the corresponding year through notice and comment in the applicable annual Payment Notice.

We seek comment on this proposal.

d. List of Factors To Be Employed in the Model (§ 153.320)

For the 2018 benefit year, in addition to the RXCs we are proposing to include in the adult risk adjustment model, we are also proposing to separate the

Chronic Hepatitis HCC into two new HCCs for Hepatitis C and Hepatitis A and B, in the adult, child, and infant models. This would increase the total HCCs in the HHS risk adjustment methodology from 127 to 128. The proposed factors resulting from the blended factors from the 2013 and 2014 separately solved models (with the incorporation of partial year enrollment and prescription drugs reflected in the adult models only) are shown in the Tables 4 through 9. The adult, child, and infant models have been truncated to account for the high-cost enrollee pool payment parameters ($2 million threshold, 60 percent coinsurance). Table 4 contains factors for each adult model, including the interactions.[32]

Table 5 contains the HHS HCCs in the severity illness indicator variable. Table 6 contains the factors for each child model. Table 6 contains the factors for each infant model.

TABLE 3—FINAL ADULT RISK ADJUSTMENT MODEL FACTORS FOR 2017 BENEFIT YEAR

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Demographic Factors					
Age 21–24, Male	0.199	0.148	0.092	0.056	0.055
Age 25–29, Male	0.189	0.137	0.080	0.043	0.043
Age 30–34, Male	0.245	0.180	0.107	0.059	0.059
Age 35–39, Male	0.312	0.234	0.147	0.089	0.088
Age 40–44, Male	0.391	0.301	0.199	0.130	0.129
Age 45–49, Male	0.471	0.369	0.253	0.174	0.173
Age 50–54, Male	0.611	0.492	0.355	0.260	0.258
Age 55–59, Male	0.701	0.567	0.414	0.306	0.304
Age 60–64, Male	0.810	0.654	0.478	0.349	0.347
Age 21–24, Female	0.339	0.262	0.171	0.111	0.110
Age 25–29, Female	0.399	0.308	0.203	0.132	0.130
Age 30–34, Female	0.539	0.428	0.305	0.224	0.222
Age 35–39, Female	0.633	0.513	0.380	0.294	0.292
Age 40–44, Female	0.713	0.579	0.433	0.336	0.335
Age 45–49, Female	0.724	0.585	0.432	0.327	0.325
Age 50–54, Female	0.821	0.671	0.501	0.382	0.379
Age 55–59, Female	0.829	0.672	0.495	0.367	0.364
Age 60–64, Female	0.876	0.706	0.513	0.372	0.370
Diagnosis Factors					
HIV/AIDS	8.943	8.450	8.099	8.142	8.143
Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	10.685	10.510	10.404	10.460	10.461
Central Nervous System Infections, Except Viral Meningitis	6.636	6.535	6.470	6.491	6.492
Viral or Unspecified Meningitis	4.664	4.428	4.269	4.227	4.227
Opportunistic Infections	8.507	8.406	8.340	8.322	8.321
Metastatic Cancer	24.307	23.874	23.573	23.632	23.633
Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	12.629	12.295	12.061	12.065	12.066
Non-Hodgkin's Lymphomas and Other Cancers and Tumors	5.852	5.617	5.440	5.393	5.392
Colorectal, Breast (Age < 50), Kidney, and Other Cancers	5.159	4.924	4.743	4.695	4.694
Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors	2.965	2.792	2.655	2.602	2.601
Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors	1.459	1.304	1.167	1.076	1.074
Pancreas Transplant Status/Complications	5.458	5.236	5.093	5.115	5.115
Diabetes with Acute Complications	1.192	1.053	0.929	0.825	0.824
Diabetes with Chronic Complications	1.192	1.053	0.929	0.825	0.824
Diabetes without Complication	1.192	1.053	0.929	0.825	0.824
Protein-Calorie Malnutrition	13.677	13.685	13.695	13.756	13.757
Mucopolysaccharidosis	2.285	2.165	2.066	2.013	2.013
Lipidoses and Glycogenosis	2.285	2.165	2.066	2.013	2.013
Amyloidosis, Porphyria, and Other Metabolic Disorders	2.285	2.165	2.066	2.013	2.013
Adrenal, Pituitary, and Other Significant Endocrine Disorders	2.285	2.165	2.066	2.013	2.013
Liver Transplant Status/Complications	16.044	15.870	15.760	15.773	15.773
End-Stage Liver Disease	7.110	6.870	6.712	6.730	6.731
Cirrhosis of Liver	3.856	3.694	3.572	3.538	3.537
Chronic Hepatitis	3.856	3.694	3.572	3.538	3.537
Acute Liver Failure/Disease, Including Neonatal Hepatitis	4.429	4.268	4.158	4.147	4.147
Intestine Transplant Status/Complications	32.610	32.560	32.521	32.564	32.563
Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis	11.825	11.566	11.387	11.416	11.417
Intestinal Obstruction	6.542	6.277	6.105	6.124	6.124

[32] We note that the interaction factors are additive, and not hierarchical in nature—that is, an enrollee could have several, additive interactions.

TABLE 3—FINAL ADULT RISK ADJUSTMENT MODEL FACTORS FOR 2017 BENEFIT YEAR—Continued

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Chronic Pancreatitis	5.458	5.236	5.093	5.115	5.115
Acute Pancreatitis/Other Pancreatic Disorders and Intestinal Malabsorption	2.710	2.522	2.385	2.337	2.336
Inflammatory Bowel Disease	3.667	3.401	3.197	3.105	3.103
Necrotizing Fasciitis	6.581	6.382	6.243	6.258	6.258
Bone/Joint/Muscle Infections/Necrosis	6.581	6.382	6.243	6.258	6.258
Rheumatoid Arthritis and Specified Autoimmune Disorders	4.854	4.592	4.399	4.389	4.389
Systemic Lupus Erythematosus and Other Autoimmune Disorders	1.212	1.077	0.957	0.872	0.871
Osteogenesis Imperfecta and Other Osteodystrophies	3.126	2.927	2.766	2.706	2.705
Congenital/Developmental Skeletal and Connective Tissue Disorders	3.126	2.927	2.766	2.706	2.705
Cleft Lip/Cleft Palate	1.310	1.149	1.020	0.952	0.951
Hemophilia	46.447	46.159	45.940	45.946	45.947
Myelodysplastic Syndromes and Myelofibrosis	12.671	12.534	12.439	12.449	12.449
Aplastic Anemia	12.671	12.534	12.439	12.449	12.449
Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn	9.742	9.580	9.457	9.448	9.448
Sickle Cell Anemia (Hb-SS)	9.742	9.580	9.457	9.448	9.448
Thalassemia Major	9.742	9.580	9.457	9.448	9.448
Combined and Other Severe Immunodeficiencies	5.438	5.290	5.186	5.188	5.188
Disorders of the Immune Mechanism	5.438	5.290	5.186	5.188	5.188
Coagulation Defects and Other Specified Hematological Disorders	2.810	2.712	2.631	2.603	2.603
Drug Psychosis	3.832	3.576	3.381	3.288	3.286
Drug Dependence	3.832	3.576	3.381	3.288	3.286
Schizophrenia	3.196	2.940	2.749	2.685	2.684
Major Depressive and Bipolar Disorders	1.720	1.552	1.408	1.312	1.311
Reactive and Unspecified Psychosis, Delusional Disorders	1.720	1.552	1.408	1.312	1.311
Personality Disorders	1.190	1.054	0.920	0.823	0.822
Anorexia/Bulimia Nervosa	2.704	2.537	2.400	2.342	2.341
Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes	2.648	2.517	2.414	2.364	2.364
Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes	1.073	0.965	0.861	0.788	0.787
Autistic Disorder	1.190	1.054	0.920	0.823	0.822
Pervasive Developmental Disorders, Except Autistic Disorder	1.190	1.054	0.920	0.823	0.822
Traumatic Complete Lesion Cervical Spinal Cord	12.012	11.856	11.742	11.739	11.740
Quadriplegia	12.012	11.856	11.742	11.739	11.740
Traumatic Complete Lesion Dorsal Spinal Cord	9.161	9.003	8.889	8.877	8.877
Paraplegia	9.161	9.003	8.889	8.877	8.877
Spinal Cord Disorders/Injuries	5.641	5.430	5.278	5.249	5.249
Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease	3.027	2.790	2.623	2.583	2.583
Quadriplegic Cerebral Palsy	1.229	1.016	0.855	0.791	0.790
Cerebral Palsy, Except Quadriplegic	0.135	0.073	0.039	0.016	0.015
Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies	0.077	0.022	0.000	0.000	0.000
Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	5.252	5.104	4.998	4.975	4.975
Muscular Dystrophy	2.150	1.984	1.862	1.787	1.786
Multiple Sclerosis	13.598	13.194	12.910	12.956	12.957
Parkinson's, Huntington's, and Spinocerebellar Disease, and Other Neurodegenerative Disorders	2.150	1.984	1.862	1.787	1.786
Seizure Disorders and Convulsions	1.503	1.344	1.213	1.143	1.142
Hydrocephalus	6.394	6.272	6.171	6.144	6.144
Non-Traumatic Coma, and Brain Compression/Anoxic Damage	9.200	9.064	8.958	8.953	8.952
Respirator Dependence/Tracheostomy Status	34.709	34.699	34.698	34.764	34.765
Respiratory Arrest	10.541	10.391	10.296	10.360	10.361
Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes	10.541	10.391	10.296	10.360	10.361
Heart Assistive Device/Artificial Heart	35.115	34.870	34.711	34.771	34.772
Heart Transplant	35.115	34.870	34.711	34.771	34.772
Congestive Heart Failure	3.281	3.173	3.096	3.090	3.090
Acute Myocardial Infarction	10.133	9.797	9.582	9.693	9.695
Unstable Angina and Other Acute Ischemic Heart Disease	5.231	4.955	4.782	4.796	4.797
Heart Infection/Inflammation, Except Rheumatic	6.303	6.168	6.068	6.046	6.046
Specified Heart Arrhythmias	2.834	2.685	2.569	2.515	2.515
Intracranial Hemorrhage	9.426	9.147	8.956	8.965	8.965
Ischemic or Unspecified Stroke	3.167	2.982	2.870	2.875	2.876

TABLE 3—FINAL ADULT RISK ADJUSTMENT MODEL FACTORS FOR 2017 BENEFIT YEAR—Continued

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Cerebral Aneurysm and Arteriovenous Malformation	3.947	3.748	3.605	3.563	3.563
Hemiplegia/Hemiparesis	5.466	5.372	5.315	5.358	5.359
Monoplegia, Other Paralytic Syndromes	3.457	3.324	3.230	3.211	3.211
Atherosclerosis of the Extremities with Ulceration or Gangrene	10.936	10.837	10.782	10.850	10.852
Vascular Disease with Complications	7.731	7.546	7.419	7.419	7.420
Pulmonary Embolism and Deep Vein Thrombosis	3.845	3.678	3.558	3.531	3.531
Lung Transplant Status/Complications	36.420	36.228	36.104	36.181	36.182
Cystic Fibrosis	18.022	17.696	17.452	17.474	17.474
Chronic Obstructive Pulmonary Disease, Including Bronchiectasis	0.951	0.833	0.723	0.648	0.646
Asthma	0.951	0.833	0.723	0.648	0.646
Fibrosis of Lung and Other Lung Disorders	1.894	1.774	1.685	1.644	1.643
Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	7.595	7.521	7.472	7.486	7.486
Kidney Transplant Status	10.187	9.922	9.747	9.738	9.738
End Stage Renal Disease	38.453	38.219	38.071	38.191	38.193
Chronic Kidney Disease, Stage 5	2.087	1.988	1.924	1.919	1.919
Chronic Kidney Disease, Severe (Stage 4)	2.087	1.988	1.924	1.919	1.919
Ectopic and Molar Pregnancy, Except with Renal Failure, Shock, or Embolism	1.357	1.170	0.991	0.806	0.803
Miscarriage with Complications	1.357	1.170	0.991	0.806	0.803
Miscarriage with No or Minor Complications	1.357	1.170	0.991	0.806	0.803
Completed Pregnancy With Major Complications	3.651	3.168	2.877	2.726	2.727
Completed Pregnancy With Complications	3.651	3.168	2.877	2.726	2.727
Completed Pregnancy with No or Minor Complications	3.651	3.168	2.877	2.726	2.727
Chronic Ulcer of Skin, Except Pressure	2.360	2.236	2.153	2.137	2.137
Hip Fractures and Pathological Vertebral or Humerus Fractures	9.462	9.246	9.102	9.137	9.138
Pathological Fractures, Except of Vertebrae, Hip, or Humerus	2.011	1.880	1.766	1.695	1.694
Stem Cell, Including Bone Marrow, Transplant Status/ Complications	31.030	31.024	31.019	31.037	31.037
Artificial Openings for Feeding or Elimination	10.041	9.948	9.888	9.926	9.927
Amputation Status, Lower Limb/Amputation Complications	5.262	5.111	5.014	5.043	5.044
Interaction Factors					
Severe illness × Opportunistic Infections	10.392	10.618	10.787	10.882	10.884
Severe illness × Metastatic Cancer	10.392	10.618	10.787	10.882	10.884
Severe illness × Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	10.392	10.618	10.787	10.882	10.884
Severe illness × Non-Hodgkin's Lymphomas and Other Cancers and Tumors	10.392	10.618	10.787	10.882	10.884
Severe illness × Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	10.392	10.618	10.787	10.882	10.884
Severe illness × Heart Infection/Inflammation, Except Rheumatic	10.392	10.618	10.787	10.882	10.884
Severe illness × Intracranial Hemorrhage	10.392	10.618	10.787	10.882	10.884
Severe illness × HCC group G06 (G06 is HCC Group 6 which includes the following HCCs in the blood disease category: 67, 68)	10.392	10.618	10.787	10.882	10.884
Severe illness × HCC group G08 (G08 is HCC Group 8 which includes the following HCCs in the blood disease category: 73, 74)	10.392	10.618	10.787	10.882	10.884
Severe illness × End-Stage Liver Disease	1.899	2.034	2.136	2.220	2.221
Severe illness × Acute Liver Failure/Disease, Including Neonatal Hepatitis	1.899	2.034	2.136	2.220	2.221
Severe illness × Atherosclerosis of the Extremities with Ulceration or Gangrene	1.899	2.034	2.136	2.220	2.221
Severe illness × Vascular Disease with Complications	1.899	2.034	2.136	2.220	2.221
Severe illness × Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	1.899	2.034	2.136	2.220	2.221
Severe illness × Artificial Openings for Feeding or Elimination	1.899	2.034	2.136	2.220	2.221
Severe illness × HCC group G03 (G03 is HCC Group 3 which includes the following HCCs in the musculoskeletal disease category: 54, 55)	1.899	2.034	2.136	2.220	2.221

TABLE 3—FINAL ADULT RISK ADJUSTMENT MODEL FACTORS FOR 2017 BENEFIT YEAR—Continued

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Enrollment Duration Factors					
One month of enrollment	0.515	0.441	0.396	0.386	0.386
Two months of enrollment	0.454	0.381	0.329	0.318	0.318
Three months of enrollment	0.387	0.321	0.270	0.258	0.258
Four months of enrollment	0.316	0.264	0.221	0.211	0.211
Five months of enrollment	0.273	0.228	0.188	0.176	0.176
Six months of enrollment	0.248	0.208	0.170	0.156	0.156
Seven months of enrollment	0.217	0.186	0.155	0.145	0.144
Eight months of enrollment	0.166	0.142	0.118	0.110	0.109
Nine months of enrollment	0.114	0.103	0.092	0.089	0.089
Ten months of enrollment	0.114	0.103	0.092	0.089	0.089
Eleven months of enrollment	0.100	0.092	0.084	0.082	0.082

TABLE 4—DRAFT ADULT RISK ADJUSTMENT MODEL FACTORS FOR 2018 BENEFIT YEAR

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Demographic Factors						
	Age 21–24, Male	0.176	0.140	0.095	0.052	0.049
	Age 25–29, Male	0.160	0.125	0.080	0.036	0.033
	Age 30–34, Male	0.206	0.160	0.105	0.048	0.044
	Age 35–39, Male	0.270	0.215	0.148	0.079	0.074
	Age 40–44, Male	0.337	0.273	0.196	0.114	0.108
	Age 45–49, Male	0.408	0.335	0.249	0.155	0.149
	Age 50–54, Male	0.533	0.447	0.346	0.234	0.227
	Age 55–59, Male	0.608	0.510	0.397	0.272	0.264
	Age 60–64, Male	0.702	0.588	0.460	0.312	0.304
	Age 21–24, Female	0.303	0.249	0.179	0.106	0.101
	Age 25–29, Female	0.351	0.286	0.207	0.122	0.116
	Age 30–34, Female	0.485	0.405	0.312	0.214	0.209
	Age 35–39, Female	0.572	0.483	0.383	0.280	0.275
	Age 40–44, Female	0.644	0.545	0.434	0.320	0.315
	Age 45–49, Female	0.652	0.549	0.434	0.310	0.304
	Age 50–54, Female	0.738	0.627	0.501	0.361	0.353
	Age 55–59, Female	0.742	0.626	0.496	0.347	0.339
	Age 60–64, Female	0.780	0.654	0.513	0.351	0.341
Diagnosis Factors						
HCC001	HIV/AIDS	6.183	5.760	5.473	5.469	5.539
HCC002	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock.	9.552	9.383	9.283	9.330	9.368
HCC003	Central Nervous System Infections, Except Viral Meningitis.	6.422	6.330	6.272	6.293	6.313
HCC004	Viral or Unspecified Meningitis	4.503	4.287	4.163	4.106	4.139
HCC006	Opportunistic Infections	7.320	7.228	7.177	7.153	7.165
HCC008	Metastatic Cancer	22.731	22.324	22.054	22.096	22.169
HCC009	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia.	11.734	11.425	11.226	11.215	11.265
HCC010	Non-Hodgkin's Lymphomas and Other Cancers and Tumors.	5.463	5.251	5.110	5.051	5.077
HCC011	Colorectal, Breast (Age <50), Kidney, and Other Cancers.	4.767	4.556	4.412	4.350	4.375
HCC012	Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors.	2.781	2.627	2.522	2.457	2.472
HCC013	Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors.	1.329	1.199	1.101	0.996	1.002
HCC018	Pancreas Transplant Status/Complications.	4.775	4.576	4.459	4.475	4.514
HCC019	Diabetes with Acute Complications	0.647	0.575	0.511	0.432	0.430
HCC020	Diabetes with Chronic Complications	0.647	0.575	0.511	0.432	0.430
HCC021	Diabetes without Complication	0.647	0.575	0.511	0.432	0.430
HCC023	Protein-Calorie Malnutrition	12.908	12.906	12.897	12.961	12.969
HCC026	Mucopolysaccharidosis	2.037	1.934	1.861	1.798	1.806
HCC027	Lipidoses and Glycogenosis	2.037	1.934	1.861	1.798	1.806

TABLE 4—DRAFT ADULT RISK ADJUSTMENT MODEL FACTORS FOR 2018 BENEFIT YEAR—Continued

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
HCC029	Amyloidosis, Porphyria, and Other Metabolic Disorders.	2.037	1.934	1.861	1.798	1.806
HCC030	Adrenal, Pituitary, and Other Significant Endocrine Disorders.	2.037	1.934	1.861	1.798	1.806
HCC034	Liver Transplant Status/Complications	11.899	11.778	11.711	11.700	11.720
HCC035	End-Stage Liver Disease	3.843	3.664	3.556	3.533	3.561
HCC036	Cirrhosis of Liver	1.336	1.218	1.144	1.089	1.101
HCC037C	Chronic Viral Hepatitis C	0.913	0.801	0.726	0.667	0.677
HCC037B	Chronic Hepatitis, Other/Unspecified	0.913	0.801	0.726	0.667	0.677
HCC038	Acute Liver Failure/Disease, Including Neonatal Hepatitis.	3.843	3.664	3.556	3.533	3.561
HCC041	Intestine Transplant Status/Complications	30.139	30.077	30.019	30.075	30.090
HCC042	Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis.	10.733	10.494	10.340	10.353	10.395
HCC045	Intestinal Obstruction	6.002	5.756	5.611	5.611	5.654
HCC046	Chronic Pancreatitis	4.775	4.576	4.459	4.475	4.514
HCC047	Acute Pancreatitis/Other Pancreatic Disorders and Intestinal Malabsorption.	2.419	2.255	2.152	2.092	2.112
HCC048	Inflammatory Bowel Disease	2.046	1.872	1.751	1.655	1.669
HCC054	Necrotizing Fasciitis	6.007	5.828	5.710	5.716	5.748
HCC055	Bone/Joint/Muscle Infections/Necrosis	6.007	5.828	5.710	5.716	5.748
HCC056	Rheumatoid Arthritis and Specified Autoimmune Disorders.	2.278	2.137	2.035	1.968	1.982
HCC057	Systemic Lupus Erythematosus and Other Autoimmune Disorders.	1.030	0.918	0.836	0.737	0.740
HCC061	Osteogenesis Imperfecta and Other Osteodystrophies.	2.905	2.727	2.600	2.526	2.543
HCC062	Congenital/Developmental Skeletal and Connective Tissue Disorders.	2.905	2.727	2.600	2.526	2.543
HCC063	Cleft Lip/Cleft Palate	1.143	1.002	0.908	0.827	0.839
HCC066	Hemophilia	42.231	41.976	41.792	41.785	41.825
HCC067	Myelodysplastic Syndromes and Myelofibrosis.	12.207	12.080	11.999	12.004	12.026
HCC068	Aplastic Anemia	12.207	12.080	11.999	12.004	12.026
HCC069	Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn.	8.782	8.635	8.534	8.511	8.532
HCC070	Sickle Cell Anemia (Hb-SS)	8.782	8.635	8.534	8.511	8.532
HCC071	Thalassemia Major	8.782	8.635	8.534	8.511	8.532
HCC073	Combined and Other Severe Immunodeficiencies.	4.911	4.779	4.696	4.688	4.709
HCC074	Disorders of the Immune Mechanism	4.911	4.779	4.696	4.688	4.709
HCC075	Coagulation Defects and Other Specified Hematological Disorders.	2.568	2.480	2.417	2.380	2.388
HCC081	Drug Psychosis	3.749	3.517	3.368	3.255	3.277
HCC082	Drug Dependence	3.749	3.517	3.368	3.255	3.277
HCC087	Schizophrenia	3.103	2.871	2.722	2.639	2.668
HCC088	Major Depressive and Bipolar Disorders	1.630	1.484	1.381	1.273	1.282
HCC089	Reactive and Unspecified Psychosis, Delusional Disorders.	1.630	1.484	1.381	1.273	1.282
HCC090	Personality Disorders	1.142	1.028	0.930	0.819	0.820
HCC094	Anorexia/Bulimia Nervosa	2.692	2.539	2.431	2.367	2.382
HCC096	Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes.	2.409	2.290	2.211	2.148	2.159
HCC097	Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes.	0.849	0.756	0.680	0.594	0.595
HCC102	Autistic Disorder	1.142	1.028	0.930	0.819	0.820
HCC103	Pervasive Developmental Disorders, Except Autistic Disorder.	1.142	1.028	0.930	0.819	0.820
HCC106	Traumatic Complete Lesion Cervical Spinal Cord.	11.189	11.036	10.934	10.921	10.945
HCC107	Quadriplegia	11.189	11.036	10.934	10.921	10.945
HCC108	Traumatic Complete Lesion Dorsal Spinal Cord.	8.762	8.617	8.520	8.501	8.523
HCC109	Paraplegia	8.762	8.617	8.520	8.501	8.523
HCC110	Spinal Cord Disorders/Injuries	5.523	5.325	5.201	5.163	5.191
HCC111	Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease.	2.567	2.353	2.220	2.162	2.191
HCC112	Quadriplegic Cerebral Palsy	1.020	0.881	0.784	0.706	0.716
HCC113	Cerebral Palsy, Except Quadriplegic	0.168	0.111	0.070	0.030	0.033
HCC114	Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies.	0.046	0.000	0.000	0.000	0.000

TABLE 4—DRAFT ADULT RISK ADJUSTMENT MODEL FACTORS FOR 2018 BENEFIT YEAR—Continued

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
HCC115	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy.	5.158	5.020	4.933	4.905	4.924
HCC117	Muscular Dystrophy	2.075	1.927	1.838	1.751	1.763
HCC118	Multiple Sclerosis	3.652	3.459	3.335	3.267	3.289
HCC119	Parkinson's, Huntington's, and Spinocerebellar Disease, and Other Neurodegenerative Disorders.	2.075	1.927	1.838	1.751	1.763
HCC120	Seizure Disorders and Convulsions	1.447	1.308	1.211	1.127	1.137
HCC121	Hydrocephalus	5.884	5.771	5.685	5.652	5.667
HCC122	Non-Traumatic Coma, and Brain Compression/Anoxic Damage.	8.606	8.480	8.389	8.378	8.396
HCC125	Respirator Dependence/Tracheostomy Status.	32.063	32.042	32.021	32.093	32.106
HCC126	Respiratory Arrest	9.458	9.316	9.223	9.280	9.312
HCC127	Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes.	9.458	9.316	9.223	9.280	9.312
HCC128	Heart Assistive Device/Artificial Heart	31.966	31.751	31.611	31.636	31.677
HCC129	Heart Transplant	31.966	31.751	31.611	31.636	31.677
HCC130	Congestive Heart Failure	2.074	1.978	1.912	1.873	1.883
HCC131	Acute Myocardial Infarction	9.396	9.079	8.878	8.975	9.044
HCC132	Unstable Angina and Other Acute Ischemic Heart Disease.	4.759	4.510	4.368	4.366	4.412
HCC135	Heart Infection/Inflammation, Except Rheumatic.	5.703	5.585	5.507	5.477	5.492
HCC142	Specified Heart Arrhythmias	2.065	1.948	1.869	1.802	1.811
HCC145	Intracranial Hemorrhage	8.616	8.359	8.198	8.189	8.231
HCC146	Ischemic or Unspecified Stroke	2.891	2.725	2.634	2.629	2.660
HCC149	Cerebral Aneurysm and Arteriovenous Malformation.	3.677	3.501	3.391	3.335	3.357
HCC150	Hemiplegia/Hemiparesis	4.955	4.864	4.808	4.848	4.869
HCC151	Monoplegia, Other Paralytic Syndromes	3.104	2.983	2.909	2.881	2.899
HCC153	Atherosclerosis of the Extremities with Ulceration or Gangrene.	9.488	9.411	9.360	9.434	9.459
HCC154	Vascular Disease with Complications	7.268	7.097	6.989	6.978	7.005
HCC156	Pulmonary Embolism and Deep Vein Thrombosis.	3.480	3.331	3.236	3.195	3.215
HCC158	Lung Transplant Status/Complications	31.358	31.201	31.097	31.176	31.215
HCC159	Cystic Fibrosis	7.004	6.736	6.550	6.529	6.569
HCC160	Chronic Obstructive Pulmonary Disease, Including Bronchiectasis.	0.897	0.797	0.718	0.631	0.634
HCC161	Asthma	0.897	0.797	0.718	0.631	0.634
HCC162	Fibrosis of Lung and Other Lung Disorders.	1.730	1.624	1.557	1.508	1.518
HCC163	Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections.	6.798	6.731	6.689	6.697	6.711
HCC183	Kidney Transplant Status	7.065	6.838	6.705	6.674	6.710
HCC184	End Stage Renal Disease	23.772	23.578	23.450	23.516	23.559
HCC187	Chronic Kidney Disease, Stage 5	0.395	0.326	0.286	0.280	0.292
HCC188	Chronic Kidney Disease, Severe (Stage 4).	0.395	0.326	0.286	0.280	0.292
HCC203	Ectopic and Molar Pregnancy, Except with Renal Failure, Shock, or Embolism.	1.283	1.127	1.008	0.814	0.806
HCC204	Miscarriage with Complications	1.283	1.127	1.008	0.814	0.806
HCC205	Miscarriage with No or Minor Complications.	1.283	1.127	1.008	0.814	0.806
HCC207	Completed Pregnancy With Major Complications.	3.466	3.027	2.823	2.625	2.694
HCC208	Completed Pregnancy With Complications.	3.466	3.027	2.823	2.625	2.694
HCC209	Completed Pregnancy with No or Minor Complications.	3.466	3.027	2.823	2.625	2.694
HCC217	Chronic Ulcer of Skin, Except Pressure	2.003	1.903	1.843	1.825	1.840
HCC226	Hip Fractures and Pathological Vertebral or Humerus Fractures.	9.015	8.812	8.682	8.709	8.747
HCC227	Pathological Fractures, Except of Vertebrae, Hip, or Humerus.	2.028	1.913	1.830	1.750	1.758
HCC251	Stem Cell, Including Bone Marrow, Transplant Status/Complications.	28.116	28.117	28.113	28.139	28.143

TABLE 4—DRAFT ADULT RISK ADJUSTMENT MODEL FACTORS FOR 2018 BENEFIT YEAR—Continued

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
HCC253	Artificial Openings for Feeding or Elimination.	9.095	9.005	8.946	8.979	8.999
HCC254	Amputation Status, Lower Limb/Amputation Complications.	4.508	4.378	4.298	4.323	4.351
	Interaction Factors					
SEVERE × HCC006	Severe illness × Opportunistic Infections	9.355	9.550	9.669	9.785	9.768
SEVERE × HCC008	Severe illness × Metastatic Cancer	9.355	9.550	9.669	9.785	9.768
SEVERE × HCC009	Severe illness × Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia.	9.355	9.550	9.669	9.785	9.768
SEVERE × HCC010	Severe illness × Non-Hodgkin's Lymphomas and Other Cancers and Tumors.	9.355	9.550	9.669	9.785	9.768
SEVERE × HCC115	Severe illness × Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy.	9.355	9.550	9.669	9.785	9.768
SEVERE × HCC135	Severe illness × Heart Infection/Inflammation, Except Rheumatic.	9.355	9.550	9.669	9.785	9.768
SEVERE × HCC145	Severe illness × Intracranial Hemorrhage	9.355	9.550	9.669	9.785	9.768
SEVERE × G06	Severe illness × HCC group G06 (G06 is HCC Group 6 which includes the following HCCs in the blood disease category: 67, 68).	9.355	9.550	9.669	9.785	9.768
SEVERE × G08	Severe illness × HCC group G08 (G08 is HCC Group 8 which includes the following HCCs in the blood disease category: 73, 74).	9.355	9.550	9.669	9.785	9.768
SEVERE × HCC035	Severe illness × End-Stage Liver Disease.	1.895	2.007	2.070	2.170	2.164
SEVERE × HCC038	Severe illness × Acute Liver Failure/Disease, Including Neonatal Hepatitis.	1.895	2.007	2.070	2.170	2.164
SEVERE × HCC153	Severe illness × Atherosclerosis of the Extremities with Ulceration or Gangrene.	1.895	2.007	2.070	2.170	2.164
SEVERE × HCC154	Severe illness × Vascular Disease with Complications.	1.895	2.007	2.070	2.170	2.164
SEVERE × HCC163	Severe illness × Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections.	1.895	2.007	2.070	2.170	2.164
SEVERE × HCC253	Severe illness × Artificial Openings for Feeding or Elimination.	1.895	2.007	2.070	2.170	2.164
SEVERE × G03	Severe illness × HCC group G03 (G03 is HCC Group 3 which includes the following HCCs in the musculoskeletal disease category: 54, 55).	1.895	2.007	2.070	2.170	2.164
	Enrollment Duration Factors					
	One month of enrollment	0.526	0.470	0.427	0.411	0.414
	Two months of enrollment	0.434	0.381	0.335	0.316	0.319
	Three months of enrollment	0.386	0.337	0.291	0.270	0.272
	Four months of enrollment	0.303	0.264	0.226	0.209	0.211
	Five months of enrollment	0.263	0.229	0.194	0.175	0.176
	Six months of enrollment	0.241	0.212	0.180	0.163	0.163
	Seven months of enrollment	0.214	0.190	0.163	0.148	0.148
	Eight months of enrollment	0.166	0.148	0.128	0.115	0.116
	Nine months of enrollment	0.111	0.100	0.089	0.085	0.085
	Ten months of enrollment	0.106	0.098	0.089	0.085	0.085
	Eleven months of enrollment	0.088	0.083	0.079	0.077	0.077
	Prescription Drug Utilization Indicators					
RXC 01	Anti-Hepatitis C (HCV) Agents	23.898	23.451	23.158	23.236	23.320
RXC 02	Anti-HIV Agents	6.331	5.889	5.594	5.432	5.482
RXC 03	Antiarrhythmics	2.320	2.226	2.149	2.079	2.083
RXC 04	Phosphate Binders	13.417	13.308	13.238	13.249	13.271
RXC 05	Inflammatory Bowel Disease Agents	1.990	1.822	1.708	1.541	1.543
RXC 06b	Insulin	1.379	1.258	1.134	0.975	0.966

TABLE 4—DRAFT ADULT RISK ADJUSTMENT MODEL FACTORS FOR 2018 BENEFIT YEAR—Continued

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
RXC 06a	Anti-Diabetic Agents, Except Insulin and Metformin Only.	0.575	0.502	0.428	0.326	0.319
RXC 07	Multiple Sclerosis Agents	16.971	16.286	15.836	15.832	15.945
RXC 08	Immune Suppressants and Immunomodulators.	10.134	9.586	9.234	9.242	9.339
RXC 09	Cystic Fibrosis Agents	17.443	17.133	16.931	17.071	17.144
RXC 01 × HCC37C, 036, 035, 034	Additional effect for enrollees with RXC Anti-Hepatitis C (HCV) Agents and HCC (Liver Transplant Status/Complications or End-Stage Liver Disease or Cirrhosis of Liver or Chronic Viral Hepatitis).	3.212	3.350	3.439	3.522	3.512
RXC 02 × HCC001	Additional effect for enrollees with RXC Anti-HIV Agents and HCC HIV/AIDS.	−2.238	−1.888	−1.645	−1.437	−1.465
RXC 03 × HCC142	Additional effect for enrollees with RXC Antiarrhythmics and HCC Specified Heart Arrhythmias.	−0.102	−0.076	−0.035	0.037	0.046
RXC 04 × HCC184, 183, 187, 188	Additional effect for enrollees with RXC Phosphate Binders and HCC (End Stage Renal Disease or Kidney Transplant Status or Chronic Kidney Disease, Stage 5 or Chronic Kidney Disease, Severe (Stage 4)).	7.775	7.850	7.890	7.978	7.973
RXC 05 × HCC048, 041	Additional effect for enrollees with RXC Inflammatory Bowel Disease Agents and (HCC Inflammatory Bowel Disease or Intestine Transplant Status/Complications).	−1.296	−1.208	−1.126	−1.028	−1.026
RXC 06b × HCC018, 019, 020, 021	Additional effect for enrollees with RXC Insulin and (HCC Pancreas Transplant Status/Complications or Diabetes with Acute Complications or Diabetes with Chronic Complications or Diabetes without Complication).	0.265	0.233	0.289	0.371	0.397
RXC 06a × HCC018, 019, 020, 021	Additional effect for enrollees with RXC Anti-Diabetic Agents, Except Insulin and Metformin Only and (HCC Pancreas Transplant Status/Complications or Diabetes with Acute Complications or Diabetes with Chronic Complications or Diabetes without Complication).	−0.203	−0.184	−0.141	−0.118	−0.116
RXC 07 × HCC118	Additional effect for enrollees with RXC Multiple Sclerosis Agents and HCC Multiple Sclerosis.	−1.213	−0.849	−0.619	−0.449	−0.484
RXC 08 × HCC056 or 057, and 048 or 041.	Additional effect for enrollees with RXC Immune Suppressants and Immunomodulators and (HCC Inflammatory Bowel Disease or Intestine Transplant Status/Complications) and (HCC Rheumatoid Arthritis and Specified Autoimmune Disorders or Systemic Lupus Erythematosus and Other Autoimmune Disorders).	0.022	0.024	0.038	0.012	0.009
RXC 08 × HCC056	Additional effect for enrollees with RXC Immune Suppressants and Immunomodulators and HCC Rheumatoid Arthritis and Specified Autoimmune Disorders.	−1.934	−1.747	−1.615	−1.481	−1.495
RXC 08 × HCC057	Additional effect for enrollees with RXC Immune Suppressants and Immunomodulators and HCC Systemic Lupus Erythematosus and Other Autoimmune Disorders.	−0.891	−0.759	−0.656	−0.522	−0.526
RXC 08 × HCC048, 041	Additional effect for enrollees with RXC Immune Suppressants and Immunomodulators and (HCC Inflammatory Bowel Disease or Intestine Transplant Status/Complications).	0.948	1.194	1.330	1.513	1.493

TABLE 4—DRAFT ADULT RISK ADJUSTMENT MODEL FACTORS FOR 2018 BENEFIT YEAR—Continued

HCC or RXC No.	Factor	Platinum	Gold	Silver	Bronze	Catastrophic
RXC 09 × HCC159, 158	Additional effect for enrollees with RXC Cystic Fibrosis Agents and (HCC Cystic Fibrosis or Lung Transplant Status/Complications).	18.100	18.294	18.402	18.379	18.340
RXC 10 × HCC036, 035, 034	Additional effect for enrollees with RXC Ammonia Detoxicants and (HCC Liver Transplant Status/Complications or End-Stage Liver Disease or Cirrhosis of Liver).	7.113	7.080	7.054	7.145	7.164
RXC 11 × HCC130, 129, 128	Additional effect for enrollees with RXC Diuretics, Loop and Select Potassium-sparing and (HCC Heart Assistive Device/Artificial Heart or Heart Transplant or Congestive Heart Failure).	2.263	2.270	2.284	2.369	2.382

TABLE 5—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 6—DRAFT CHILD RISK ADJUSTMENT MODEL FACTORS FOR 2018 BENEFIT YEAR

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Demographic Factors					
Age 2–4, Male	0.207	0.151	0.085	0.029	0.025
Age 5–9, Male	0.142	0.102	0.053	0.011	0.008
Age 10–14, Male	0.204	0.160	0.103	0.057	0.053
Age 15–20, Male	0.271	0.220	0.158	0.102	0.098
Age 2–4, Female	0.163	0.114	0.058	0.015	0.012
Age 5–9, Female	0.116	0.081	0.039	0.008	0.006
Age 10–14, Female	0.192	0.150	0.099	0.059	0.056
Age 15–20, Female	0.309	0.250	0.177	0.109	0.104
Diagnosis Factors					
HIV/AIDS	4.686	4.277	4.006	3.895	3.948
Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	15.212	15.056	14.964	14.980	15.011
Central Nervous System Infections, Except Viral Meningitis	9.957	9.790	9.682	9.681	9.708
Viral or Unspecified Meningitis	2.484	2.302	2.192	2.092	2.112
Opportunistic Infections	20.790	20.728	20.685	20.673	20.682
Metastatic Cancer	32.805	32.584	32.417	32.401	32.434
Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	11.049	10.801	10.617	10.544	10.573
Non-Hodgkin's Lymphomas and Other Cancers and Tumors	8.747	8.507	8.333	8.231	8.255
Colorectal, Breast (Age <50), Kidney, and Other Cancers	3.175	2.986	2.846	2.724	2.737
Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors	2.813	2.640	2.513	2.398	2.408
Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors	1.561	1.423	1.311	1.190	1.194
Pancreas Transplant Status/Complications	26.035	25.914	25.841	25.846	25.867
Diabetes with Acute Complications	2.340	2.054	1.887	1.622	1.632
Diabetes with Chronic Complications	2.340	2.054	1.887	1.622	1.632
Diabetes without Complication	2.340	2.054	1.887	1.622	1.632
Protein-Calorie Malnutrition	12.106	12.025	11.965	11.995	12.012
Mucopolysaccharidosis	8.087	7.841	7.660	7.612	7.644
Lipidoses and Glycogenosis	8.087	7.841	7.660	7.612	7.644
Congenital Metabolic Disorders, Not Elsewhere Classified	8.087	7.841	7.660	7.612	7.644

TABLE 6—DRAFT CHILD RISK ADJUSTMENT MODEL FACTORS FOR 2018 BENEFIT YEAR—Continued

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Amyloidosis, Porphyria, and Other Metabolic Disorders	8.087	7.841	7.660	7.612	7.644
Adrenal, Pituitary, and Other Significant Endocrine Disorders	8.087	7.841	7.660	7.612	7.644
Liver Transplant Status/Complications	26.035	25.914	25.841	25.846	25.867
End-Stage Liver Disease	11.991	11.852	11.762	11.751	11.773
Cirrhosis of Liver	9.308	9.167	9.070	9.044	9.062
Chronic Viral Hepatitis C	4.024	3.889	3.787	3.730	3.743
Chronic Hepatitis, Other/Unspecified	2.271	2.151	2.049	1.965	1.971
Acute Liver Failure/Disease, Including Neonatal Hepatitis	11.991	11.852	11.762	11.751	11.773
Intestine Transplant Status/Complications	26.035	25.914	25.841	25.846	25.867
Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis	13.534	13.230	13.022	13.021	13.071
Intestinal Obstruction	4.748	4.541	4.395	4.297	4.317
Chronic Pancreatitis	9.837	9.629	9.502	9.493	9.527
Acute Pancreatitis/Other Pancreatic Disorders and Intestinal Malabsorption	2.186	2.075	1.987	1.889	1.892
Inflammatory Bowel Disease	6.044	5.699	5.465	5.348	5.386
Necrotizing Fasciitis	3.999	3.795	3.647	3.572	3.596
Bone/Joint/Muscle Infections/Necrosis	3.999	3.795	3.647	3.572	3.596
Rheumatoid Arthritis and Specified Autoimmune Disorders	3.788	3.572	3.404	3.301	3.321
Systemic Lupus Erythematosus and Other Autoimmune Disorders	1.335	1.216	1.112	0.990	0.989
Osteogenesis Imperfecta and Other Osteodystrophies	1.489	1.379	1.285	1.201	1.206
Congenital/Developmental Skeletal and Connective Tissue Disorders	1.489	1.379	1.285	1.201	1.206
Cleft Lip/Cleft Palate	1.502	1.322	1.192	1.064	1.075
Hemophilia	55.750	55.302	54.985	54.945	55.012
Myelodysplastic Syndromes and Myelofibrosis	15.915	15.761	15.654	15.632	15.652
Aplastic Anemia	15.915	15.761	15.654	15.632	15.652
Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn	7.294	7.048	6.875	6.784	6.812
Sickle Cell Anemia (Hb-SS)	7.294	7.048	6.875	6.784	6.812
Thalassemia Major	7.294	7.048	6.875	6.784	6.812
Combined and Other Severe Immunodeficiencies	6.252	6.092	5.982	5.915	5.931
Disorders of the Immune Mechanism	6.252	6.092	5.982	5.915	5.931
Coagulation Defects and Other Specified Hematological Disorders	4.546	4.429	4.333	4.257	4.264
Drug Psychosis	5.380	5.147	4.999	4.923	4.952
Drug Dependence	5.380	5.147	4.999	4.923	4.952
Schizophrenia	5.083	4.726	4.492	4.375	4.420
Major Depressive and Bipolar Disorders	1.873	1.677	1.527	1.350	1.356
Reactive and Unspecified Psychosis, Delusional Disorders	1.873	1.677	1.527	1.350	1.356
Personality Disorders	0.729	0.624	0.520	0.377	0.372
Anorexia/Bulimia Nervosa	2.892	2.708	2.576	2.504	2.524
Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes	3.492	3.304	3.194	3.154	3.180
Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes	1.736	1.577	1.469	1.376	1.390
Autistic Disorder	1.671	1.512	1.383	1.224	1.226
Pervasive Developmental Disorders, Except Autistic Disorder	0.835	0.726	0.612	0.447	0.437
Traumatic Complete Lesion Cervical Spinal Cord	12.558	12.507	12.489	12.562	12.579
Quadriplegia	12.558	12.507	12.489	12.562	12.579
Traumatic Complete Lesion Dorsal Spinal Cord	12.180	12.010	11.883	11.877	11.912
Paraplegia	12.180	12.010	11.883	11.877	11.912
Spinal Cord Disorders/Injuries	4.250	4.044	3.905	3.816	3.836
Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease	7.619	7.407	7.257	7.196	7.221
Quadriplegic Cerebral Palsy	2.991	2.764	2.631	2.634	2.675
Cerebral Palsy, Except Quadriplegic	0.778	0.617	0.514	0.422	0.436
Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies	1.275	1.146	1.054	0.976	0.986
Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	8.788	8.631	8.520	8.481	8.502
Muscular Dystrophy	2.941	2.765	2.650	2.563	2.580
Multiple Sclerosis	7.769	7.471	7.263	7.206	7.246
Parkinson's, Huntington's, and Spinocerebellar Disease, and Other Neurodegenerative Disorders	2.941	2.765	2.650	2.563	2.580
Seizure Disorders and Convulsions	1.905	1.753	1.628	1.483	1.486
Hydrocephalus	4.590	4.479	4.408	4.389	4.406
Non-Traumatic Coma, and Brain Compression/Anoxic Damage	6.647	6.522	6.434	6.385	6.397

TABLE 6—DRAFT CHILD RISK ADJUSTMENT MODEL FACTORS FOR 2018 BENEFIT YEAR—Continued

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Respirator Dependence/Tracheostomy Status	34.991	34.882	34.817	34.931	34.967
Respiratory Arrest	11.820	11.625	11.511	11.500	11.535
Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes	11.820	11.625	11.511	11.500	11.535
Heart Assistive Device/Artificial Heart	26.035	25.914	25.841	25.846	25.867
Heart Transplant	26.035	25.914	25.841	25.846	25.867
Congestive Heart Failure	6.567	6.472	6.394	6.342	6.348
Acute Myocardial Infarction	9.084	8.927	8.826	8.828	8.852
Unstable Angina and Other Acute Ischemic Heart Disease	5.051	4.971	4.917	4.926	4.938
Heart Infection/Inflammation, Except Rheumatic	14.351	14.240	14.165	14.137	14.149
Hypoplastic Left Heart Syndrome and Other Severe Congenital Heart Disorders	5.764	5.584	5.432	5.305	5.313
Major Congenital Heart/Circulatory Disorders	1.573	1.475	1.361	1.239	1.235
Atrial and Ventricular Septal Defects, Patent Ductus Arteriosus, and Other Congenital Heart/Circulatory Disorders	1.097	1.010	0.908	0.808	0.807
Specified Heart Arrhythmias	3.684	3.526	3.401	3.320	3.333
Intracranial Hemorrhage	14.176	13.948	13.803	13.784	13.820
Ischemic or Unspecified Stroke	7.895	7.786	7.721	7.720	7.739
Cerebral Aneurysm and Arteriovenous Malformation	3.545	3.356	3.235	3.172	3.192
Hemiplegia/Hemiparesis	4.484	4.389	4.333	4.314	4.330
Monoplegia, Other Paralytic Syndromes	3.148	3.018	2.937	2.899	2.917
Atherosclerosis of the Extremities with Ulceration or Gangrene	14.633	14.377	14.225	14.131	14.168
Vascular Disease with Complications	16.113	15.969	15.873	15.876	15.899
Pulmonary Embolism and Deep Vein Thrombosis	14.661	14.521	14.435	14.448	14.475
Lung Transplant Status/Complications	26.035	25.914	25.841	25.846	25.867
Cystic Fibrosis	19.127	18.718	18.428	18.452	18.522
Chronic Obstructive Pulmonary Disease, Including Bronchiectasis	0.396	0.334	0.249	0.153	0.147
Asthma	0.396	0.334	0.249	0.153	0.147
Fibrosis of Lung and Other Lung Disorders	4.160	4.036	3.936	3.862	3.873
Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	10.367	10.322	10.287	10.315	10.324
Kidney Transplant Status	15.081	14.777	14.581	14.566	14.616
End Stage Renal Disease	38.217	38.061	37.962	38.031	38.065
Chronic Kidney Disease, Stage 5	3.038	2.903	2.802	2.685	2.688
Chronic Kidney Disease, Severe (Stage 4)	3.038	2.903	2.802	2.685	2.688
Ectopic and Molar Pregnancy, Except with Renal Failure, Shock, or Embolism	1.033	0.878	0.754	0.549	0.541
Miscarriage with Complications	1.033	0.878	0.754	0.549	0.541
Miscarriage with No or Minor Complications	1.033	0.878	0.754	0.549	0.541
Completed Pregnancy With Major Complications	2.991	2.587	2.391	2.161	2.216
Completed Pregnancy With Complications	2.991	2.587	2.391	2.161	2.216
Completed Pregnancy with No or Minor Complications	2.991	2.587	2.391	2.161	2.216
Chronic Ulcer of Skin, Except Pressure	2.057	1.969	1.888	1.819	1.823
Hip Fractures and Pathological Vertebral or Humerus Fractures	5.729	5.486	5.302	5.192	5.214
Pathological Fractures, Except of Vertebrae, Hip, or Humerus	1.351	1.233	1.116	0.982	0.977
Stem Cell, Including Bone Marrow, Transplant Status/ Complications	26.035	25.914	25.841	25.846	25.867
Artificial Openings for Feeding or Elimination	13.409	13.305	13.251	13.357	13.391
Amputation Status, Lower Limb/Amputation Complications	7.806	7.556	7.407	7.306	7.336

TABLE 7—DRAFT INFANT RISK ADJUSTMENT MODEL FACTORS FOR 2018 BENEFIT YEAR

Group	Platinum	Gold	Silver	Bronze	Catastrophic
Extremely Immature * Severity Level 5 (Highest)	336.506	335.265	334.332	334.271	334.459
Extremely Immature * Severity Level 4	183.468	182.244	181.331	181.224	181.402
Extremely Immature * Severity Level 3	70.513	69.447	68.657	68.493	68.642
Extremely Immature * Severity Level 2	29.465	28.557	27.854	27.519	27.614
Extremely Immature * Severity Level 1 (Lowest)	29.465	28.557	27.854	27.519	27.614
Immature * Severity Level 5 (Highest)	178.009	176.784	175.861	175.795	175.980
Immature * Severity Level 4	80.832	79.582	78.649	78.554	78.740
Immature * Severity Level 3	45.204	44.114	43.299	43.140	43.289
Immature * Severity Level 2	29.465	28.557	27.854	27.519	27.614
Immature * Severity Level 1 (Lowest)	26.402	25.374	24.608	24.351	24.477
Premature/Multiples * Severity Level 5 (Highest)	133.590	132.392	131.511	131.378	131.555
Premature/Multiples * Severity Level 4	30.629	29.458	28.605	28.391	28.552

TABLE 7—DRAFT INFANT RISK ADJUSTMENT MODEL FACTORS FOR 2018 BENEFIT YEAR—Continued

Group	Platinum	Gold	Silver	Bronze	Catastrophic
Premature/Multiples * Severity Level 3	16.302	15.378	14.694	14.308	14.399
Premature/Multiples * Severity Level 2	8.445	7.691	7.131	6.599	6.637
Premature/Multiples * Severity Level 1 (Lowest)	5.825	5.277	4.774	4.196	4.187
Term * Severity Level 5 (Highest)	115.287	114.176	113.343	113.147	113.297
Term * Severity Level 4	16.144	15.252	14.603	14.155	14.235
Term * Severity Level 3	6.053	5.490	4.998	4.409	4.397
Term * Severity Level 2	3.715	3.284	2.849	2.209	2.166
Term * Severity Level 1 (Lowest)	1.570	1.351	0.965	0.436	0.387
Age 1 * Severity Level 5 (Highest)	49.286	48.692	48.242	48.122	48.198
Age 1 * Severity Level 4	8.659	8.213	7.871	7.641	7.678
Age 1 * Severity Level 3	3.182	2.901	2.635	2.374	2.380
Age 1 * Severity Level 2	1.997	1.779	1.544	1.267	1.257
Age 1 * Severity Level 1 (Lowest)	0.529	0.441	0.299	0.196	0.189
Age 0 Male	0.601	0.558	0.540	0.494	0.490
Age 1 Male	0.140	0.123	0.112	0.085	0.084

TABLE 8—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 9—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 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.

TABLE 9—HHS HCCS INCLUDED IN INFANT MODEL SEVERITY CATEGORIES—Continued

Severity category	HCC
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 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 Level 1	Autistic Disorder.

TABLE 9—HHS HCCs INCLUDED IN INFANT MODEL SEVERITY CATEGORIES—Continued

Severity category	HCC
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.

e. Cost-Sharing Reductions (§ 153.320)

We propose to continue including an adjustment for the receipt of cost-sharing reductions in the model to account for increased plan liability due to increased utilization of health care services by enrollees receiving cost-sharing reductions. The proposed cost-sharing reductions adjustment factors for 2018 risk adjustment are unchanged from those finalized in the 2017 Payment Notice and are set forth in Table 10. These adjustments are effective for 2016, 2017, and 2018 risk adjustment, and are multiplied against the sum of the demographic, diagnosis, and interaction factors. We anticipate adjusting these factors in the annual HHS notice of benefit and payment parameters for the 2019 benefit year as additional enrollee-level data from the individual market becomes available. We seek comment on this approach.

TABLE 10—COST-SHARING REDUCTIONS ADJUSTMENT

Household income	Plan AV	Induced utilization factor
Silver Plan Variant Recipients		
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
Zero Cost-Sharing Recipients		
<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
Limited Cost-Sharing Recipients		
>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

f. Model Performance Statistics (§ 153.320)

To evaluate the model's performance, we examined its R-squared and predictive ratios. The R-squared statistic, which calculates the percentage of individual variation explained by a model, measures the predictive accuracy of the model overall. The predictive ratios measure the predictive accuracy of a model for different validation groups or subpopulations. The predictive ratio for each of the HHS risk adjustment models is the ratio of the weighted mean predicted plan liability for the model sample population to the weighted mean actual plan liability for the model sample population. The predictive ratio represents how well the model does on average at predicting plan liability for that subpopulation. A subpopulation that is predicted perfectly would have a predictive ratio of 1.0. For each of the HHS risk adjustment models, the R-squared statistic and the predictive ratio are in the range of published estimates for concurrent risk adjustment models.[33] Because we are proposing to blend the coefficients from separately solved models based on MarketScan® 2013 and 2014 data in the proposed rule, we are publishing the R-squared statistic for each model and year separately to verify their statistical validity. The R-squared statistic for each model is shown in Table 11.

[33] Winkleman, Ross and Syed Mehmud. ''A Comparative Analysis of Claims-Based Tools for Health Risk Assessment.'' Society of Actuaries. April 2007.

TABLE 11—R-SQUARED STATISTIC FOR HHS RISK ADJUSTMENT MODELS

Risk adjustment model	R-Squared statistic	
	2013	2014
Platinum Adult	0.4070	0.4005
Platinum Child	0.2947	0.2908
Platinum Infant	0.3354	0.3200
Gold Adult	0.4026	0.3956
Gold Child	0.2902	0.2860
Gold Infant	0.3335	0.3180
Silver Adult	0.3993	0.3918
Silver Child	0.2866	0.2821
Silver Infant	0.3324	0.3168
Bronze Adult	0.3971	0.3893
Bronze Child	0.2836	0.2789
Bronze Infant	0.3323	0.3165
Catastrophic Adult	0.3975	0.3898
Catastrophic Child	0.2839	0.2792
Catastrophic Infant	0.3326	0.3168

g. Overview of the Payment Transfer Formula (§ 153.320)

In order to maintain the balance of payments and charges that net to zero within each State market, we propose to account for high-cost enrollees through transfer terms (a payment term and a charge term) that would be calculated separately from the State transfer formula. Thus, the non-outlier pooling portion of plan risk will continue to be calculated as the member month-weighted average of individual enrollee risk scores. 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 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, we propose to add to the risk adjustment methodology additional transfers that would reflect the payments and charges assessed with respect to the costs of high-risk enrollees. In particular, we would add one term that would reflect 60 percent of costs above $2 million, the proposed threshold for our payments for these enrollees, and another term that would reflect 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. We seek comment on this approach to balance transfers between high and low risk plans.

We received feedback in the 2017 Payment Notice and the White Paper from commenters who believe that the inclusion of administrative costs in the Statewide average premium incorrectly increases risk adjustment transfers based on costs that are unrelated to the risk of the enrollee population. Comments ranged from requesting that administrative expenses be removed entirely from the Statewide average premium to requesting that HHS consider basing risk adjustment transfers on a portion of Statewide average premium—namely, the portion representing the sum of claims, claims adjustment expenses, and taxes that are calculated on premiums after risk adjustment transfers by using a specified percentage of Statewide average premiums. While commenters have stated that the inclusion of administrative costs in the Statewide average premium harms efficient plans, we note that low cost plans do not necessarily indicate efficient plans. Should a plan be low cost with low claims costs, it is likely an indication of mispricing, as the issuer should be pricing for average risk. However, we recognize that commenters are concerned that including fixed administrative costs in the Statewide average premium may increase risk adjustment transfers for all issuers based on a percentage of costs that are not dependent on enrollee risk. We have considered some of the potential effects of excluding certain fixed administrative costs from the Statewide average premium. This modification to the treatment of administrative costs in the Statewide average premium would lower absolute risk adjustment transfers for all issuers by an equal percentage. We also note that administrative costs are affected by claims costs and that correctly measuring the portion of administrative costs unaffected by claims costs may be difficult. An incorrect measurement of administrative costs could then result in plans with high risk enrollees being undercompensated. We are continuing to evaluate the impact of administrative expenses on risk adjustment transfers, and seek comment on removing a portion of administrative expenses from the Statewide average premium for the 2018 benefit year or for future benefit years.

i. The Payment Transfer Formula

The payment transfer formula is 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:

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

Where:

$\overline{P}_S$ = State average premium;
$PLRS_i$ = plan *i*'s plan liability risk score;
AV_i = plan *i*'s metal level AV;
ARF_i = allowable rating factor;
IDF_i = plan *i*'s induced demand factor;
GCF_i = plan *i*'s geographic cost factor;
s_i = plan *i*'s share of State enrollment.

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

The difference between the two premium estimates in the payment transfer formula determines whether a plan pays a risk 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 for 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.

h. Risk Adjustment Issuer Data Requirements (§ 153.610)

In the 2014 Payment Notice, HHS established an approach for obtaining the necessary data for reinsurance and risk adjustment calculations through a distributed data collection model that prevented the transfer of individuals' protected health information. Under § 153.700, each issuer must establish an EDGE server through which it provides HHS access to enrollment, claims, and encounter data. To safeguard enrollees' privacy, each issuer must establish a unique masked enrollee identification number for each enrollee, and may not include personally identifiable information in such masked enrollee identification number. Under the EDGE server approach issuers currently provide plan-level data to HHS.

The lack of enrollee-level data under this approach limits HHS's ability to use that enrollee-level data from risk adjustment covered plans to improve the risk adjustment model recalibration. As we discussed in the White Paper, access to enrollee-level data with masked enrollee IDs would permit HHS to recalibrate the risk adjustment model using actual data from issuers' individual and small group populations, as opposed to the MarketScan® commercial database that approximates individual and small group market populations, while continuing to safeguard the privacy and security of protected health information. Therefore, beginning for the 2019 benefit year, while maintaining the underlying goals of the distributed data approach, including information privacy and security, we propose to recalibrate the risk adjustment model using masked, enrollee-level EDGE server data from the 2016 benefit year. A separate report would be run on issuers' EDGE servers to access select data elements in the enrollee, medical claim, pharmacy claim and supplemental diagnosis files, with masked enrollee ID, plan/issuer ID, rating area, and State. This approach would allow for the creation of a masked, enrollee-level dataset and would not permit HHS to know the identity of the enrollee, the plan ID, the issuer ID, rating area, State or the EDGE server from which the data was extracted. HHS would provide additional information regarding the data elements it would collect and the related process considerations in future guidance.

HHS would use the enrollee-level dataset to recalibrate the risk adjustment model and inform development of the Actuarial Value Calculator and Methodology, which HHS releases annually, to describe how issuers of non-grandfathered health plans in the individual and small group markets are to calculate actuarial value for purposes of determining metal levels. We believe this data could prove a valuable source for calibrating other HHS programs in the individual and small group markets, and that a public use file derived from these data could be a valuable tool for governmental entities and independent researchers to better understand these markets.

We believe that the proposal described above, which minimizes the burden from the issuer by only requiring issuers to execute a new EDGE command for the report to be run on issuers' EDGE servers, permits important improvements to the HHS-operated risk adjustment program while continuing to safeguard privacy and security. We request comment on this proposal.

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

As noted above, if a State is not approved to operate or chooses to forgo operating its own risk adjustment program, HHS will operate risk adjustment on the State's behalf. As described in the 2014 Payment Notice, HHS's operation of risk adjustment on behalf of States is funded through a risk adjustment user fee. Section 153.610(f)(2) provides that an issuer of a risk adjustment covered plan, as defined in § 153.20, must remit a user fee to HHS equal to the product of its monthly enrollment in the plan and the per enrollee per month risk adjustment user fee specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year.

To promote operational efficiency, we propose to amend § 153.610(f)(2) to revise the calculation of the risk adjustment user fee to be equal to the product of an issuer's billable monthly enrollment (billable member months) and the per enrollee per month risk adjustment user fee specified in the annual HHS notice of benefit and payment parameters. Billable member months exclude children who do not count toward family rates or family policy premiums.[34] This revision to base the total user fee on billable member months rather than enrollment member months ensures consistency with calculating user fees based on premium revenue generated by issuers, which aligns with the FFE user fee policy. We note that this change would not affect the PMPM risk adjustment user fee rate due to the small relative difference between billable member months and enrollee member months. Therefore, we propose to implement this change beginning for the 2016 benefit year risk adjustment user fee collection, which will be collected in 2017, maintaining the user fee rate set in the 2016 and 2017 Payment Notices. We seek comment on this proposal.

OMB Circular No. A–25R establishes Federal policy regarding user fees, and

[34] 78 FR 15432.

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

In the 2017 Payment Notice, we estimated Federal administrative expenses of operating the risk adjustment program to be $1.56 per enrollee per year, or $0.13 PMPM, based on our estimated contract costs for risk adjustment operations. For the 2018 benefit year, we propose to use the same methodology to estimate our administrative expenses to operate the program. These contracts cover development of the model and methodology, collections, payments, account management, data collection, data validation, program integrity and audit functions, operational and fraud analytics, stakeholder training, and operational support. To calculate the user fee, we divide HHS's projected total costs for administering the risk adjustment programs on behalf of States by the expected number of billable member months in risk adjustment covered plans (other than plans not subject to market reforms and student health plans, which are not subject to payments and charges under the risk adjustment methodology HHS uses when it operates risk adjustment on behalf of a State) in HHS-operated risk adjustment programs for the benefit year.

We estimate that the total cost for HHS to operate the risk adjustment program on behalf of States for the 2018 benefit year will be approximately $35 million, and that the risk adjustment user fee would be $1.32 per billable enrollee per year (assuming we finalize our proposal to assess these costs by billable member months discussed above), or $0.12 PMPM. The risk adjustment user fee contract costs for 2018 include costs related to 2018 risk adjustment data validation, and are higher than the 2017 contract costs because some contracts were modified and rebid. However, because enrollment is estimated to be higher in 2018 than 2017, the PMPM amount is lower than that finalized for the 2017 benefit year. We seek comment on this proposal.

j. Data Validation Requirements When HHS Operates Risk Adjustment (§ 153.630)

HHS will conduct risk adjustment data validation in any State where HHS is operating risk adjustment on a State's behalf under § 153.630. 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 audit entity for data validation.

i. Materiality Threshold for Risk Adjustment Data Validation

HHS has been evaluating the burden associated with the risk adjustment data validation program, particularly considering the fixed costs associated with hiring an initial validation audit entity and submitting results to HHS, which may be a large portion of some issuers' administrative costs. Beginning for the 2017 benefit year risk adjustment data validation program, HHS is proposing to implement a materiality threshold. This would mean that issuers that fall below a certain threshold would not be required to conduct risk adjustment data validation each year and would instead be subject to random and targeted sampling. We would expect the random sampling to include issuers below the threshold being subject to an initial validation audit approximately every 3 years, barring any risk-based triggers that would warrant annual participation. Potential risk-based metrics we are considering using to select issuers at or below this threshold for more frequent initial validation audits include the issuer's prior risk adjustment data validation results, and material changes in risk adjustment data submission, as measured by our quality metrics. We are proposing to use a threshold of total premiums of $15 million—a threshold at which 1 percent of an issuer's premiums would cover the estimated $150,000 cost of the initial validation audit. Issuers at or below this threshold would not be subject to annual initial validation audit requirements. We estimate that issuers above this threshold represent risk adjustment covered plans that cover approximately 98.5 percent of membership nationally and as such, annual audit of issuers at or below the threshold is not material for purposes of risk adjustment data validation. We seek comment on this proposal, including with respect to the appropriate threshold and the risk-based metrics we should use.

Because risk adjustment data validation error rates are applied to the subsequent year's data, we are considering whether to base the participation requirement metric on the benefit year or the subsequent benefit year. On the one hand, risk adjustment data validation is measuring the accuracy of risk scores from the benefit year. On the other hand, risk adjustment data validation results directly adjust the risk adjustment transfers of issuers participating in risk adjustment in the following benefit year. We note that, even if an issuer is exempt from initial validation audit requirements using the proposed materiality threshold, HHS may require issuers to make records available for review or to comply with an audit by the Federal government under § 153.620. We seek comment on this approach.

We propose that issuers not materially affecting risk adjustment data validation that are not required to perform an initial validation audit would still have their payments adjusted based on an error rate. We are considering an error rate for an issuer not subject to an initial validation audit in a particular year that could be the average negative error rate nationally, or the average negative error rate within a State, or its error rate in past audits. We seek comment on this approach.

ii. Inclusion of Pharmacy Claims in Risk Adjustment Data Validation

Beginning with the 2018 benefit year, as discussed above, the proposed HHS risk adjustment methodology would take into account prescription drug utilization for purposes of determining an enrollee's risk score. HHS proposes to use a hybrid model that employs prescription drug data to supplement diagnostic data by serving as a proxy for a missing diagnosis in cases where diagnostic data are likely to be incomplete and as an indicator of the severity of an enrollee's illness. We propose to require that, with respect to validation of prescription drug utilization of sampled enrollees, an issuer must provide an initial validation audit entity all paid pharmacy claims for an enrollee, against which the initial validation audit entity will validate the associated prescription drug class in the HHS risk adjustment methodology and the impact on the enrollee's risk score.

Therefore, we propose to amend the first sentence of § 153.630(b)(7)(ii) to include enrollees' paid pharmacy claims.

iii. Risk Adjustment Data Validation Discrepancy and Administrative Appeals Process

Under § 153.630(d), an issuer may appeal the findings of a second validation audit or the application of a risk score error rate to its risk adjustment payments and charges. In the 2015 Payment Notice, we stated that we would ''provide additional guidance on the appeals process and schedule in future rulemaking.'' [35] As we noted in the 2015 Payment Notice, HHS will not permit an issuer to appeal the results of the initial validation audit, as the initial validation audit entity is under contract with the issuer and HHS does not produce the initial validation audit results. We are proposing to amend § 153.630(d) to clarify that an issuer may appeal the findings of a second validation audit or the calculation of a risk score error rate. We make this clarification to distinguish the calculation of a risk score error rate from the application of a risk score error rate as the calculation is a separate reason for which an issuer could appeal. We further propose to clarify that if an issuer intends to appeal the application of a risk score error rate to its risk adjustment payments and charges, HHS would deem this a risk adjustment payment or charge amount appeal under § 156.1220(a)(1)(ii). In this proposed rule, we also propose an interim and final discrepancy reporting process for the risk adjustment data validation program and we propose codification of the process by which an issuer may file an appeal of the findings of a second validation audit or the calculation of a risk score error rate.

First, we propose an interim discrepancy reporting process by which an issuer must confirm the risk adjustment data validation initial audit sample provided by HHS under § 153.630(b)(1) or file a discrepancy report. We propose amending § 153.630 by removing the introductory language and adding paragraph (d)(1) to provide that in the manner set forth by HHS, within 15 calendar days of notification of the initial validation audit sample set forth by HHS, an issuer must confirm the sample or file a discrepancy report to dispute the HHS risk adjustment data validation initial validation audit sample set forth by HHS. In light of the timing of this interim discrepancy reporting process, we do not propose to permit issuers to appeal the resolution of any interim discrepancy disputing the sample. We believe that providing an interim administrative appeals process or permitting issuers to appeal the HHS risk adjustment data validation initial validation audit sample after completion of the entire risk adjustment data validation process for a benefit year would delay the HHS risk adjustment data validation process. Additionally, we believe that it could be efficient to resolve any issues related to the risk adjustment data validation initial audit sample provided by HHS under § 153.630(b)(1) during an interim discrepancy reporting process. We propose to require confirmation of the sample, in the form of an attestation, in order to ensure that issuers thoroughly review the initial validation audit sample determined by HHS.

Second, we propose a final, formal discrepancy reporting process, by which an issuer must confirm the findings of the second validation audit or the calculation of a risk score error rate, or notify us if the issuer identifies a discrepancy with the findings of a second validation audit or the calculation of a risk score error rate. We propose adding paragraph (d)(2) to § 153.630 to provide that in the manner set forth by HHS, an issuer must attest to or report a discrepancy within 15 calendar days of notification of the findings of a second validation audit or the calculation of a risk score error rate to dispute the findings of a second validation audit or the calculation of a risk score error rate. We believe this discrepancy reporting process will enable HHS to work with issuers to resolve discrepancies prior to the notification or risk adjustment payments or charges due under § 153.310(e) and application of the risk score error rate to the issuer's risk adjustment payments and charges.

As we will discuss in further detail in the preamble to § 156.1220(a), we also propose requiring issuers to report a discrepancy if the issue is identifiable prior to filing a request for reconsideration as set forth in 45 CFR 156.1220. As such, we propose to amend § 156.1220(a)(4)(ii), to provide that notwithstanding § 156.1220(a)(1), a reconsideration with respect to a processing error by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical error may be requested only if, to the extent the issue could have been previously identified by the issuer to HHS under § 153.630(d)(2) or § 153.710(d)(2), it was so identified and remains unresolved.

Third, we propose to amend § 153.630 to add paragraph (d)(3) to clarify the process by which an issuer can appeal the findings of a second validation audit or the calculation of a risk score error rate. We propose requiring issuers to use the administrative appeals process set forth in § 156.1220. We believe issuers will appreciate a discrepancy reporting window and leveraging the existing administrative appeals processes.

HHS will provide in future guidance the process for issuers to report discrepancies. We believe that providing issuers 15 calendar days to review the HHS risk adjustment data validation sample set, will provide adequate time for issuers to notify HHS prior to the execution of the initial validation audit. Additionally, we believe providing issuers 30 calendar days from the results of the second validation audit or the calculation of a risk score error rate based on risk adjustment data validation, will provide adequate time for issuers to notify HHS prior to filing a formal request for reconsideration of such discrepancy. As with the discrepancy reporting process set forth in § 153.710(d), HHS will work with issuers to resolve any discrepancies related to risk adjustment data validation prior to final risk adjustment payments and charges for a benefit year. We seek comment on these timeframes and these discrepancy reporting and appeal proposals.

G. Part 154—Health Insurance Issuer Rate Increases: Disclosure and Review Requirements

1. Definitions (§ 154.102)

We propose to revise the definition of ''product'' in § 154.102. Specifically, we propose to remove language that would restrict a product's being considered the same product when it is no longer offered by the same issuer, but by a different issuer in the same controlled group. This amendment is necessary in light of our proposed interpretation of guaranteed renewability provisions, as discussed in the preamble to § 147.106. We are not proposing changes to the definition of ''plan'' because the definition for that term in § 154.102 cross-references the definition in § 144.103. Therefore, if finalized as proposed, the amendments to the definition of ''plan'' in § 144.103 would also apply for purposes of the rate review requirements under 45 CFR part 154. For further discussion of the reason for this proposed amendment, please see the preamble to § 147.106.

[35] HHS Notice of Benefit and Payment Parameters for 2015, 79 FR 13768

H. Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

1. Standardized Options (§ 155.20)

a. Standardized Options Approach for 2018

In the 2017 Payment Notice, HHS finalized six standardized options (also now referred to as Simple Choice plans), one at each of the bronze, silver, silver cost-sharing reduction variation, and gold levels of coverage, designed to be similar to the most popular (enrollment-weighted) QHPs in the 2015 individual market FFEs. We propose to change the standardized options from the 2017 versions in order to reflect changes in QHP enrollment-weighted data from 2015 to 2016, including SBE–FP QHP enrollment-weighted data, and to the extent practicable, to comply with various State cost-sharing standards. Therefore, for the 2018 plan year, HHS proposes three new sets of standardized options, based on an analysis of enrollment-weighted 2016 individual market FFE and SBE–FP QHPs (see Tables 12, 13 and 14). The second and third sets are different from the first set only to the extent necessary to comply with State cost-sharing laws. The second set of standardized options is designed to work in States that: (1) Require that cost sharing for physical therapy, occupational therapy, or speech therapy be no greater than the cost sharing for primary care visits; (2) limit the amount that can be charged for each drug tier; or (3) require that all drug tiers carry a copayment rather than coinsurance. The third set of standardized options is designed to work in a State with maximum deductible requirements and other cost-sharing standards.

Like the 2017 standardized options, the proposed 2018 standardized options each have a single provider tier, fixed deductible, fixed annual limitation on cost sharing, and fixed copayment or coinsurance for a key set of essential health benefits that comprise a large percentage of the total allowed costs for a typical population of enrollees. These fixed cost-sharing values are for in-network care only. Unlike the 2017 standardized options, the proposed 2018 options at the silver, silver cost-sharing reduction variations, and gold levels of coverage have separate medical and drug deductibles, reflecting the commonality of this cost-sharing structure in QHPs at these levels of coverage. The proposed standardized options at the silver 87 percent cost-sharing reduction plan variation, silver 94 percent cost-sharing reduction plan variation, and gold levels of coverage have a drug deductible equal to $0, meaning no deductible applies to the drugs.

The bronze standardized options as proposed rely on finalization of the proposal discussed in the preamble to § 156.140 to permit a broader de minimis range for bronze plans. If that proposal is not adopted, the plans would be revised to comply with the de minimis range in our regulations, while still reflecting 2016 enrollment weighted data, and State cost-sharing requirements for the second set of standardized options.

For 2018, we also propose a fourth standardized option at the bronze level of coverage that qualifies as a high deductible health plan (HDHP) under section 223 of the Code, eligible for use with a health savings account (HSA). HDHPs are an option valued by many consumers—enrollment in HDHPs across 2016 individual market FFE and SBE–FP QHPs constituted 9.2 percent of all FFE and SBE–FP QHP enrollment in 2016. Pursuant to the terms of the Code, the IRS releases the maximum annual limitation on cost sharing and minimum annual deductible for HDHPs annually in the spring, subsequent to the annual HHS notice of benefit and payment parameters rulemaking process. Therefore, we propose that if any changes to the HDHP standardized option would be required to reflect differences between the HDHP standardized option finalized in the 2018 Payment Notice and the subsequently released maximum annual limitation on cost sharing and minimum annual deductible for HDHPs, HHS would publish those changes in guidance. Accordingly, we propose to amend the definition of ''standardized option'' at § 155.20 to provide for a plan to be considered a standardized option if it is: (1) A QHP offered for sale through an individual market Exchange with a standardized cost-sharing structure specified by HHS in rulemaking; or (2) an HDHP QHP offered for sale through an individual market Exchange with a standardized cost-sharing structure specified by HHS in guidance issued solely to modify the cost-sharing structure specified by HHS in rulemaking to the extent necessary to align with requirements to qualify as an HDHP under section 223 of the Code and meet HHS AV requirements.

b. Standardized Options in SBE–FPs

In the 2017 Payment Notice, we designed a set of standardized options based on enrollment-weighted 2015 FFE QHP data, and indicated we anticipated differentially displaying these HHS-designed standardized options. We noted that SBE–FPs may have their own State-designed standardized plans that differ from HHS-designed standardized options, but that the *HealthCare.gov* platform would not be able to differentially display these State-designed standardized plans.

For 2018, the *HealthCare.gov* platform remains unable to provide differential display to State-designed standardized plans that differ from the HHS-designed standardized options. However, we propose that SBE–FPs may choose to allow HHS-designed standardized options to receive differential display on *HealthCare.gov,* just as the plans would if offered through an FFE. We propose that an SBE–FP must notify HHS if it wants HHS-designed standardized options to receive differential display by a date to be specified in guidance that will be set to provide sufficient time to operationalize the State's choice on *HealthCare.gov.* We seek comment on this proposal.

c. State Customization

In the 2017 Final Payment Notice, HHS explained that it would not be possible for *HealthCare.gov* to accommodate customization of standardized options by State in 2017. Specifically, to reduce operational complexity, HHS did not vary the standardized options by State or by region, and instead finalized one set of standardized options across all FFEs that issuers would have the option to offer in 2017.

As noted above, some States regulate cost sharing on specific benefits under State authorities. We seek to accommodate, to the extent practicable, State cost-sharing requirements under our proposed 2018 standardized options. To do so, we have designed three bronze standardized options (in addition to the bronze HDHP), and three standardized options at each of the silver, silver cost-sharing reduction plan variations, and gold levels of coverage, as set forth in Tables 13 and 14. We propose to select for each FFE State one of the three standardized options at each level of coverage (plus the HDHP option at the bronze level, if permissible under State cost-sharing standards) that meets any existing State cost-sharing requirements. We propose that this selection will be published in the final 2018 Payment Notice. We propose to do the same for each SBE–FP State that notifies HHS that it chooses to have HHS standardized options receive differential display on the *HealthCare.gov* platform. If issuers in the FFE States and those in the SBE–FP States that choose to have differential

display of HHS standardized options offer the standardized options selected for the State (that is, the one standardized option at each level of coverage selected for the State, in addition to the HDHP option if permissible under State standards), those plans would receive differential display in the Exchange for the 2018 plan year.

Additionally, many States have oral chemotherapy access laws, which require coverage of oral chemotherapy at parity with intravenous chemotherapy or cap patients' monthly cost sharing for chemotherapy drugs (both oral and intravenous). We propose to clarify that these chemotherapy access requirements do not conflict with the HHS standardized plan designs because issuers can design benefit packages that comply with both the standardized options requirements and State oral chemotherapy access laws.

We believe that the proposals discussed above will allow issuers in States with cost-sharing laws that would conflict with a single set of standardized options to offer standardized options. Furthermore, by making it possible for issuers to offer standardized options while complying with State cost-sharing rules, we believe this limited State customization will enhance the shopping experience of consumers in more States than was previously possible. We welcome comments from each State regarding the standardized option at each level of coverage that the State believes would be most suitable for that State, and whether modifications should be made to any of the proposed State-customized standardized options to further accommodate State cost-sharing rules. We also seek comment from States, issuers, and other stakeholders on State cost-sharing requirements that would affect the design of standardized options, as well as comments generally on this approach for standardized options in 2018.

TABLE 12—2018 PROPOSED STANDARDIZED OPTIONS

	Bronze	HSA-eligible bronze HDHP	Silver	Silver 73% CSR plan variation	Silver 87% CSR plan variation	Silver 94% CSR plan variation	Gold
Actuarial Value (%)	62.68%	61.97%	71.05%	73.95%	87.61	94.69	80.65%.
Deductible (Med/Rx)	$6,650	$6,000	$3,500/$500	$3,000/$200	$700/$0	$250/$0	$1,400/$0.
Annual Limitation on Cost Sharing.	$7,350	$6,000	$7,350	$5,850	$2,450	$1,250	$5,000.
Emergency Room Services.	40%	No charge after deductible.	20%	20%	20%	5%	20%.
Urgent Care	$75 (*)	No charge after deductible.	$75 (*)	$75 (*)	$40 (*)	$25 (*)	$60 (*).
Inpatient Hospital Services	40%	No charge after deductible.	20%	20%	20%	5%	20%.
Primary Care Visit	$35 (*)	No charge after deductible.	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*).
Specialist Visit	$75 (*)	No charge after deductible.	$65 (*)	$65 (*)	$25 (*)	$10 (*)	$50 (*).
Mental Health/Substance Use Disorder Outpatient Office Visit.	$35 (*)	No charge after deductible.	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*).
Imaging (CT/PET Scans, MRIs).	40%	No charge after deductible.	20%	20%	20%	5%	20%.
Speech Therapy	40%	No charge after deductible.	20%	20%	20%	5%	20%.
Occupational Therapy/ Physical Therapy.	40%	No charge after deductible.	20%	20%	20%	5%	20%.
Laboratory Services	40%	No charge after deductible.	20%	20%	20%	5%	20%.
X-rays and Diagnostic Imaging**.	40%	No charge after deductible.	20%	20%	20%	5%	20%.
Skilled Nursing Facility	40%	No charge after deductible.	20%	20%	20%	5%	20%.
Outpatient Facility Fee (for example, Ambulatory Surgery Center).	40%	No charge after deductible.	20%	20%	20%	5%	20%.
Outpatient Surgery Physician/Surgical Services.	40%	No charge after deductible.	20%	20%	20%	5%	20%.
Generic Drugs	$35 (*)	No charge after deductible.	$15 (*)	$15 (*)	$5 (*)	$3 (*)	$10 (*).
Preferred Brand Drugs	35%	No charge after deductible.	$50 (*)	$50 (*)	$25 (*)	$5 (*)	$40 (*).
Non-Preferred Brand Drugs.	40%	No charge after deductible.	$100 (*)	$100 (*)	$50 (*)	$10 (*)	$75 (*).
Specialty Drugs	45%	No charge after deductible.	40%	40%	30%	25%	30%.

(*) = not subject to the deductible

** **Note:** Excludes x-rays and diagnostic imaging associated with office visits (except for high-deductible health plans (HDHPs).

TABLE 13—2018 PROPOSED STANDARDIZED OPTIONS FOR STATES REQUIRING OCCUPATIONAL THERAPY, PHYSICAL THERAPY, OR SPEECH THERAPY COST-SHARING PARITY WITH PRIMARY CARE VISITS OR STATES REQUIRING COPAYMENTS OR COPAYMENT LIMITS ON DRUGS

	Bronze	Silver	Silver 73% CSR plan variation	Silver 87% CSR plan variation	Silver 94% CSR plan variation	Gold
Actuarial Value (%)	62.79%	71.03%	73.88%	87.70	94.68	80.60%.
Deductible (Med/Rx)	$6,650	$3,500/$500 Rx	$3,000/$200 Rx	$700/$0	$250/$0	$1,400/$0.
Annual Limitation on Cost Sharing.	$7,350	$7,350	$5,850	$2,450	$1,250	$5,000.
Emergency Room Services.	40%	20%	20%	20%	5%	20%.
Urgent Care	$75 (*)	$75 (*)	$75 (*)	$40 (*)	$25 (*)	$60 (*).
Inpatient Hospital Services.	40%	20%	20%	20%	5%	20%.
Primary Care Visit	$35 (*)	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*).
Specialist Visit	$75 (*)	$65 (*)	$65 (*)	$25 (*)	$10 (*)	$50 (*).
Mental Health/Substance Use Disorder Outpatient Office Visit.	$35 (*)	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*).
Imaging (CT/PET Scans, MRIs).	40%	20%	20%	20%	5%	20%.
Speech Therapy	$35 (*)	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*).
Occupational Therapy/ Physical Therapy.	$35 (*)	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*).
Laboratory Services	40%	20%	20%	20%	5%	20%.
X-rays and Diagnostic Imaging **.	40%	20%	20%	20%	5%	20%.
Skilled Nursing Facility	40%	20%	20%	20%	5%	20%.
Outpatient Facility Fee (e.g., Ambulatory Surgery Center).	40%	20%	20%	20%	5%	20%.
Outpatient Surgery Physician/Surgical Services.	40%	20%	20%	20%	5%	20%.
Generic Drugs	$35 (*)	$15 (*)	$15 (*)	$5 (*)	$3 (*)	$10 (*).
Preferred Brand Drugs	$40 (copay applies only after deductible).	$50 (*)	$50 (*)	$25 (*)	$5 (*)	$40 (*).
Non-Preferred Brand Drugs.	$45 (copay applies only after deductible).	$100 (*)	$100 (*)	$50 (*)	$10 (*)	$75 (*).
Specialty Drugs	$50 (copay applies only after deductible).	$150 (copay applies only after deductible).	$150 (copay applies only after deductible).	$75 (*)	$20 (*)	$100(*).

(*) = not subject to the deductible.
** **Note:** Excludes x-rays and diagnostic imaging associated with office visits.

TABLE 14—2018 PROPOSED STANDARDIZED OPTIONS FOR STATES WITH DEDUCTIBLE MAXIMUMS AND OTHER COST-SHARING REQUIREMENTS

	Bronze	Silver	Silver 73% CSR plan variation	Silver 87% CSR plan variation	Silver 94% CSR plan variation	Gold
Actuarial Value (%)	64.84%	70.28%	73.94%	87.61%	94.53%	80.80%.
Deductible	$3,000	$3,000	$3,000	$700	$250	$1,000.
Annual Limitation on Cost Sharing	$7,150	$7,000	$5,850	$2,450	$1,250	$5,000.
Emergency Room Services	50%	40%	20%	20%	5%	30%.
Urgent Care	$50 (*)	$50 (*)	$50 (*)	$40 (*)	$25 (*)	$40 (*).
Inpatient Hospital Services	$500 (per day; applies only after deductible).	40%	20%	20%	5%	30%.
Primary Care Visit	$35 (*first 3 visits; then subject to deductible and $35 copay after deductible).	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$25 (*).
Specialist Visit	$75 (applies only after deductible).	$60 (*)	$60 (*)	$25 (*)	$10 (*)	$40 (*).
Mental Health/Substance Use Disorder Outpatient Office Visit.	$35 (applies only after deductible).	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$25 (*).
Imaging (CT/PET Scans, MRIs)	$100 (applies only after deductible).	$100 (*)	$100 (*)	$75 (*)	$40 (*)	$100 (*).
Speech Therapy	$35 (applies only after deductible).	$50 (*)	$30 (*)	$10 (*)	$5 (*)	$25 (*).
Occupational Therapy/Physical Therapy.	$35 (applies only after deductible).	$50 (*)	$30 (*)	$10 (*)	$5 (*)	$25 (*).

TABLE 14—2018 PROPOSED STANDARDIZED OPTIONS FOR STATES WITH DEDUCTIBLE MAXIMUMS AND OTHER COST-SHARING REQUIREMENTS—Continued

	Bronze	Silver	Silver 73% CSR plan variation	Silver 87% CSR plan variation	Silver 94% CSR plan variation	Gold
Laboratory Services	50%	40%	20%	20%	5%	30%.
X-rays and Diagnostic Imaging**	50%	40%	20%	20%	5%	30%.
Skilled Nursing Facility	$500 (per day; applies only after deductible).	40%	20%	20%	5%	30%.
Outpatient Facility Fee (e.g., Ambulatory Surgery Center).	50%	40%	20%	20%	5%	30%.
Outpatient Surgery Physician/Surgical Services.	50%	40%	20%	20%	5%	30%.
Generic Drugs	$25 (*)	$25 (*)	$15 (*)	$5 (*)	$3 (*)	$10 (*).
Preferred Brand Drugs	50%	$75 (*)	$75 (*)	$25 (*)	$5 (*)	$25 (*).
Non-Preferred Brand Drugs	50%	$75 (*)	$75 (*)	$50 (*)	$10 (*)	$50 (*).
Specialty Drugs	50%	$75 (*)	$75 (*)	$50 (*)	$10 (*)	$50 (*).

(*) = not subject to the deductible
** Note: Excludes x-rays and diagnostic imaging associated with office visits.

2. General Functions of an Exchange

a. Functions of an Exchange (§ 155.200)

In the 2017 Payment Notice, we established that a State Exchange could elect to enter into a Federal platform agreement through which it agrees to rely on HHS for services related to the individual market Exchange, the SHOP Exchange, or both. In § 155.200(f)(2), we required an SBE–FP to establish and oversee certain requirements for its QHPs and QHP issuers that are no less strict than the requirements that apply to QHPs and QHP issuers in an FFE. Requiring QHPs and QHP issuers in SBE–FPs to meet these same requirements ensures that all QHPs on HealthCare.gov meet a consistent minimum standard and that consumers obtaining coverage as a result of applying through HealthCare.gov are guaranteed plans that meet these minimum standards.

We propose to amend § 155.200(f) by adding a new paragraph (f)(4) that would require State Exchanges that use the Federal platform for certain SHOP functions to establish standards and policies consistent with certain Federally-facilitated Small Business Health Options Program (FF–SHOP) requirements. In contrast to the requirements contained in § 155.200(f)(2), which pertain primarily to ensuring a consistent experience on *HealthCare.gov,* compliance with the requirements we propose to include in § 155.200(f)(4) would be necessary because the FF–SHOP requirements listed in paragraph (f)(4) are an integral part of the FF–SHOP platform's functionality and system build, making compliance with the requirements necessary from an operational perspective for State Exchanges to use the Federal platform for these SHOP functions. Additionally, requiring compliance with these requirements, rather than customizing the FF–SHOP platform's system build, would avoid sizeable costs associated with permitting State-based Exchanges to use the Federal platform for SHOP functions. Therefore, we propose to add a new paragraph (f)(4) to require that SBE–FPs that utilize the Federal platform for certain SHOP functions establish standards and policies with respect to the following topics that are consistent with the following rules applicable in FF–SHOPs:

- Premium calculation, payment, and collection requirements as specified at § 155.705(b)(4) (for SBE–FPs using the Federal platform for SHOP eligibility, enrollment, or premium aggregation functions);
- The timeline for rate changes set forth at § 155.705(b)(6)(i)(A) (for SBE–FPs using the Federal platform for SHOP enrollment or premium aggregation functions);
- Minimum participation rate requirements and calculation methodologies set forth at § 155.705(b)(10) (for SBE–FPs using the Federal platform for SHOP enrollment functions);
- Employer contribution methodologies set forth at § 155.705(b)(11)(ii) (for SBE–FPs using the Federal platform for SHOP enrollment or premium aggregation functions);
- Annual employee open enrollment period requirements set forth at § 155.725(e)(2) (for SBE–FPs using the Federal platform for SHOP enrollment functions);
- Initial group enrollment or renewal coverage effective date requirements set forth at § 155.725(h)(2) (for SBE–FPs using the Federal platform for SHOP enrollment functions); and
- Termination of SHOP coverage or enrollment rules set forth at § 155.735 (for SBE–FPs using the Federal platform for SHOP eligibility, enrollment, or premium aggregation functions).

These amendments would become effective with the effective date of the final rule.

We seek comment on this proposal, including on whether it would conflict with current State requirements, and on whether other FF–SHOP requirements should apply in SBE–FPs utilizing the Federal platform for SHOP functions, for the reasons discussed above.

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

Section 155.205(c)(2)(iii)(A) and (B) require Exchanges, QHP issuers, and agents or brokers subject to § 155.220(c)(3)(i) (''web-brokers'') to provide taglines in non-English languages indicating the availability of language services. These entities must include taglines on Web site content and documents that are critical for obtaining health insurance coverage or access to health care services through a QHP for qualified individuals, applicants, qualified employers, qualified employees, or enrollees. The taglines must indicate the availability of language services in at least the top 15 languages spoken by the limited English proficient (LEP) population of the relevant State, as determined in HHS guidance. In March 2016, HHS issued guidance providing language data and sample taglines in the top 15 languages spoken by the LEP population in each State.[36] A similar tagline requirement

[36] Ctr. Consumer Info. & Ins. Oversight, Ctrs. for Medicaid & Medicare Serv., Guidance and

Continued

appears in the final rule implementing section 1557 of the Affordable Care Act (81 FR 31376 (May 18, 2016)), which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities.[37] The section 1557 implementing regulation applies to every health program or activity administered by an Exchange, every health program or activity administered by HHS, and every health program or activity, any part of which receives Federal financial assistance provided or made available by HHS.[38] The section 1557 implementing regulation, as well as other applicable Federal civil rights laws, apply independently of the regulations governing Exchanges and health insurance issuers.

In the preamble to the 2016 Payment Notice, we stated that if an entity's service area covers multiple States, the top 15 languages spoken by LEP individuals may be determined by aggregating the top 15 languages spoken by all LEP individuals among the total population of the relevant States (80 FR 10788). We also restated this policy in the March 2016 guidance. We propose to amend § 155.205(c)(2)(iii) to provide more specificity about when entities subject to § 155.205(c)(2)(iii)(A) and (B) would be permitted to aggregate LEP populations across States to determine the languages in which taglines must be provided, in light of questions that have arisen about this issue since publication of the 2016 Payment Notice.

At § 155.205(c)(2)(iii)(A), we propose that if an Exchange is operated by an entity operating multiple Exchanges, or relies on an eligibility or enrollment platform that is relied on by multiple Exchanges, the Exchange may aggregate the LEP populations across all the States served by the entity that operates the Exchange or its eligibility or enrollment platform to determine the top 15 languages required for taglines under § 155.205(c)(2)(iii)(A). For example, under this proposal, all Exchanges that use the eligibility and enrollment platform on which the FFEs (including FFEs where States perform plan management functions) and SBE–FPs rely would be permitted to aggregate languages across the States with Exchanges that rely on this platform.

At § 155.205(c)(2)(iii)(A), we also propose that a QHP issuer would be permitted to aggregate the LEP populations across all States served by the health insurance issuers within the issuer's controlled group, whether or not those health insurance issuers offer plans through the Exchange in each of those States, to determine the top 15 languages in which it must provide taglines. For consistency, we propose to define an issuer's controlled group using the definition in § 147.106(d)(3)(i) of this proposed rule, which would define a controlled group as a group of two or more persons that is treated as a single employer under section 52(a), 52(b), 414(m), or 414(o) of the Code. Therefore, a QHP issuer that is a subsidiary of a corporate entity or holding company that is treated as a single employer under section 52(a), 52(b), 414(m), or 414(o) of the Code, and whose subsidiary health insurance issuers serve multiple States, would be permitted to meet the tagline requirement by including taglines on Web sites and critical documents in at least the top 15 languages spoken by the aggregated LEP populations of all States served by the corporate entity's or holding company's subsidiary health insurance issuers, rather than in the top 15 languages spoken by the limited English proficient population of each individual QHP issuer's State of licensure or State served. On the other hand, a QHP issuer association or federation comprised of multiple companies that are not treated as a single employer under section 52(a), 52(b), 414(m), or 414(o) of the Code, and are thus not considered to be a controlled group, would not be permitted to aggregate across the States served by the health insurance issuers in its entire association or federation; rather, the QHP issuer members of the association or federation would be permitted to aggregate only across the States served by the health insurance issuers within each issuer's controlled group.

With respect to summaries of benefits and coverage (SBCs) provided under section 2715 of the PHS Act, consistent with the SBC Instruction Guide for Individual Health Insurance Coverage[39] and the SBC Instruction Guide for Group Coverage,[40] QHP issuers would still be required to provide an addendum with their SBCs with language taglines in the top 15 languages spoken by the LEP populations of the relevant State or States for QHPs offered through an Exchange. Any additional taglines required under section 2715 of the PHS Act and the implementing regulations[41] must also be included in this addendum. However, any taglines that are included in the addendum are not required to also be included in the SBC document. The addendum, which must only include tagline information required by the applicable language access standards, must be provided along with the SBC and is not considered a part of the SBC document. Therefore, the addendum will not count towards the four double-sided page limit for the SBC under PHS Act section 2715(b)(1).

Additionally, our proposed policy related to aggregating LEP populations to determine the top 15 languages in which taglines must be provided does not apply to the tagline requirements under rules implementing sections 2715 and 2719 of the PHS Act. This means, for example, that a QHP issuer that is a member of a controlled group whose health insurance issuers serve three States, and that therefore aggregates the LEP populations across those three States to determine the top 15 languages in which it must provide taglines in its SBC addendum under § 155.205(c)(2)(iii)(A), must still include in its SBC addendum taglines in all of the languages triggered by the threshold under § 147.200(a)(5), which requires a tagline when 10 percent or more of the population residing in a county is

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Population Data for Exchanges, Qualified Health Plan Issuers, and Web-Brokers to Ensure Meaningful Access by Limited-English Proficient Speakers Under 45 CFR 155.205(c) and 156.250 (March 30, 2016), *available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Language-access-guidance.pdf*; Appendix A—Top 15 Non-English Languages by State, *available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Appendix-A-Top-15.pdf*; Appendix B—Sample Translated Taglines, *available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Appendix-B-Sample-Translated-Taglines.pdf*.

[37] 42 U.S.C. 18116; 45 CFR part 92. Section 92.8(d)(1) requires each covered entity to ''post taglines in at least the top 15 languages spoken by individuals with limited English proficiency of the relevant State or States.'' The principle of aggregation with respect to the tagline requirement at § 92.8(d)(1) is discussed in the section 1557 final rule at 81 FR 31376, 31400.

[38] 45 CFR 92.2(a). In addition to the tagline requirement at § 92.8(d)(1), the section 1557 implementing regulation identifies other obligations of a covered entity, such as the obligation to have marketing practices and benefit designs in a health-related insurance plan or policy or other health-related coverage that are nondiscriminatory. *See id.* § 92.207.

[39] Summary of Benefits and Coverage: Instruction Guide for Individual Health Insurance Coverage (April 2017), *available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Individual-Instructions-508–MM.pdf*.

[40] Summary of Benefits and Coverage: Instruction Guide for Group Coverage (April 2017), *available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Group-Instructions-4–4-clean-MM–508.pdf*

[41] 45 CFR 147.200(a)(5) requires that group health plans and health insurance issuers offering group and individual health insurance coverage provide taglines in a particular non-English language if 10 percent or more of the population residing in the county is literate only in that same non-English language.

literate only in a particular non-English language, *without* aggregating the LEP populations across the counties in its service area. The same would apply to tagline requirements under section 2719 of the PHS Act and its implementing regulations.

We also propose amendments to § 155.205(c)(2)(iii)(B), to specify that web-brokers that are licensed in and serving multiple States would be permitted to aggregate the LEP populations in the States they serve to determine the top 15 languages in which they must provide taglines under § 155.205(c)(2)(iii)(B).

We believe our proposed approach balances two important policy objectives: Ensuring that LEP individuals have notice of language assistance services, and minimizing burden on the entities subject to the rule, including by minimizing the potential need for costly information systems changes. This approach would establish a floor, and if it is finalized, QHP issuers, web-brokers, and Exchanges would be permitted to provide non-aggregated, State-specific taglines, or taglines in more than the required 15 languages. We believe our proposed approach would help promote consistency with the tagline requirements at 45 CFR 92.8(d)(1) and 81 FR 31400, which permit covered entities that serve individuals in more than one State to aggregate the number of individuals with limited English proficiency in those States to determine the top 15 languages required by § 92.8(d)(1). We seek comment on whether the proposed approach strikes the appropriate balance.

We are also proposing amendments to § 155.205(c)(2)(iii)(A) and (B) to specify that Exchanges, QHP issuers, and web-brokers may satisfy tagline requirements with respect to Web site content if they post a Web link prominently on their home page that directs individuals to the full text of the taglines indicating how individuals may obtain language assistance services, and if they also include taglines on any standalone document linked to or embedded in the Web site, such as one in portable document format (PDF) or word processing software format, that is critical within the meaning of the rule. Thus, for example, if a QHP issuer included a link to a PDF of its provider directory or formulary drug list on its Web site, it would be required to provide a link to taglines on its Web site home page and to provide taglines on that PDF document. In HHS's view, providing a prominent link to taglines on the home page of a Web site gives sufficient notice to consumers that language services are available. We note that entities subject to section 1557 of the Affordable Care Act are still required to comply with the section 1557 requirements regarding taglines placed on their home pages.[42]

In the case of ''critical'' standalone documents linked to or embedded in the Web site, there is a good chance that a consumer might land on such documents without going through an entity's home page first (for example, from a link on another Web site), and it is also likely that such documents would not contain a link to the entity's home page. In contrast, Web pages within the Web site that are not standalone linked or embedded documents are more likely to contain a prominent link to the home page. Under this proposal, if an entity subject to § 155.205(c)(2)(iii)(A) or (B) includes the required taglines in a standalone ''critical'' document linked to or embedded in the Web site of another entity subject to § 155.205(c)(2)(iii)(A) or (B), then the taglines standard will be deemed to be met by the entity that links to or embeds the ''critical'' document in its Web site, for purposes of that document. For example, if a web-broker posts a ''critical'' document provided to it by an affiliated QHP issuer, and the QHP issuer includes the taglines in that document that the issuer would be required to include, then the web-broker can rely on those taglines for purposes of compliance with § 155.205(c)(2)(iii)(B) when it posts that document (as provided by the QHP issuer with the required taglines), even if the QHP issuer and web-broker are not required to provide taglines in the same 15 languages.

We solicit comments on all aspects of these proposals. In particular, we seek comments on whether we should consider alternative standards for identifying the States across which Exchanges, QHP issuers, and web-brokers may aggregate languages for purposes of § 155.205(c)(2)(iii)(A) and (B), and on whether our proposed approach strikes an appropriate balance between facilitating access for LEP populations and minimizing burden on the entities subject to the rule.

Additionally, because the final rule implementing section 1557 of the Affordable Care Act (81 FR 31376 (May 18, 2016)) imposes on the covered entities to which that rule applies a similar set of obligations with respect to language access taglines, we are considering whether there is a need for the separate language access tagline requirements for Exchanges, QHP issuers, and web-brokers under § 155.205(c)(2)(iii)(A) and (B). We seek comment on what, if any, additional protections for LEP consumers the standards under § 155.205(c)(2)(iii)(A) and (B) provide that are not included in the section 1557 implementing regulation, and on whether the § 155.205(c)(2)(iii)(A) and (B) requirements are largely duplicative of the section 1557 implementing regulation. We note that not every entity subject to § 155.205(c)(2)(iii)(A) or (B) is a ''covered entity'' subject to section 1557 and its implementing regulation. We are committed to ensuring that LEP consumers have sufficient notice of language assistance services, while also seeking to minimize the burden on the entities subject to both the section 1557 implementing regulation and Exchange language access requirements, including by minimizing duplicative requirements and the potential need for costly information systems changes. For these reasons, and for continuity with our existing requirements and the principle that LEP consumers should have notice of language access services whether they are being served by an Exchange, QHP issuer, or a web-broker,[43] we are considering amending § 155.205(c)(2)(iii) to replace the tagline requirements currently set forth at § 155.205(c)(2)(iii)(A) and (B) with a provision requiring Exchanges, QHP issuers, and web-brokers to follow certain standards under § 92.8 when providing the taglines required under § 155.205(c)(2)(iii). Under this alternative proposal, to the extent that any entity subject to existing § 155.205(c)(2)(iii)(A) and (B) is not a covered entity within the meaning of section 1557 and its implementing regulation, the standards under § 92.8 would apply as if such entity were a covered entity. We are also considering limiting the cross-reference such that Exchanges, QHP issuers, and web-brokers would have to comply only with the standards related to taglines at § 92.8(d)(1) and (f) when providing the taglines required under § 155.205(c)(2)(iii), and would not have

[42] In particular, we note the separate requirement for entities covered under section 1557 of the Affordable Care Act that links to taglines from the home page of a covered entity's Web site must be posted as ''in language'' Web links, which are links written in each of the 15 non-English languages posted conspicuously on the home page that direct the individual to the full text of the tagline indicating how the individual may obtain language assistance services. For instance, a tagline directing an individual to a Web site with the full text of a tagline written in Haitian Creole should appear as ''Kreyôl'' rather than ''Haitian Creole.'' (45 CFR 92.8(1)(iii); 81 FR 31396.)

[43] See 80 FR 10788.

to comply with other notice requirements in § 92.8, such as § 92.8(a). This approach would be similar to our existing regulations and would not require documents to include additional information, such as nondiscrimination disclosures and grievance processes, that are not contemplated by § 155.205(c)(2)(iii)(A) and (B), unless the entity providing taglines is separately subject to § 92.8. Under this alternative proposal, we are also considering retaining the requirement that taglines must be provided on critical documents within the meaning of § 155.205(c)(2)(iii)(A) and (B), rather than applying the requirement at § 92.8(f)(1)(i) related to significant publications and significant communications. However, we seek comment on this approach and on whether describing the types of materials on which taglines must be provided by Exchanges, QHP issuers, and web-brokers by instead referring to significant publications and significant communications at § 92.8(f)(1)(i) would help streamline these requirements for entities subject to § 155.205(c)(2)(iii)(A) and (B). We are also considering removing § 155.205(c)(2)(iii)(A) and (B) entirely. In any case, as noted above, the section 1557 implementing regulation applies independently of the regulations governing Exchanges and health insurance issuers. We request comments on all of these considerations, including with respect to what other conforming changes to § 155.205(c)(2)(iii) or other regulations such as § 156.250 might be advisable in order to implement a policy of relying upon the substantive standards under section 1557 and associated rulemaking and guidance for the language access protections under § 155.205(c)(2)(iii).

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

Consistent with section 1312(e) of the Affordable Care Act, we established procedures under § 155.220 to support the States' ability to permit agents and brokers to assist individuals, employers or employees with enrollment in QHPs offered through an Exchange, subject to applicable Federal and State requirements. At § 155.220(c), we established parameters for enrollment of qualified individuals through an Exchange with the assistance of an agent or broker. At § 155.220(c)(1), we established that an agent or broker who assists with enrollment through the Exchange must ensure completion of an eligibility verification and enrollment application through the Exchange Web site as described § 155.405. In § 155.220(c)(3), we established standards that apply when using the direct enrollment pathway and a Web site of an agent or broker is used to complete the QHP selection. As described at § 155.220(d), an agent or broker that enrolls qualified individuals through an Exchange, or assists individuals in applying for Exchange financial assistance, must comply with the terms of a general agreement with the Exchange, as well as register with the Exchange and receive training in the range of QHP options and insurance affordability programs. In addition, all agents and brokers must execute the applicable privacy and security agreement required by § 155.260(b) to provide assistance with enrollment through the Exchange. We also established FFE standards of conduct under § 155.220(j) for agents and brokers that assist consumers in enrolling in coverage through the FFEs to protect consumers and ensure the proper administration of the FFEs. In this rulemaking, we propose to build on this foundation with the adoption of new procedures and additional consumer protection standards for agents and brokers that assist with enrollments through Exchanges. We also solicit additional comments to help further inform the development and implementation of the enhanced direct enrollment pathway.

i. Differential Display of Standardized Options on the Web Sites of Agents and Brokers

Under current rules, web-brokers and issuers that use the direct enrollment pathway to facilitate enrollment through an Exchange that offers standardized options are not required to give differential display to standardized options. In the 2017 Payment Notice, we noted that we would be conducting consumer testing to help us evaluate ways in which standardized options, when certified by an FFE, could be displayed on our consumer-facing plan comparison features in a manner that makes it easier to find and identify them, including distinguishing them from non-standardized plans. We noted that we anticipate differentially displaying the standardized options to allow consumers to compare plans based on differences in price and quality rather than cost-sharing structure, as well as providing information to explain the standardized options concept to consumers.

We added a new provision to § 155.205(b)(1) codifying the Exchange's authority to differentially display standardized options on our consumer-facing plan comparison and shopping tools. We did not require QHP issuers or web-brokers to adhere to differential display requirements of standardized options when using a non-Exchange Web site to facilitate enrollment in a QHP through an Exchange for the 2017 plan year, but we noted that we would consider whether to propose such a requirement in the future. Elsewhere in this document, we propose for the 2018 plan year and beyond, to allow SBE–FPs to choose to allow HHS-designed standardized options to receive differential display on *HealthCare.gov*, just as the plans would if offered through an FFE.

For the 2018 plan year and beyond, we propose to require web-brokers and issuers that use the direct enrollment pathway to differentially display standardized options when they facilitate enrollment through an FFE or an SBE–FP that has elected to implement differential display; however, we would not require the manner of differentiation to be identical to the one adopted for displaying standardized options on *HealthCare.gov*. We recognize that web-brokers and issuers may have system constraints that prevent them from mirroring the *HealthCare.gov* display approach, and so propose that if a web-broker or issuer that uses the direct enrollment pathway wants to deviate from the manner adopted by HHS for display on *HealthCare.gov*, such deviations would be permitted, subject to approval by HHS. In approving deviations, HHS would consider whether the same level of differentiation and clarity is being provided under the deviation requested by the web-broker or issuer as is provided on *HealthCare.gov*. Therefore, we propose to amend § 155.220(c)(3)(i) governing web-brokers by adding new paragraph (c)(3)(i)(H), and to amend § 156.265(b)(3) governing QHP issuers engaged in direct enrollment by adding new paragraph (b)(3)(iv) to require differential display of all standardized options in accordance with the requirements under § 155.205(b)(1) in a manner consistent with that adopted by HHS for display on the FFE Web site, unless HHS approves a deviation.

ii. Enhanced Direct Enrollment Process

In the 2017 Payment Notice (81 FR at 12258), we discussed a proposal to implement an enhanced direct enrollment process to facilitate enrollment through Exchanges that rely on the Federal platform for their eligibility and enrollment functions, namely FFEs or SBE–FPs. If we were to

implement this process, it would be an additional option for a web-broker or QHP issuer to conduct direct enrollment activities; those entities could also continue to conduct direct enrollment through the current process, which requires a consumer to be redirected to *HealthCare.gov* in order to apply for coverage and receive an eligibility determination. In the 2017 Payment Notice, we discussed establishing an enhanced direct enrollment pathway, and stated that HHS would continue to analyze the necessary protections that need to be in place before moving forward with that new process. We now seek additional comments from the public as described below.

Under the direct enrollment process today, a consumer is redirected from the Web site of the direct enrollment partner (issuer or web-broker) to *HealthCare.gov* to complete the eligibility application and obtain an eligibility determination. Under the enhanced direct enrollment process that we are considering, a consumer might remain on the Web site of the direct enrollment partner (QHP issuer or web-broker) to submit information necessary for an eligibility determination without being redirected to *HealthCare.gov*. The enhanced direct enrollment partner would pass information collected for the eligibility application to the Exchange. The Exchange would then generate the eligibility determination and pass the eligibility results back to the enhanced direct enrollment partner. The consumer could see the results on the direct enrollment partner's Web site. Just as with the current direct enrollment process, the Exchanges would continue to make the eligibility determination under enhanced direct enrollment, and eligibility verification information the Exchanges receive from other government agencies would not be disclosed to the enhanced direct enrollment partner. We believe that an enhanced direct enrollment process would allow the consumer to have a more streamlined experience and would permit the Exchange to offer a diverse set of enrollment channels to reach consumers.

Although offering additional enrollment channels may make it easier for consumers to access coverage under qualified health plans, we must consider any additional risks this enrollment channel may pose to consumer privacy and the security of the consumer data that will be provided to enhanced direct enrollment partners. We solicit comment on these additional risks, as well as comment on any additional privacy and security safeguards and other consumer protections that should be implemented. We intend to conduct a privacy impact assessment as required by OMB Memorandum M–10–23. These comments will inform our identification and assessment of privacy and security risks presented by the enhanced direct enrollment pathway. This assessment will also help us to identify necessary safeguards that need to be in place to protect the personal data that consumers would entrust to enhanced direct enrollment partners.

iii. Additional Protections for the Current Direct Enrollment Process and FFE Standard of conduct for Agents and Brokers

We also propose in this rule a number of modifications to existing requirements and the establishment of new requirements for agents and brokers that use the current direct enrollment process to ensure adequate consumer protection if a web-broker is facilitating enrollment through an FFE or SBE–FP. We propose to make a number of the same changes to § 156.1230, which governs QHP issuers using direct enrollment, to ensure that consumers have similar protections when enrolling through a direct enrollment channel, whether they enroll using a web-broker, or a QHP issuer, and seek comment on whether any additional requirements should apply, or if any of these requirements should be modified, removed, or enhanced when applied to QHP issuers using the direct enrollment channel. First, we propose to add § 155.220(c)(3)(i)(I) to require web-brokers to display information provided by HHS pertaining to eligibility for the advance payments of the premium tax credit (APTC) and cost-sharing reductions in a prominent manner. This will increase the likelihood that consumers understand their potential eligibility for APTC and cost-sharing reductions and potential liability for excess APTC repayment, and can factor those determinations into their QHP selection and the amount of APTC they elect to take.

Second, under § 155.310(d)(2), an Exchange may only provide APTC if the Exchange receives certain attestations from the tax filer, and must permit an enrollee to accept less than the full amount of APTC for which the enrollee is eligible. Therefore, in order for an Exchange to provide APTC to a consumer who enrolls through the enhanced direct enrollment pathway, the direct enrollment partner must provide enrollees with an opportunity to input their desired amount of APTC and provide the required APTC-related attestations. HHS is aware that some web-brokers are not consistently permitting enrollees to select an amount for APTC under the existing direct enrollment pathway, and believes that permitting such would streamline the current direct enrollment pathway for consumers. Accordingly, we propose to add § 155.220(c)(3)(i)(J) to require web-brokers to allow consumers to select an APTC amount and make related attestations in accordance with the requirements of § 155.310(d)(2). We note that this would be consistent with 45 CFR 156.1230(a)(1)(v), under which QHP issuer direct enrollment partners are currently required to allow consumers to select an APTC amount and make related attestations.

Third, we propose to add § 155.220(c)(3)(i)(K) to require the agent or broker of record who assisted the consumer with enrollment through the Exchange (that is, the agent or broker whose National Producer Number is listed on the Exchange application) to support post-enrollment activities necessary for the consumer to effectuate his or her coverage or resolve issues related to his or her enrollment, including discrepancies related to eligibility. For example, we are aware of situations when consumers inadvertently failed to make their binder payments and lost their coverage without their knowledge. HHS would require the agent or broker to support the consumer to help ensure that consumers are educated about how to make the binder payment. Similarly, we would require the agent or broker to support the resolution of open data matching issues. We understand that many agents and brokers provide this type of assistance today to their clients after initial enrollment, helping with questions or problems that may arise regarding billing, claims or appeals. We believe that this proposal will help ensure that consumers who access an agent or broker's direct enrollment channel would have access to the skilled assistance and expertise of licensed agents and brokers beyond the initial QHP selection and enrollment process. We intend to provide further guidance on the extent of this required post-enrollment support, and solicit comment on types and extent of support that agents and brokers should be required to provide. We also solicit comments on what additional safeguards, if any, should be put in place to protect consumers and their data.

Fourth, we propose to add § 155.220(c)(3)(i)(L) to require web-brokers to demonstrate operational readiness, including compliance with applicable privacy and security

requirements, prior to accessing either the current or enhanced direct enrollment pathway. This is intended to build upon the onboarding and testing process that web-brokers undergo under existing procedures for the current direct enrollment process. This process would require the web-broker to demonstrate that it has implemented required privacy and security measures and that it satisfies the technical specifications, testing requirements, and onboarding procedures applicable to the direct enrollment process that the web broker is using prior to accessing the Exchange. Consistent with § 155.220(c)(5), we intend to conduct ongoing monitoring and audits to verify that compliance throughout the term of the web-broker's registration with the Exchange.

Fifth, we propose adding § 155.220(c)(3)(i)(M), to allow HHS to immediately suspend the agent or broker's ability to transact information with the Exchange as part of the direct enrollment pathway if HHS discovers circumstances that pose unacceptable risk to Exchange operations or its information technology systems. The suspension would last until HHS is satisfied that the risk has been removed or sufficiently mitigated. For example, a web-broker's access to the direct enrollment pathway may be suspended if it is determined that the web-broker is using an enrollment process other than the HHS-approved processes, presenting a risk of inaccurate eligibility determinations or presenting unacceptable security or privacy risks to consumer data. We note that this direct enrollment requirement is similar to the one at § 155.220(c), which applies to agents or brokers making their Web site available to another agent or broker. We seek comment on whether these or other similar requirements should be combined. In addition, we propose to add language to § 155.220(c)(3)(i)(E) to require an agent or broker to cooperate with any audit under this section. This would include responding to requests for information in a timely fashion, as well as providing access upon request to documents or other materials necessary to confirm compliance with applicable requirements.

Sixth, consistent with § 155.220(c)(4), web-brokers are permitted to provide access, through a contract or other arrangement, to their direct enrollment pathway to another agent or broker to help an applicant complete the QHP selection process, and must comply with certain obligations when doing so. We understand that a number of web-brokers provide access to their direct enrollment pathway to other agents and brokers who host their own third-party Web sites. To better protect consumers accessing these downstream third-party Web sites that connect to the web-broker's direct enrollment pathway, we are proposing to add language to § 155.220(c)(4)(i)(E) to require web-brokers that provide this access to be responsible for ensuring those Web sites are compliant with this section.

HHS is also considering different methods for completing the monitoring and audits authorized by § 155.220(c)(5). For example, HHS, its designee, or an approved third party could perform the onboarding testing or audit. Where approved third parties perform onboarding reviews and audits, we anticipate that they would be approved by HHS and would need the capability to audit web-brokers' ability to securely collect, maintain, and transmit eligibility application information in a manner determined by HHS and to otherwise review compliance with HHS rules. For third parties to be approved to conduct these activities, we expect that the auditor would need to submit an application to HHS demonstrating prior experience in verifying these sorts of capabilities, and, if approved, enter into an agreement with HHS governing the auditor's compliance with HHS audit and verification standards, interface with HHS systems, and data use. The auditor would be required to collect, store, and share data with HHS on these verifications, and protect that data in accordance with HHS standards. The auditor would be subject to monitoring and periodic certification by HHS, and would be compensated by the agents or brokers who engaged the auditor. If HHS elects to allow third parties to perform such verifications, we would establish a process for evaluating and approving third party vendors in a manner similar to the one established in § 155.222. We solicit comment on our proposal to allow third parties to perform monitoring and audits authorized by § 155.220(c). We also seek comment on whether we should establish a process for recognizing third parties to perform such monitoring, what protections are needed, and the factors HHS should consider in evaluating and approving organizations for this type of role.

Finally, we propose to amend § 155.220(j)(2)(i) to provide that an agent or broker that assists with or facilitates enrollment of qualified individuals in a manner that constitutes enrollment through an FFE or SBE–FP, or assists individuals in applying for APTC and cost-sharing reductions for QHPs sold through an FFE or SBE–FP, must refrain from having a Web site that HHS determines could mislead consumers into believing they are visiting *HealthCare.gov*. For example, our experience shows that Web sites that utilize combinations of colors, text sizes and fonts or layout similar to those used on *HealthCare.gov* have caused confusion among consumers. Web sites whose URL address or marketing name could suggest the Web site is owned or endorsed by *HealthCare.gov* would also be inappropriate. We believe that it is important to avoid consumer confusion around which Web sites are operated by the FFE or SBE–FP, and which ones are operated by issuers, or agents or brokers. We would be interested in feedback on criteria for determining whether a Web site is misleading to consumers.

We seek comment on all aspects of this proposal and specifically seek comment on whether direct enrollment with a QHP issuer should be permitted for enrollments through all SBE–FPs, or at the option of SBE–FPs.

d. General Standards for Exchange Notices (§ 155.230)

Section 155.230 outlines standards for notices required to be sent by the Exchange to individuals or employers. We propose amending paragraph § 155.230(d)(2) to specify that electronic notices would be the default method for sending required SHOP Exchange notices, unless otherwise required by Federal or State law. The proposed amendment would make mailed paper notices optional, at the election of the employer or employee, as applicable, unless other Federal or State law would not permit this.[44] We propose this change because we have received feedback from SHOP consumers and issuers that electronic notices are the preferred method of communication. In addition, electronic notices provide a more cost effective way for SHOPs to distribute required notices. However, we are aware that some people (and employers) may still prefer mailed paper notices, and therefore propose that paper notices distributed through standard mail would continue to be available for those that select paper notices as the preferred method of communication. Employers and employees participating in FF–SHOPs or in SBE–FPs utilizing the Federal platform for SHOP functions will continue to be able to select their preferred communication method when

[44] See Federally-facilitated Marketplace (FFM) and Federally-facilitated Small Business Health Options Program (FF–SHOP) Enrollment Manual available at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ENR_FFMSHOP_Manual_080916.pdf*, for a list of the FF–SHOP Exchange notices.

completing the eligibility applications online at *HealthCare.gov*. We note that to the extent that a SHOP is required to provide notices in a particular format to meet its obligation to perform effective communication with an individual with a disability under the Americans with Disabilities Act of 1990 (42 U.S.C. Ch. 126), section 504 of the Rehabilitation Act, or section 1557 of the Affordable Care Act, a SHOP should comply with those requirements.

We note that this amendment would not change the requirement that a SHOP comply with the requirements for electronic notices in 42 CFR 435.918(b)(2) through (5) for the employer or employee. We seek comment on this proposal.

We also propose to add a new paragraph § 155.230(d)(3) to give individual market Exchanges and SHOPs flexibility to send notices through standard mail, instead of electronically, if an individual market Exchange or SHOP is unable to send select notices electronically due to technical limitations, even if an election has been made to receive such notices electronically. Our regulation currently requires that, should an individual's, employee's, or employer's notice preference be electronic notices, an individual market Exchange must send required notices according to this preference, and our proposed amendment to paragraph (d)(2) would require that a SHOP provide electronic notices unless paper notices are selected as the preferred communication method. However, Exchanges or SHOPs may have technological limitations that prevent them from sending certain notices electronically. In these situations, we would like to provide flexibility for an individual market Exchange or SHOP to instead notify the individual, employee, or employer through standard mail. We encourage individual market Exchanges or SHOPs who might need to exercise this option to explain to individuals, employees, or employers that some required notices may be sent through standard mail, and encourage additional outreach be conducted, as needed, so the individual, employee, or employer understands the content of the standard mail notice itself. We seek comment on this proposal.

e. Payment of Premiums (§ 155.240)

When an enrollee stops receiving the benefit of advance payments of the premium tax credit, for example as a result of a data matching inconsistency period expiring, the enrollee will be responsible for a greater premium amount. For individuals who have agreed to pay premiums via electronic funds transfer (EFT), this could mean the withdrawal of a larger than expected amount from the enrollee's bank account, and could result in financial hardship. We recognize that issuers have different procedures in place to provide notice to enrollees affected by a larger-than-expected EFT withdrawal and to avoid potential consumer hardship. We are considering future rulemaking that would require safeguards for consumers, such as reversal or termination of EFTs, with or without simultaneous paper-billing, when EFT amounts are of a larger-than-expected amount. We seek comment regarding the scope of any potential problem related to larger-than-expected EFT withdrawals, issuers' experience with these withdrawals, industry best practices, State regulations in this area, and whether Federal rulemaking is needed.

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

a. Eligibility Redetermination During a Benefit Year (§ 155.330)

Paragraph (d)(1)(ii) of § 155.330 requires the Exchange to periodically examine available data sources for eligibility determinations for certain government health programs, including Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), for Exchange enrollees on whose behalf APTC or the cost-sharing reduction portion of advance payments are being paid. We are proposing to amend paragraph (d)(1)(ii) to require the Exchange to periodically examine data sources for information on either eligibility determinations for or enrollment in the specified government programs.

The proposed change would provide Exchanges with flexibility to use information about enrollment in the specified government health programs, rather than information about eligibility determinations. Having this flexibility may be particularly valuable if data on eligibility determinations (as distinct from enrollment) are not available. When deciding whether to examine data sources for eligibility determinations or enrollment information, Exchanges should consider which data source best meets the criteria of timeliness, accuracy, and availability.

We propose to add a new paragraph § 155.330(e)(2)(iii) related to periodic examination of data sources. Currently, paragraph (e)(2)(i) describes the procedures for redetermination and notification of eligibility when, through a data matching process under § 155.330(d), an Exchange identifies updated information regarding death or any factor of eligibility not regarding income, family size, or family composition. Our regulations have not previously addressed how an Exchange should use updated information regarding compliance with the income tax filing and reconciliation requirement under § 155.305(f)(4). Due to certain operational and legal impediments explained below, we believe that the procedures in paragraph (e)(2)(i) may not be appropriate in these cases. Proposed new paragraph (e)(2)(iii) would require an Exchange to choose among three alternatives for when the Exchange identifies updated information regarding compliance with the income tax filing and reconciliation requirement under § 155.305(f)(4): (A) Follow the procedures specified in paragraph (e)(2)(i) of this section; (B) follow alternative procedures specified by the Secretary in guidance; or (C) follow an alternative process proposed by the Exchange and approved by the Secretary based on a showing that the process meets the approval criteria outlined below.

An Exchange enrollee's continued eligibility for APTC may be jeopardized when the person responsible for reconciling the tax credit on a tax return fails to do so as required in § 155.305(f)(4). However, Exchange operational concerns, the need for close cooperation with the IRS, timelines for tax filing (including requesting an extension of the tax filing deadline), timelines for updating the IRS database that provides information about income tax return filing and reconciliation, and restrictions on the disclosure of Federal tax information affect an Exchange's processes for making redeterminations and communicating with enrollees regarding redeterminations.

In light of these complexities, specific procedures for handling these redeterminations may be warranted that balance Exchange operational flexibility, the need for program integrity protections and procedural protections for enrollees and tax filers. Accordingly, under proposed paragraph (e)(2)(iii), Exchanges must follow the procedures specified in § 155.330(e)(2)(i) (provided the Exchange is able to maintain adequate safeguards for Federal tax information consistent with section 6103 of the Code with respect to the confidentiality, disclosure, maintenance, or use of such information), procedures described in guidance published by the Secretary, or alternative procedures approved by the

Secretary. The guidance established by the Secretary could, for example, provide that an Exchange would follow specified procedures for providing notice and, if there is a dispute about the IRS tax filing data regarding the tax filer (or his or her spouse, if applicable), provide an opportunity for the enrollee to contest.

An Exchange would also be permitted to choose alternative procedures for periodic data matching to verify whether a tax filer has complied with the filing and reconciliation requirement, subject to approval by the Secretary. Approval would require a showing by the Exchange that the alternative procedures would facilitate continued enrollment in coverage with financial assistance for which the enrollee remains eligible, provide appropriate information about the process to the enrollee (including regarding any action by the enrollee necessary to obtain the most accurate redetermination of eligibility), and provide adequate program integrity protections and safeguards for Federal tax information under section 6103 of the Code with respect to the confidentiality, disclosure, maintenance, or use of such information.

Additionally, in paragraph (g), we propose to allow alternate methods of recalculating APTC during the benefit year. Currently, paragraph (g) provides that when an Exchange makes an eligibility redetermination in accordance with § 155.330 that results in a change in the amount of APTC, the Exchange must recalculate the amount of APTC to account for any payments already made on behalf of the tax filer for the benefit year. The goal of the recalculation is to provide the total advance payments for the benefit year that correspond to the tax filer's total projected and allowed premium tax credit for the benefit year.

We propose for coverage years through 2023 to permit the Exchange to recalculate APTC in accordance with an eligibility redetermination under § 155.330 using an alternate method approved by the Secretary. Approval would require a showing by the Exchange that the alternative procedure provides adequate program integrity protections, minimizes administrative burden on the Exchange, and limits negative impacts on consumers, where possible. We make this change based on Exchange feedback and believe the proposed change will account for the differences in Exchange systems and mitigate complexities. We believe this change balances the need for Exchange flexibility in the near term with the goal of providing accurate determinations for APTC and protecting tax filers from the potential for an excess APTC repayment, where possible. We seek comment on this proposal and on the period of time for which it should be available.

We seek comment on these proposals.

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

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

We propose to amend § 155.400 to add additional flexibility to the binder payment rules. Specifically, we propose to add § 155.400(e)(2) to give Exchanges the discretion to allow issuers experiencing billing or enrollment problems due to high volume or technical errors to implement a reasonable extension of the binder payment deadlines the issuer has set under § 155.400(e)(1). We propose that the FFEs and SBE–FPs will, and State Exchanges may, allow these reasonable extensions, which in the case of most high volume situations or technical errors we would not expect to be more than 45 calendar days' duration. Based on our experience from multiple open enrollment periods, billing or enrollment problems, particularly in cases where an issuer experienced technical errors or a processing backlog caused by a large volume of enrollments, can affect enrollees' ability to submit timely binder payments. We believe providing issuers with the option to allow reasonable binder payment deadline extensions, which must be implemented in a uniform and nondiscriminatory manner, would prevent enrollees from having their coverage cancelled due to non-payment when those enrollees did not have adequate time to make their binder payments and appropriately balances issuer flexibility and consumer protectiveness.

We also propose to specify that all binder payment rules, including the proposed amendment, in § 155.400(e) apply to SBE–FPs in addition to FFEs. We believe that all entities on the Federal platform should utilize the same binder payment rules in order to simplify operational implementation of enrollment processing and confirmation using the Federal platform, and consider these rules to fall within the regulations pertaining to issuer eligibility and enrollment functions that a QHP issuer must comply with in order to participate in an SBE–FP, under § 156.350. We seek comment on this proposal.

Additionally, in the preamble to § 156.270 in the 2017 Payment Notice, we stated as part of our interpretation of § 156.270(d) that a binder payment is not necessary when an enrollee enrolls, either actively or passively, in a plan within the same insurance product. We understand that this may be different than issuer practice prior to the Affordable Care Act and that issuers may have operational challenges in distinguishing between enrollment in the same product versus a different product. To minimize operational concerns, we seek comment on whether we should amend the binder payment requirement in § 155.400(e) to not require a binder payment when a current enrollee enrolls, either actively or passively, in any plan with the same issuer, and on the appropriate timeframe for making such a change.

b. Special Enrollment Periods (§ 155.420)

Special enrollment periods, a longstanding feature of employer-sponsored coverage, exist to ensure that people who lose health insurance during the year, or who experience other qualifying events, have the opportunity to enroll in coverage. We are committed to making sure that special enrollment periods are available to those who are eligible for them and equally committed to avoiding any misuse or abuse of special enrollment periods.

In 2016, we added warnings on *HealthCare.gov* about inappropriate use of special enrollment periods, eliminated special enrollment periods that are no longer needed as the Exchanges mature, and tightened eligibility rules. In addition, we introduced a special enrollment confirmation process under which consumers enrolling through the most common special enrollment periods are directed to provide documentation to confirm their eligibility for the special enrollment period.

We have heard competing concerns about how these actions are affecting the Exchange risk pools. Some have stated that additional changes are needed to prevent individuals from misusing special enrollment periods to sign up for coverage only after they become sick.[45] Others have stated that any differential costs for the special enrollment period

[45] We have heard similar concerns about potential gaming and adverse selection that could result from the grace period for payment of premiums for qualified individuals receiving advance payments of the premium tax credit. While we seek additional information on this concern as well, we expect that changes to grace period policy would require legislation.

population reflect the very low take-up rates for special enrollment periods among eligible individuals. They claim that verification processes worsen the problem by creating new barriers to enrollment, with healthier, less motivated individuals, the most likely to be deterred.

We seek comment on these issues, especially data that could help distinguish misuse of special enrollment periods from low take-up of special enrollment periods among healthier eligible individuals, evidence on the impact of eligibility verification approaches, including pre-enrollment verification, on health insurance enrollment, continuity of coverage, and risk pools (whether in the Exchange or other contexts), and input on what special enrollment period-related policy or outreach changes, including in the final rule, could help strengthen risk pools.

In this rule, we also seek to ensure transparency, stability, and appropriate utilization of special enrollment periods by codifying certain special enrollment periods that were made available through prior guidance. Therefore, in order to provide clarity and certainty to all stakeholders, we propose to codify:

- Paragraph (d)(8)(ii) for the special enrollment period for dependents of Indians who are enrolled or are enrolling in a QHP through an Exchange at the same time as an Indian;
- Paragraph (d)(10) for the special enrollment period for victims of domestic abuse or spousal abandonment and their dependents who seek to apply for coverage apart from the perpetrator of the abuse or abandonment;
- Paragraph (d)(11) for the special enrollment period for consumers and their dependents who apply for coverage and are later determined ineligible for Medicaid or CHIP;
- Paragraph (d)(12) for the special enrollment period that may be triggered by material plan or benefit display errors on the Exchange Web site, including errors related to service areas, covered services, and premiums; and
- Paragraph (d)(13) for the special enrollment period that may be triggered when a consumer resolves a data matching issue following the expiration of an inconsistency period.

We propose to codify the special enrollment period for dependents of Indians who are enrolling at the same time as the Indian, as defined by section 4 of the Indian Health Care Improvement Act, in paragraph (d)(8)(ii) so that Indians and non-Indian members of the household may maintain the same coverage and so that this special enrollment period is consistently applied across Exchanges. This special enrollment period has enabled mixed status Indian families to enroll in or change coverage together through the Exchange. We propose to codify the special enrollment period for victims of domestic abuse or spousal abandonment in paragraph (d)(10) so that, as specified in July 2015 guidance,[46] victims of domestic abuse or spousal abandonment, along with their dependents, can enroll in coverage separate from their abuser or abandoner. This special enrollment period has provided a needed pathway to new coverage for consumers in these situations. We propose to codify the special enrollment period for consumers who apply for coverage during the Exchange annual open enrollment period or due to a qualifying event and are determined ineligible for Medicaid or CHIP in paragraph (d)(11), so that consumers who applied for coverage when they were eligible to do so can ultimately enroll in coverage through the Exchange. This special enrollment period has ensured that consumers who were incorrectly assessed potentially eligible for Medicaid or CHIP have a pathway to coverage. We propose to codify the special enrollment period for material plan or benefit display errors in paragraph (d)(12), so that consumers who enrolled in a plan based on incorrect plan or benefit information can select a new plan that better suits their needs. We propose to codify the special enrollment period for data matching issues that are cleared after the deadline for resolving has passed in paragraph (d)(13), so that consumers who submit required documents to prove that they are qualified individuals may enroll in coverage through the Exchange. This special enrollment period has enabled consumers who are not able to submit required documents prior to the deadline associated with their data matching issue to enroll in coverage upon submitting sufficient documents. We seek comments on these proposals to codify existing special enrollment periods.

We also propose to make a variety of technical corrections to correct punctuation in paragraphs (d)(1)(i) and (iii), and to update the cross-references in paragraph (b)(2)(iii) (regarding coverage effective dates) to reflect the applicable newly codified special enrollment periods. All of these changes reflect existing FFE practice in implementing special enrollment periods authorized by the Affordable Care Act and existing regulations, and do not create new special enrollment periods for consumers.

We note that certain special enrollment periods in § 155.420 are incorporated into the individual market guaranteed availability regulations at § 147.104(b) and apply to all issuers offering non-grandfathered individual market coverage, whether through or outside of an Exchange. Additionally, certain special enrollment periods in § 155.420 also apply in the SHOPs and are incorporated into the SHOP regulations at §§ 155.725(j) and 156.285(b). Except for the proposed additions of paragraphs (d)(8)(ii) and (d)(13), which are applicable only with respect to coverage offered through an Exchange, the proposed changes to special enrollment periods in this notice of proposed rulemaking would apply throughout the individual market, and we therefore propose conforming amendments to § 147.104(b). We seek comment on this approach to aligning the proposed amendments with the individual-market-wide and SHOP special enrollment periods.

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

We propose to amend § 155.430(b)(2)(iii) to specify that when an issuer seeks to rescind coverage, in accordance with § 147.128, in a QHP purchased through an Exchange, the issuer must first demonstrate, to the reasonable satisfaction of the Exchange, that the rescission is appropriate, if so required by the Exchange. In FFEs and SBE–FPs, HHS anticipates generally requiring such a demonstration. Section 2712 of the PHS Act and § 147.128 prohibit an issuer from rescinding coverage unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. We do not seek to restrict issuers' ability to rescind coverage when an individual or a party seeking coverage on behalf of an individual fraudulently enrolls the individual in coverage. However, because the Exchanges generally must be involved in all enrollment processes, including the process of rescinding coverage for plans purchased through the Exchange, it is necessary for the issuer to provide information to the Exchange in order to implement the rescission. Additionally, it is important for consumer protection and the orderly functioning of Exchanges that

[46] Updated Guidance on Victims of Domestic Abuse and Spousal Abandonment (Jul. 27, 2015). Available at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Updated-Guidance-on-Victims-of-Domestic-Abuse-and-Spousal-Abandonment_7.pdf.*

individuals whose eligibility has been verified and enrollments processed according to Exchange rules can be sure that their coverage will not be rescinded by issuers without a showing that the enrollment was fraudulent, or due to an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage, meeting the requirements for rescission under § 147.128. The FFEs or SBE–FPs would not hinder an issuer seeking to rescind on grounds demonstrating fraud or intentional misrepresentation of material fact, such as the enrollment of a non-existent or deceased person. We seek comment on this proposal.

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

a. General Eligibility Appeals Requirements (§ 155.505)

In § 155.505, we propose to add paragraph (h) permitting the Exchange appeals entity to utilize paper-based appeals processes for the acceptance of appeal requests, the provision of appeals notices, and the secure transmission of appeals-related information between entities, when the Exchange appeals entity is unable to establish and perform otherwise required related electronic functions, as further described below. In the first Program Integrity Rule, 78 FR 54069 (Aug. 30, 2013), we provided flexibility for Exchanges to implement a paper-based appeals process for the first year of operations (October 1, 2013 through December 31, 2014). Our goal was to allow Exchanges to operate efficient, effective paper-based appeals processes, while providing time to modernize their appeals programs. We believed this approach balanced the interests of both appellants and Exchanges.

We extended this flexibility through December 31, 2016 in guidance published on October 23, 2014 [47] and March 22, 2016.[48] In these documents, we acknowledged that Exchanges face many challenges and competing priorities regarding system development. Currently, some Exchange appeals entities are continuing to work towards full compliance with the regulatory requirements related to electronic appeals processes.

Accordingly, we are proposing to add § 155.505(h) so the Exchange appeals entity may establish secure and expedient paper-based appeals processes that ensure appropriate procedural protections for appellants when it is unable to fulfill the electronic requirements related to individual market eligibility appeals, employer appeals, and SHOP employer and employee appeals as described in part 155, subparts C, D, F, and H. These electronic requirements include: Accepting appeal requests submitted by telephone or internet (§ 155.520(a)(1)(i) and (iv)), sending electronic notices (§ 155.230(d)), and establishing secure electronic interfaces to transfer eligibility and appeal records between appeals entities and Exchanges or Medicaid or CHIP agencies (§ 155.345(i)(1); § 155.510(b)(1)(ii) and (b)(2); § 155.520(d)(1)(ii) and (iii) and (d)(3) and (4); § 155.545(b)(3); § 155.555(e)(1); and § 155.740(h)(1)). We are also proposing corresponding amendments to § 155.555(b) (regarding employer appeals) and § 155.740(b)(2) (regarding SHOP appeals) to include cross-references to proposed § 155.505(h).

This proposal addresses the ongoing challenge of implementing complex electronic appeals processes, while adequately protecting appellants' procedural rights. We expect that appeals entities will continue to work towards modernizing and automating their appeals processes, and that they will implement electronic appeals processes as they are able, to the extent such processes may enhance appellants' experience or the overall efficiency of eligibility appeals.

We seek comment on this proposal.

b. Employer Appeals Process (§ 155.555)

Section 155.555(b) sets forth the requirements for employer appeals processes established either by an Exchange or HHS. As described above, we propose to amend § 155.555(b) to include cross-references to proposed § 155.505(h), which would permit an employer appeals process to utilize paper-based appeals processes for the acceptance of appeal requests, the provision of appeals notices, and the secure transmission of appeals-related information between entities, when the Exchange appeals entity is unable to establish and perform otherwise required related electronic functions.

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

Under section 5000A of the Code, an individual must have minimum essential coverage for each month, qualify for an exemption, or make a shared responsibility payment with his or her Federal income tax return. Under section 5000A(e)(1) of the Code, an individual is exempt if the amount that he or she would be required to pay for minimum essential coverage (the required contribution) exceeds a particular percentage (the required contribution percentage) of his or her actual household income for a taxable year. In addition, under § 155.605(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 said future adjustments would be published annually in the HHS notice of benefit and payment parameters.

Under the HHS methodology, the rate of premium growth over the rate of income growth for a particular calendar year is the quotient of (x) 1 plus the rate of premium growth between the preceding calendar year and 2013, carried out to ten significant digits, divided by (y) 1 plus the rate of income growth between the preceding calendar year and 2013, carried out to ten significant digits.[49]

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

[47] Subregulatory Guidance Memorandum (Oct. 23, 2014), *available at https://www.cms.gov/CCIIO/Resources/Regulations-andGuidance/Downloads/Paper-based-Appeals-Process-Guidance.pdf*.

[48] Subregulatory Guidance Memorandum (Mar. 22, 2016), *available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Extension-for-paper-based-appeals-3-22-2016.pdf*).

[49] 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.

percentage is based on projections of average per enrollee employer-sponsored insurance premiums from the National Health Expenditure Accounts (NHEA), which are calculated by the CMS Office of the Actuary.[50] (Below, in § 156.130, we propose the 2018 premium adjustment percentage of 16.17303196 (or an increase of about 16.2 percent) over the period from 2013 to 2017. This reflects an increase of about 2.6 percent over the 2017 premium adjustment percentage (1.1617303196/1.1325256291).)

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 2018 is the percentage (if any) by which the most recent projection of per capita PI for the preceding calendar year ($51,388 for 2017) exceeds per capita PI for 2013 ($44,528), carried out to ten significant digits. The ratio of per capita PI for 2017 over the per capita PI for 2013 is estimated to be 1.1540603665 (that is, per capita income growth of about 15.4 percent). This reflects an increase of about 4.0 percent relative to the increase for 2013 to 2016 (1.1540603665/1.1101836394).

Thus, using the 2018 premium adjustment percentage proposed in this rule, the excess of the rate of premium growth over the rate of income growth for 2013 to 2017 is 1.1617303196/1.1540603665, or 1.0066460588. This results in a proposed required contribution percentage for 2018 of 8.00*1.0066460588, or 8.05 percent, when rounded to the nearest one-hundredth of one percent, a decrease of 0.11 percentage points from 2017 (8.05317 − 8.16100). The excess of the rate of premium growth over the rate of income growth also is used for determining the applicable percentage in section 36B(b)(3)(A) and the required contribution percentage in section 36B(c)(2)(C).

7. Enrollment Periods Under SHOP (§ 155.725)

Section 155.725(g) describes the process for newly qualified employees to enroll in coverage through a SHOP and the coverage effective date for newly qualified employees. We propose to amend paragraphs (g)(1) and (2) and add new paragraph (g)(3).

Currently, § 155.725(g)(1) requires both that: (1) The enrollment period for an employee who becomes a qualified employee outside of the initial or annual open enrollment period starts on the first day of becoming a newly qualified employee; and (2) a newly qualified employee must have at least 30 days from the beginning of his or her enrollment period to make a plan selection. The latter requirement is intended to guarantee that the employee has sufficient time to make an informed decision about his or her health coverage needs. We do not propose changes to this latter requirement, but we propose to change the day the enrollment period begins.

Before a newly qualified employee may make a plan selection through a SHOP, his or her employer must notify the SHOP about the newly qualified employee. Qualified employers in an FF–SHOP or SBE–FP using the Federal platform for SHOP eligibility or enrollment functions generally report newly qualified employees by adding the employee to the employee roster or by calling the FF–SHOP call center. If, however, a qualified employer waits to take either action, a newly qualified employee might not be able to begin the enrollment process until after the date upon which the employee became eligible, and might not have a full 30 days to make a coverage decision, as contemplated by the current regulations. We are concerned that there might be a similar delay in State-based SHOPs.

To ensure that newly qualified employees have the full 30 days to enroll, we propose, at § 155.725(g)(1), that SHOPs would be required to provide an employee who becomes a qualified employee outside of the initial or annual open enrollment period with a 30-day enrollment period that begins on the date the qualified employer notifies the SHOP about the newly qualified employee. We also propose that qualified employers would be required to notify the SHOP about a newly qualified employee on or before the 30th day after the day that the employee becomes eligible for coverage, and are also proposing a conforming amendment to the requirements for qualified employers at § 157.205(f)(1). Together with the other proposed amendments to paragraph (g) discussed below, this proposal would ensure that the proposed policy of starting the 30-day enrollment period on the date of the qualified employer's notice to the SHOP would not delay the effective date of coverage beyond the limits on waiting periods imposed under § 147.116, and would also ensure that newly qualified employees are provided with a full 30 days to make their health coverage decisions after their employer has notified the SHOP about them.

We also propose to remove the requirement in current § 155.725(g)(1) that enrollment periods for newly qualified employees must end no sooner than 15 days prior to the date that any applicable employee waiting period longer than 45 days would end if the employee made a plan selection on the first day of becoming eligible. We are proposing to remove this requirement because the proposed amendments at paragraphs (g)(2) and (3) discussed below are expected to minimize the risk of employers exceeding waiting period limitations, as defined at § 147.116, and because we believe that removing this requirement will in some circumstances give newly qualified employees a longer period of time to make coverage decisions. For example, suppose that a new employee who is not a variable hour employee is hired and offered coverage by the qualified employer on April 25 and that the qualified employer imposes a 60-day waiting period that begins on the date of hire (and under § 147.116 and the proposed amendments to paragraph (g)(3) discussed below ends June 23). The qualified employer notifies the SHOP on May 25 about the newly qualified employee, and the enrollment period begins on that date and will end on June 23. The newly qualified employee makes a plan selection on May 26. If we maintained the requirements that coverage effective dates for newly qualified employees must generally be determined in accordance with § 155.725(h) (see discussion below of proposed amendments to this requirement) and that enrollment periods for newly qualified employees must begin on the date that the employee becomes eligible, and end no sooner than 15 days prior to the date that any applicable employee waiting period longer than 45 days would end if the employee made a plan selection on the first day of becoming eligible, the newly qualified employee's enrollment period would have ended on June 9 and the employee would have a coverage effective date of July 1. However, under the proposed amendments we are making to this section, the newly qualified employee would be provided a full 30-day enrollment period with the same coverage effective date of July 1.

Current paragraph (g)(2) provides that a newly qualified employee's coverage effective date must always be the first day of a month, and must generally be determined in accordance with

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

paragraph (h), unless the employee is subject to a waiting period consistent with § 147.116, in which case the effective date may be on the first day of a later month, but in no case may the effective date fail to comply with § 147.116. Thus, in an FF–SHOP, under the current rule, coverage for a newly qualified employee generally takes effect the first day of the following month for a plan selection made on or before the 15th day of a month, and takes effect the first day of the second following month for a plan selection made after the 15th day of a month, unless coverage must take effect on a later date due to the application of a waiting period consistent with § 147.116. We propose to modify paragraph (g)(2) to specify that the coverage effective date for a newly qualified employee would be the first day of the month following the plan selection, (rather than being determined in accordance with paragraph (h)), unless the employee is subject to a waiting period consistent with § 147.116 and proposed paragraph (g)(3), in which case the effective date would be on the first day of the month following the end of the waiting period, but in no case may the effective date fail to comply with § 147.116. The proposed amendments to paragraph (g)(2) also specify that: (1) If a newly qualified employee's waiting period ends on the first day of a month and the employee has already made a plan selection by that date, coverage would also be effective on that date; and (2) if a newly qualified employee makes a plan selection on the first day of a month and any applicable waiting period has ended by that date, coverage would be effective on that date. These amendments would minimize the risk of an employer exceeding the limitations on waiting period length at § 147.116 due to SHOP enrollment timelines and processes.

Additionally, in order to ensure that SHOP operations consistent with these proposed amendments would not cause a qualified employer to exceed the limits on waiting periods under § 147.116, we propose to amend § 155.725(g)(2) to require that if a qualified employer with variable hour employees makes regularly having a specified number of hours of service per period (or working full-time) a condition of employee eligibility for coverage offered through a SHOP, any measurement period that the qualified employer uses to determine eligibility under § 147.116(c)(3)(i) must not exceed 10 months with respect to coverage offered through the SHOP (rather than the 12-month measurement period otherwise allowed under § 147.116(c)(3)(i)). This aspect of the proposal is intended to ensure that coverage takes effect within the limitations on waiting period length at § 147.116(c)(3)(i) for variable hour employees, under which coverage must take effect no later than 13 months from the employee's start date, plus, if the employee's start date is not the first day of a calendar month, the time remaining until the first day of the next calendar month. Specifically, for qualified employers that condition eligibility for coverage on an employee regularly having a specified number of hours of service per period (or working full-time), if it cannot be determined that a newly-hired employee is reasonably expected to regularly work that number of hours per period (or work full-time), the qualified employer may take a reasonable period of time, not to exceed 10 months and beginning on any date between the employee's start date and the first day of the first calendar month following the employee's start date, to determine whether the employee meets the eligibility condition.

We seek comment on whether any of the proposed timeframes might result in a situation in which an employer or issuer falls out of compliance with § 147.116.

Consistent with § 147.116, as long as the employee subject to a waiting period may make a plan selection that results in coverage becoming effective within the timeframes required under § 147.116, coverage that begins later as a result of the employee's delay in making a plan selection would not constitute a failure to comply with the waiting period limitations under § 147.116. As a result of our proposal at paragraph (g)(2) of this section, when a newly qualified employee subject to a waiting period makes a plan selection, coverage would begin the first day of the first month that follows the expiration of the waiting period, as long as that date is consistent with the requirements in § 147.116. However, if the first day of the first month following the expiration of the waiting period for this employee would be outside the limits under § 147.116, the SHOP would be required under paragraph (g)(2) to ensure that coverage takes effect within the required timeframe. To avoid this scenario and the operational complications it would cause for SHOPs, we are also proposing to specify in a new paragraph (g)(3) that waiting periods in a SHOP may not exceed 60 days in length. If an individual subject to a waiting period could have had an effective date within the timeframes in § 147.116 by making a plan selection at the beginning of the enrollment period, but delays making a plan selection, consistent with § 147.116(a), coverage would begin the first day of the first month following the end of the waiting period, even if this would not be within the timeframes in § 147.116.

In addition to specifying that waiting periods in SHOPs would not exceed 60 days, proposed paragraph (g)(3) would also specify the calculation methodology for waiting periods in SHOPs. Under this proposed amendment, waiting periods in SHOPs would be calculated beginning on the date the employee becomes eligible—regardless of when the qualified employer notifies the SHOP about the newly qualified employee. For example, a 60-day waiting period would be calculated as the date an employee becomes otherwise eligible plus 59 days. Under this methodology, the date the employee becomes otherwise eligible counts as the first day of the waiting period. We propose this amendment to ensure that employers will remain in compliance with § 147.116 when factoring in certain aspects of the SHOP enrollment timeline, such as the 30 days employers would have under these proposed amendments to notify the SHOP about a newly qualified employee, the 30 days newly qualified employees have to make a plan selection, and the coverage effective dates that would apply under these proposed amendments to § 155.725(g). To minimize operational complexity in the Federal platform build for the SHOP, we are also proposing amendments to paragraph (g)(3) to specify that a Federally-facilitated SHOP or a State-based SHOP that uses the Federal platform for SHOP eligibility or enrollment functions would only allow waiting periods of 0, 15, 30, 45, and 60 days.

Nothing in this proposal would change the rule that in no case may the effective date for a newly qualified employee fail to comply with § 147.116. This proposal would not change § 147.116 and the proposals described in this section of the preamble apply only for purposes of the SHOPs.

We propose to amend paragraph (j)(2)(i) to reflect the proposed codification of existing special enrollment periods discussed in the preamble to § 155.420, specifically those proposed to be codified at § 155.420(d)(10), (11) and (12).

We seek comment on all aspects of these proposals.

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

We propose to amend § 155.740(b)(2) to include a cross-reference to proposed § 155.505(h). This amendment would permit SHOP employer and employee eligibility appeals processes to use a secure and expedient paper-based process if the appeals entity cannot fulfill certain electronic requirements.

9. Request for Reconsideration (§ 155.1090)

We propose a new section § 155.1090 to allow an issuer to request reconsideration of denial of certification of a plan as a QHP for sale through an FFE. We propose that an issuer that has applied to an FFE for certification of QHPs and has been denied certification must submit to HHS a written request for reconsideration within 7 calendar days of the date of written notice of denial of certification in the form and manner specified by HHS in order to obtain a reconsideration. We further propose that the issuer must include any and all documentation in support of its request when it submits its request for reconsideration. We propose that requests may be submitted and considered only after an issuer has submitted a complete, initial application for certification and been denied. In § 155.1090(a)(3), we propose that HHS would provide the issuer with a written reconsideration decision, and that decision would constitute HHS's final determination. We believe this approach would afford issuers an opportunity to furnish any additional facts and information that might not have been considered as part of an FFE's initial decision to deny certification. We believe the short timeline is required to permit us to implement a decision to certify a plan following a request for reconsideration in time for open enrollment. We intend to provide future guidance on the form and manner by which issuers should submit requests for reconsideration. We intend for the Office of Personnel Management to maintain authority over reconsideration of applications from issuers to offer a multi-State plan. We invite comments on this reconsideration proposal.

I. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

1. General Provisions

a. FFE User Fee for the 2018 Benefit Year (§ 156.50)

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

OMB Circular No. A–25R establishes Federal policy regarding user fees, and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public. As in benefit years 2014 to 2017, issuers seeking to participate in an FFE in benefit year 2018 will receive two special benefits not available to the general public: (1) The certification of their plans as QHPs; and (2) the ability to sell health insurance coverage through an FFE to individuals determined eligible for enrollment in a QHP. These special benefits are provided to participating issuers through the following Federal activities in connection with the operation of FFEs:

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

OMB Circular No. A–25R further states that user fee charges should generally be set at a level so that they are sufficient to recover the full cost to the Federal government of providing the service when the government is acting in its capacity as sovereign (as is the case when HHS operates an FFE). Accordingly, we propose to set the 2018 user fee rate for all participating FFE issuers at 3.5 percent. This user fee rate assessed on FFE issuers is the same as the 2014 through 2017 user fee rate. In addition, we intend to seek an exception from OMB Circular No. A–25R, which requires that the user fee charge be sufficient to recover the full cost to the Federal government of providing the special benefit. We seek this exception to ensure that the FFE can support many of the goals of the Affordable Care Act, including improving the health of the population, reducing health care costs, and providing access to health coverage, in cases where user fee collections do not cover the full cost of the special benefit. We seek comment on this proposal.

Additionally, we note that some commenters have suggested that the FFE would be able to increase enrollment by allocating more funds to outreach and education, or reallocating resources from other funding sources when available to pay for those expenses if necessary. We seek comment on how much funding to devote to outreach and education, the method to determine such funding, and the effectiveness of certain outreach investments to inform future FFE funding allocations. We also seek comment on whether HHS should expressly designate a specific portion or amount of the FFE user fee to be allocated directly to outreach and education activities, recognizing the need for HHS to continue to adequately fund other critical Exchange operations such as the call center, *HealthCare.gov*, and eligibility and enrollment activities.

State-based Exchanges on the Federal platform enter into a Federal platform agreement with HHS to leverage the systems established by the FFE to perform certain Exchange functions, and to enhance efficiency and coordination between State and Federal programs. Accordingly, in § 156.50(c)(2), we specify that an issuer offering a plan through an SBE–FP must remit a user fee to HHS, in the timeframe and manner established by HHS, equal to the product of the sum of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for State-based Exchanges that use the Federal platform for the applicable benefit year, unless the State-based Exchange and HHS agree on an alternative mechanism to collect the funds. The functions provided to issuers in the SBE–FPs include the Federal Exchange information technology and call center infrastructure used in connection with eligibility determinations for enrollment in QHPs and other applicable State health subsidy programs, as defined at section 1413(e) of the Affordable Care Act; and enrollment in QHPs under § 155.400. As

previously discussed, OMB Circular No. A–25R establishes Federal policy regarding user fees, and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public. 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, 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 Affordable Care Act, 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 a plan offered through an SBE–FP. This fee would recover funding to support FFE operations incurred by the Federal government associated with providing the services described above. We seek comment on this proposal. In the 2017 Payment Notice, we set the user fee rate for SBE–FPs at 1.5 percent of premiums charged, rather than the full rate of 3.0, in order to provide a transition year during which States could adjust to the assessment of a user fee in SBE–FP States. We seek comment on whether the impact of increasing the SBE–FP user fee rate to the full rate should be spread over one additional year.

We note that we intend to review the costs incurred to provide these special benefits each year, and revise the user fee rate for issuers in the FFEs and SBE–FPs accordingly in the annual HHS notice of benefit and payment parameters.

b. Single Risk Pool (§ 156.80)

Under § 156.80, an issuer must establish an index rate for each State market in the single risk pool. The index rate must be based on the total combined claims costs for providing essential health benefits within the single risk pool of that State market. The index rate also must be adjusted on a market-wide basis for the State based on the total expected market-wide payments and charges under the risk adjustment program and Exchange user fees. We propose to amend § 156.80(d) to remove the reference to the transitional reinsurance program, which was for benefit years 2014 through 2016.

As stated in the Unified Rate Review Instructions, calibration for age, geography, and tobacco use is permissible as long as the calibration is applied uniformly in the single risk pool. These calibration adjustments generally allow for the permissible rating factors under section 2701 of the PHS Act and 45 CFR 147.102 to be applied correctly to the issuer's plans. For example, we use the term ''age calibration'' to refer to an adjustment to the index rate, made uniformly for all plans in the risk pool, to reflect the fact that without calibration, the plan-adjusted index rate reflects the average age of the issuer's risk pool and the uniform age rating curve does not. Therefore, age calibration is necessary in order to correctly apply the age curve and calculate the premium rates. The same rationale applies when applying geographic and tobacco rating factors to the plan-adjusted index rate.

To more explicitly reflect how the rating factors under 45 CFR 147.102 and the index rating methodology under 45 CFR 156.80 work together, we propose to restructure paragraph (d)(1) as paragraphs (d)(1)(i) through (iv), adding new paragraph (d)(1)(iii) to provide that the index rate must be calibrated on a market-wide basis to correspond to an age rating factor of 1.0, a geographic rating factor of 1.0, and a tobacco rating factor of 1.0, in a manner specified by the Secretary in guidance. Because it is essentially an adjustment to the index rate, the calibration from the single risk pool index rate to the allowable rating factors may not vary by plan; it must be made uniformly for all plans in a State and market. We would provide detailed technical guidance through Unified Rate Review Instructions to ensure accurate and uniform application of the calibration methodology proposed here. We seek comment on this proposed codification.

2. Essential Health Benefits Package

a. Premium Adjustment Percentage (§ 156.130)

Section 1302(c)(4) of the Affordable Care Act directs the Secretary to determine an annual premium adjustment percentage, which is used to set the rate of increase for three parameters detailed in the Affordable Care Act: The maximum annual limitation on cost sharing (defined at § 156.130(a)), the required contribution percentage 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. Section 156.130(e) provides that the premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013, and that this percentage will be published annually in the HHS notice of benefit and payment parameters.

Under the methodology established in the 2015 Payment Notice and amended in the 2015 Market Standards Rule for estimating average per capita premium for purposes of calculating the premium adjustment percentage, the premium adjustment percentage is calculated based on the projections of average per enrollee employer-sponsored insurance premiums from the NHEA, which is calculated by the CMS Office of the Actuary. Accordingly, using the employer-sponsored insurance data, the premium adjustment percentage for 2018 is the percentage (if any) by which the most recent NHEA projection of per enrollee employer-sponsored insurance premiums for 2017 ($5,962) exceeds the most recent NHEA projection of per enrollee employer-sponsored insurance premiums for 2013 ($5,132).[51] Using this formula, the proposed premium adjustment percentage for 2018 is 16.17303196 percent. We note that the 2013 premium used for this calculation has been updated to reflect the latest NHEA data. Based on the proposed 2018 premium adjustment percentage, we propose the following cost-sharing parameters for calendar year 2018.

Maximum Annual Limitation on Cost Sharing for Calendar Year 2018. Under § 156.130(a)(2), for the 2018 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 2018, and for other than self-only coverage, the limit is twice the dollar limit for self-only coverage. Under § 156.130(d), these amounts must be rounded down to the next lowest multiple of 50. Using the premium adjustment percentage of 16.17303196 percent for 2018 that we propose above, and the 2014 maximum annual

[51] *See* ''NHE Projections 2015–2025—Tables'' available at: *http://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/ProjectionsMethodology.pdf.*

limitation on cost sharing of $6,350 for self-only coverage, which was published by the IRS on May 2, 2013,[52] we propose that the 2018 maximum annual limitation on cost sharing would be $7,350 for self-only coverage and $14,700 for other than self-only coverage. This represents a 2.8 percent increase above the 2017 parameters of $7,150 for self-only coverage and $14,300 for other than self-only coverage.

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

Sections 1402(a) through (c) of the Affordable Care Act direct issuers to reduce cost sharing for essential health benefits for eligible individuals enrolled in a silver level QHP. In the 2014 Payment Notice, we established standards related to the provision of cost-sharing reductions. Specifically, in 45 CFR 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 limitation on cost sharing specified in the annual HHS notice of benefit and payment parameters. Although the amount of the reduction in the maximum annual limitation on cost sharing is specified in section 1402(c)(1)(A) of the Affordable Care Act, section 1402(c)(1)(B)(ii) of the Affordable Care Act states that the Secretary may adjust the cost-sharing limits to ensure that the resulting limits do not cause the AVs of the health plans to exceed the levels specified in section 1402(c)(1)(B)(i) of the Affordable Care Act (that is, 73 percent, 87 percent, or 94 percent, depending on the income of the enrollee). Accordingly, we propose to 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 2018 maximum annual limitation on cost sharing would be $7,350 for self-only coverage and $14,700 for other than self-only group coverage. We analyzed the effect on AV of the reductions in the maximum annual limitation on cost sharing described in the statute to determine whether to adjust the reductions so that the AV of a silver plan variation will not exceed the AV specified in the statute. Below, we describe our analysis for the 2018 benefit year and our proposed results.

Consistent with our analysis in the past four Payment Notices, we developed three test silver level QHPs, and analyzed the impact on AV of the reductions described in the Affordable Care Act to the estimated 2018 maximum annual limitation on cost sharing for self-only coverage ($7,350). 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 2018, the test silver level QHPs included a PPO with typical cost-sharing structure ($7,350 annual limitation on cost sharing, $2,215 deductible, and 20 percent in-network coinsurance rate), a PPO with a lower annual limitation on cost sharing ($4,950 annual limitation on cost sharing, $2,895 deductible, and 20 percent in-network coinsurance rate), and an HMO ($7,350 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, $350 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 2018 AV Calculator developed by HHS and observed how the reductions in the maximum annual limitation on cost sharing specified in the Affordable Care Act affected the AVs of the plans. We found that the reduction in the maximum annual limitation on cost sharing specified in the Affordable Care Act for enrollees with a household income between 100 and 150 percent of the Federal poverty line (FPL) (⅔ reduction in the maximum annual limitation on cost sharing), and 150 and 200 percent of the FPL (⅔ reduction), would not cause the AV of any of the model QHPs to exceed the statutorily specified AV level (94 and 87 percent, respectively). In contrast, the reduction in the maximum annual limitation on cost sharing specified in the Affordable Care Act for enrollees with a household income between 200 and 250 percent of FPL (½ 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 2018 benefit year with a household income between 200 and 250 percent of FPL be reduced by approximately ⅕, rather than ½, consistent with what we have proposed in previous years. This would allow issuers the flexibility in designing innovative plans with varying lower maximum annual limitation on cost sharing and deductibles for the 73 percent plans. 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 ⅔, as specified in the statute, and as shown in Table 15. These proposed reductions in the maximum annual limitation on cost sharing should adequately account for unique plan designs that may not be captured by our three model QHPs. We also note that selecting a reduction for the maximum annual limitation on cost sharing that is less than the reduction specified in the statute would not reduce the benefit afforded to enrollees in aggregate because QHP issuers are required to further reduce their annual limitation on cost sharing, or reduce other types of cost sharing, if the required reduction does not cause the AV of the QHP to meet the specified level. We welcome comment on this analysis and the proposed reductions in the maximum annual limitation on cost sharing for 2018.

We note that for 2018, 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. The deadline for submitting a dataset for the 2018 plan year is September 1, 2016.[53]

[52] *See http://www.irs.gov/pub/irs-drop/rp-13-25.pdf.*

[53] The annual deadline for submitting State specific data for the actuarial value calculator was announced August 15, 2014. See *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/final-state-avc-guidance.pdf.*

TABLE 15—REDUCTIONS IN MAXIMUM ANNUAL LIMITATION ON COST SHARING FOR 2018

Eligibility category	Reduced maximum annual limitation on cost sharing for self-only coverage for 2018	Reduced maximum annual limitation on cost sharing for other than self-only coverage for 2018
Individuals eligible for cost-sharing reductions under § 155.305(g)(2)(i) (that is, 100–150 percent of FPL)	$2,450	$4,900
Individuals eligible for cost-sharing reductions under § 155.305(g)(2)(ii) (that is, 150–200 percent of FPL)	2,450	4,900
Individuals eligible for cost-sharing reductions under § 155.305(g)(2)(iii) (that is, 200–250 percent of FPL)	5,850	11,700

c. Levels of Coverage: Bronze Plans (§ 156.140)

Section 2707(a) of the PHS Act and section 1302 of the Affordable Care Act direct issuers of non-grandfathered health insurance in the individual and small group markets, including QHPs, to ensure that plans meet a level of coverage specified in section 1302(d)(1) of the Affordable Care Act. A plan's level of coverage, referred to as the plan's actuarial value, is determined on the basis of the essential health benefits provided to a standard population. Section 1302(d)(1) of the Affordable Care Act requires the level of coverage for a bronze plan to have an AV of 60 percent, a silver plan to have an AV of 70 percent; a gold plan to have an AV of 80 percent; and a platinum plan to have an AV of 90 percent. In addition, section 1302(d)(3) states that the Secretary is to develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates. Currently, § 156.140(c) permits a de minimis variation of +/− 2 percentage points.[54]

All plans subject to the annual limitation on cost sharing at section 1302(c) of the Affordable Care Act have a minimum level of generosity that limits the lowest AV that a plan can achieve. For instance, a plan with a deductible of $7,350 that is equal to the annual limitation on cost sharing of $7,350 (which is the proposed 2018 annual limitation on cost sharing) with no services covered until the deductible and annual limitation on cost sharing are met, other than preventive services required to be covered without cost sharing under section 2713 of the PHS Act and 45 CFR 147.130, has an AV of 58.54 percent based on the draft 2018 AV Calculator. Because of the annual limitation on cost sharing, the AV for this type of plan is within the de minimis range of a bronze level of coverage. This type of plan does not have first dollar coverage (except for certain required preventive services), and is not a HDHP under 26 U.S.C. 223(c)(2) eligible for use with a health savings account because the annual limit on cost sharing under the plan is likely higher than the annual out of pocket expense limit for HDHPs for 2018. Furthermore, the bronze plan described above is less generous than a catastrophic plan, because a catastrophic plan is required by section 1302(e)(1)(B) of the Affordable Care Act and § 156.155(a)(4) to provide at least three primary care visits before reaching the deductible.

We note that in future recalibrations of the AV Calculator, if claims costs increase faster than the annual limitation on cost sharing, issuers' flexibility in designing different bronze plans may be reduced. In order to address this difficulty in designing bronze plans that are at least as generous as catastrophic plans and meet the AV requirements using future AV Calculators, we propose to permit a broader de minimis range for bronze plans. The purpose of the current de minimis variation of +/− 2 percentage points is to give issuers the flexibility to set cost-sharing rates while ensuring consumers can easily compare plans of similar generosity. Thus, the de minimis range is intended to allow plans to float within a reasonable range and is not intended to freeze plan designs, which could prevent innovation in the market. However, we do recognize the unique challenges that may be posed for bronze plan designs under future AV Calculators, and we therefore propose to amend § 156.140(c) to increase the allowable de minimis range for bronze plans under certain circumstances.

Outside of HDHPs, which have separate cost-sharing requirements, under future AV Calculators, if actuarial values increase significantly, bronze plans may be required to limit the services for which the plan pays before the deductible is reached. Enrollment data from the FFEs show that consumers have a preference for plans that cover and pay for services below the deductible. Because we believe that the Affordable Care Act did not intend for bronze plans to be less generous than catastrophic plans, which are required to provide at least three primary care visits before the deductible, we believe that it is important to allow bronze plans to retain at least one service before the deductible. Therefore, through our authority under section 1302(d)(3) of the Affordable Care Act, which directs the Secretary to develop guidelines to provide for a de minimis variance in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates, and section 1321(a)(1)(A) and (D) of the Affordable Care Act, which allows the Secretary to issue regulations setting standards for meeting the requirements for the establishment and operation of Exchanges, as well as such other requirements as the Secretary determines appropriate, we propose to allow bronze plans that cover and pay for at least one major service before the deductible, other than preventive services (some of which are required by Federal laws and regulations to have zero cost sharing) to have an allowable variance in AV of −2 percentage points and +5 percentage points. The purpose of this proposal is to ensure flexibility in bronze plan designs—particularly, to permit the design of bronze plans that will satisfy AV requirements and still remain at least as generous as catastrophic plans.

We therefore propose that the major services covered and paid for by the plan before the deductible that trigger the increased de minimis range be similar in scope and magnitude to the three primary care visits before the deductible required under catastrophic coverage. To permit issuers the flexibility to address enrollees' varying health needs, we propose that the major

[54] Under § 156.400, the de minimis variation for a silver plan variation means a single percentage point.

services an issuer may elect to cover and pay for before the deductible in order to access the broader de minimis range be: Primary care visits; specialist visits; inpatient hospital services; generic, specialty, or preferred branded drugs; or emergency room services. We selected these services as they can be used by individuals with a wide variety of conditions and they have a significant AV impact. We solicit comments on this proposal and the proposed definition of major services, as well as comments on whether any of these major services should be excluded from the list or other major services should added to this list. We also solicit comments on whether major services should be defined based on all or some of the service inputs listed in the AV Calculator. This policy does not exempt issuers from their obligations to comply with mental health and substance use disorder parity requirements, including the rule that a deductible cannot be applied to mental health or substance use disorder benefits in a classification unless it is no more restrictive than the predominant deductible applicable to substantially all medical/surgical benefits in the same classification.

We also propose that the major service covered and paid for before the deductible must apply a reasonable cost-sharing rate to the service to ensure that the service is reasonably covered. We also solicit comments on what should be considered a reasonable cost-sharing rate for the major service. Lastly, to ensure that a bronze plan can be as least as generous as a catastrophic plan, we propose that a bronze plan with at least three primary care services under the deductible would qualify as having a major service under the deductible.

In addition to ensuring that bronze plans can remain at least as generous as catastrophic coverage, we believe it is important to ensure that bronze plans can remain eligible to be HDHPs that may be paired with a health savings account. Therefore, we propose that if a bronze plan meets the Federal requirements to be an HDHP, the allowable variation in AV for those plans is −2 percentage points and +5 percentage points. These HDHPs would not be required to cover at least one major service before the deductible, outside of certain preventive services, to meet the requirements for the extended bronze plan de minimis range, but instead, these plans would be required to meet the requirements to be a HDHP within the meaning of 26 U.S.C. 223(c)(2), including the annual out-of-pocket expense limit for HDHPs. We solicit comments on this proposal.

We also seek comment on the proposed size of the de minimis range, which is proposed as −2 percentage points and +5 percentage points, and whether the +5 percentage points should be higher or lower. Based on our initial analysis of 2017 bronze plans submitted for QHP certification in the FFEs, most 2017 bronze plans are either HDHPs or are plans providing one of the major services defined above before deductible. We believe that this policy will not be disruptive to the current bronze plan market as it will allow more flexibility in designing bronze plans within the increased de minimis range as well as allow more options for issuers to leave 2017 cost-sharing structures unchanged.

In connection with the release of the proposed 2018 Payment Notice, we are also releasing the draft versions of the 2018 AV Calculator, including the 2018 AV Calculator Methodology and User Guide, for comment on the Center for Consumer Information and Insurance Oversight Web site.[55] As part of the draft 2018 AV Calculator, we added the option to calculate AV for a bronze plan with an extended de minimis range to align with this proposed policy. (We note that under this option, the AV Calculator will not automatically flag a plan in the bronze extended de minimis range that does not comply with the requirement to cover one major service before the deductible.) Our intention will be to align the final 2018 AV Calculator with any provisions that are finalized through this rulemaking.

d. Application to Stand-Alone Dental Plans Inside the Exchange (§ 156.150)

In the 2017 Payment Notice, we finalized § 156.150(a), which establishes a formula to increase the annual limitation on cost sharing for stand-alone dental plans. Specifically, we finalized that for plan years beginning after 2017, the annual limitation for an SADP for one covered child is $350 increased by the percentage increase of the consumer price index (CPI) for dental services for the year two years prior to the applicable plan year over the CPI for dental services for 2016; and, the annual limitation for an SADP for two or more covered children is twice that.

The formula increases the dollar limit for one covered child (currently set at $350) by the percentage increase of the CPI for dental services for the year two years prior to the applicable plan year over the CPI for 2016. For plan year 2018, the percentage increase of the CPI for dental services for the two years prior to the applicable plan year would be equal to the CPI for 2016, resulting in a zero percent increase for plan year 2018. Therefore, for plan year 2018, the dental annual limitation on cost sharing would be $350 for one child and $700 for one or more children. The annual limitation on cost sharing for plan year 2019 will be addressed in the annual HHS notice of benefit and payment parameters for the 2019 benefit year.

3. Qualified Health Plan Minimum Certification Standards

a. QHP Issuer Participation Standards (§ 156.200)

Section 156.200(c)(1) implements section 1301(a)(1)(C)(ii) of the Affordable Care Act to require as part of QHP participation standards that each QHP issuer offer at least one QHP in the silver coverage level and at least one QHP in the gold coverage level.

As evidenced by QHP application submissions to the FFEs, QHP issuers have generally interpreted this requirement to apply at the service area level, as opposed to at the Exchange level, meaning that an issuer must offer at least one QHP in the silver coverage level and at least one QHP in the gold coverage level throughout each service area in which it will offer a QHP through the Exchange (that is, one QHP that has an AV of 70 percent and one QHP that has an AV of 80 percent, plus or minus two percentage points). If the requirement were to be interpreted at the Exchange level, a QHP issuer could be in technical compliance with the requirement by offering one QHP in the silver coverage level and at least one QHP in the gold coverage level in a very limited service area, and not offer such coverage through the Exchange in a meaningful way. We believe that the Affordable Care Act did not intend to allow an issuer to offer a silver and gold QHP through the Exchange in merely one service area in a State, while offering other products through the Exchange, such as bronze or catastrophic QHPs, in other service areas. The proposal seeks to eliminate the possibility of such gaming. Provisions of the Affordable Care Act sought to ensure an adequate choice of QHPs and coverage to consumers. We are proposing this change to ensure that consumers have an adequate choice of QHPs at different coverage levels. Further, the Affordable Care Act also assumed calculation of the advance payment of the premium tax credit based on the availability of a second

[55] The draft 2018 AV Calculator and Methodology will be posted under the ''Plan Management'' section of CCIIO's Web site at: *https://www.cms.gov/cciio/resources/regulations-and-guidance/index.html.*

lowest cost silver plan. As such, we propose to modify our regulations to more accurately align with QHP issuer practice and our interpretation of the intention of the Affordable Care Act.

Section 1311(c)(1) and 1321(a)(1)(A) and (B) of the Affordable Care Act provide the Secretary of HHS with the authority to establish certification criteria for QHPs and Exchanges. Therefore, we are proposing to require QHP issuers to offer at least one silver and one gold coverage level QHP through the Exchange throughout each service area in which the issuer offers coverage through the Exchange. The offering of both silver and gold level QHPs is important to ensure adequate choice to Exchange consumers, as well as to ensure that a second lowest cost silver plan is available for calculating advance payments of the premium tax credit for consumers. We further clarify that an issuer can meet this standard by offering a multi-State plan in both silver coverage and gold coverage levels throughout each service area in which it offers other QHPs through an Exchange. We seek to establish this policy by proposing amendments to existing paragraph (c)(1).

Specifically, we propose to amend paragraph (c)(1) to require a QHP issuer to offer through the Exchange at least one QHP in the silver coverage level and at least one QHP in the gold coverage level, as described in § 156.140, throughout each service area in which it offers coverage through the Exchange. This added specificity will ensure that issuers applying for certification of their QHPs offer a silver and gold plan throughout each service area in which they offer coverage through the Exchange.

In the 2014 Payment Notice, in order to help ensure that qualified employers and qualified employees enrolling through an FF–SHOP are offered a robust set of QHP choices, we finalized a policy at § 156.200(g) under which an individual market FFE will certify a QHP only if the QHP issuer (or an issuer in the same issuer group) offers through the FF–SHOP of the State at least one QHP in the silver coverage level and at least one QHP in the gold coverage level, unless no issuer in the issuer group has at least a 20 percent share of the small group market share in the State, based on earned premiums. This policy is intended to leverage issuers' participation in the FFEs to promote fuller issuer participation in the FF–SHOPs, particularly in the initial years of the FF–SHOPs. We indicated in the preamble of the 2014 Payment Notice, in response to a commenter who suggested we reevaluate the policy in two years, that we would evaluate the effectiveness of the tying provision on an ongoing basis.

We now seek comment, based on feedback from stakeholders, on whether the policy at § 156.200(g) is still necessary or appropriate in the FF–SHOPs. We did not finalize this policy to apply to State-based SHOPs, nor are we aware of any State-based SHOPs that have implemented a similar policy. We are also cognizant that the policy may be discouraging issuer participation on the individual market FFEs. We therefore seek comment on whether we should eliminate this policy for the FF–SHOPs, for plan years beginning on or after January 1, 2018.

We recognize that eliminating the SHOP participation provision could have the effect of reducing FF–SHOP issuer participation in States, and seek comment on the implications for small businesses and how to accommodate such an effect. For example, in such a circumstance, in consideration of the ongoing investments that would be required to maintain the FF–SHOPs, including for premium aggregation services, we are considering providing for elimination of enrollment through FF–SHOP Web sites and providing for alternative means of enrollment into SHOP QHPs, either in States that would be particularly affected by this change or in all FF–SHOPs. An FF–SHOP Web site would still be maintained, consistent with section 1311(d)(4)(C) of the Affordable Care Act, but would not support online enrollment, except perhaps for the continuation of services for existing groups in the FF–SHOP through the end of any plan year that began before January 1, 2018. In addition, we seek comment on how entities such as web-brokers or third party administrators could help to facilitate enrollment in available SHOP QHPs. We seek comment on what other regulatory provisions would need to be modified or eliminated in such a circumstance, and on whether provisions relating to the operation of enrollment through a SHOP Web site should generally be optional at the election of the Exchanges, including State-based SHOPs.

b. Network Adequacy Standards (§ 156.230)

At § 156.230, we established the minimum criteria for network adequacy that issuers must meet to have plans certified as QHPs, including SADPs, in accordance with the Secretary's authority in section 1311(c)(1)(B) of the Affordable Care Act. Included at § 156.230(a)(2) is the requirement that all issuers maintain a network that is sufficient in number and types of providers to assure that all services will be accessible without unreasonable delay. Section 156.230(b) sets forth standards for access to provider directories requiring issuers to publish an up-to-date, accurate, and complete provider directory for plan years beginning on or after January 1, 2016.

In the 2017 Payment Notice, HHS finalized a policy to provide information about QHP network breadth on *HealthCare.gov* in order to assist consumers with plan selection. For the 2017 benefit year, we intend to pilot a network breadth indicator in certain States on *HealthCare.gov* to denote a QHP's relative network coverage.[56] HHS will make this network breadth classification available to consumers in those States at the point of plan comparison. The results of the pilot will determine if HHS expands the pilot to more States for 2018. The specifics of how the network breadth indicator is calculated are described in the Final 2017 Letter to Issuers in the Federally-facilitated Marketplaces.[57]

For the 2018 plan year, HHS is considering whether to incorporate more specificity into these indicators, and, in particular, how to identify for consumers whether a particular plan is offered as part of an integrated delivery system. For integrated delivery systems, the breadth of the network for a plan as calculated through the network breadth methodology may not accurately describe the ability of a consumer to access providers relative to consumers enrolled in plans that are not part of an integrated delivery system in the same county. We propose to incorporate this specificity into the network information displayed for plan year 2018 in all States where network breadth is displayed in 2018.

To define which plans utilize an integrated delivery system, we propose to use the alternate essential community provider standard in 45 CFR 156.235(b). Thus, we would identify a plan as part of an integrated delivery system if it provides a majority of covered professional services through physicians employed by the issuer, or through a single contracted medical group. If HHS finalizes this policy, we would provide additional details in the 2018 Letter to

[56] Network Breadth Pilot (August 19, 2016), available at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Network-Classification-Pilot-Guidance-81916.pdf.*

[57] Final 2017 Letter to Issuers in the Federally facilitated Marketplaces (Feb. 29, 2016) *available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf.*

Issuers in the Federally-facilitated Marketplace.

We seek comment on all aspects of this proposal. In particular, we seek comment on whether we should make such a differentiation, and how best to indicate that a plan has an integrated delivery system—including on whether we should provide additional explanatory text to the current indicator that the plan receives, or whether we should establish a separate indicator. We seek comment on what words to use in either case to best convey the value of this classification to consumers. We also seek comment on our proposal to identify integrated delivery systems by using the alternate essential community provider standard, and whether there are plans that would not meet this definition but are best categorized in this group; and, if there is a continuum of plan arrangements to consider with respect to network integration, how best to classify those plans and provide that information to consumers.

Also, as a reminder, the requirement established in the 2017 Payment Notice at § 156.230(e) that QHP issuers count an essential health benefit provided by an out-of-network ancillary provider at an in-network facility towards the in-network annual limitation on cost sharing for QHPs in certain circumstances begins applying in benefit year 2018. That is, if a QHP enrollee received an EHB in an in-network setting, such as an in-network hospital, but as part of the provision of the EHB the enrollee was charged out-of-network cost sharing for an EHB provided by an out-of-network ancillary provider, that cost sharing would apply towards the annual limitation on cost sharing.

Alternatively, the plan could provide a written notice to the enrollee by the longer of when the issuer would typically respond to a timely submitted prior authorization request, or 48 hours before the provision of the benefit. The written notice would state that additional costs may be incurred for the EHB provided by an out-of-network ancillary provider in an in-network setting, including balance billing charges, unless such costs are prohibited under State law; and that any additional charges may not count toward the in-network annual limitation on cost sharing. This alternative would not be available if the issuer does not meet the timeframe established in regulation. We are proposing that this policy applies to QHPs, both on and off Exchanges, regardless of whether the QHP covers out-of-network services, and seek comment on other policy changes that could limit ''surprise bills'' for consumers. As stated in the 2017 Payment Notice, we intend to continue to monitor these situations, including issuers' timely compliance with this provision, to consider whether further rulemaking is needed.

c. Essential Community Providers (§ 156.235)

In the 2017 Payment Notice, we finalized that, for QHP certification cycles beginning with the 2018 benefit year, HHS would credit issuers for multiple contracted or employed full-time equivalent (FTE) practitioners at a single location, up to the number of available FTE practitioners reported to HHS by the essential community provider (ECP) facility through the ECP petition process and published on the HHS ECP list. As HHS conducts additional provider outreach to collect provider data necessary to implement a methodology that would credit issuers for multiple contracted or employed full-time equivalent practitioners at a single location, we propose in § 156.235(a)(2)(i) to continue the 2017 benefit year calculation methodology that a plan applying for QHP certification to be offered through a Federally-facilitated Exchange must demonstrate in its QHP application that its network includes as participating providers at least a minimum percentage, as specified by HHS, of available ECPs in each plan's service area, with multiple providers at a single location counting as a single ECP toward both the available ECPs in the plan's service area and the issuer's satisfaction of the ECP participation standard. Similarly, in § 156.235(b)(2)(i), we propose to continue the 2017 benefit year calculation methodology that a plan described in § 156.235(a)(5) applying for QHP certification to be offered through a Federally-facilitated Exchange demonstrate in its QHP application that the number of its providers that are located in Health Professional Shortage Areas or five-digit zip codes in which 30 percent or more of the population falls below 200 percent of the Federal Poverty Line satisfies a minimum percentage, specified by HHS, of available ECPs in the plan's service area with multiple providers at a single location counting as a single ECP. We seek comment on these proposals. We are also considering changes to the counting of hospital ECPs for the 2019 benefit year and seek comment on the best approach for measuring hospital participation.

d. Enrollment Process for Qualified Individuals (§ 156.265)

We propose an amendment to § 156.265 requiring differential display of standardized options. A discussion of the proposed provision is contained in the preamble discussion regarding § 155.220, which concerns standards for agents and brokers using the direct enrollment process.

We solicit comments on this proposal.

e. Issuer Participation for the Full Plan Year (§ 156.272)

We propose adding § 156.272 to provide as a condition of certification that QHP issuers in all individual market Exchanges must make their QHPs available for enrollment through the Exchange for the full plan year for which the plan was certified, unless a basis for suppression under § 156.815 applies. We also propose that issuers in all SHOP Exchanges must make their QHPs available for enrollment through the SHOP Exchange for the full plan year for which the plan was certified, unless a basis for suppression under § 156.815 applies. This requirement would ensure that consumers enrolling in the individual market during limited open enrollment periods have the same plan choice as those who enrolled during open enrollment, and that qualified employers and qualified employees would have generally consistent plan choices throughout the plan year.

If this proposal is finalized, under our existing civil money penalty authority at § 156.805(a)(1), QHP issuers in FFEs and FF–SHOPs that do not comply with § 156.272(a) and (b) could be subject to CMPs. (Issuers would not be subject to CMPs if a basis for suppression under § 156.815 applies.) We also propose at § 156.272(c) that if an issuer fails to comply with those sections, HHS could, at its discretion, preclude that issuer from participating in the FFEs and FF–SHOPs, for up to the two succeeding years.

We seek comments on this proposal, including the applicability of this section to all Exchanges and the potential use of CMPs for QHP issuers in the FFEs and FF–SHOPs.

f. Non-Certification and Decertification of QHPs (§ 156.290)

Currently, under § 156.290(b), when a QHP issuer elects to not seek certification for a subsequent, consecutive certification cycle with the Exchange, it is required to provide notification to enrollees. However, a QHP issuer is not required to provide notification to enrollees when it seeks

but is denied certification for a subsequent, consecutive certification cycle by the Exchange. We propose to require that QHP issuers provide such notice within 30 days of the date of an Exchange's denial of certification for a subsequent, consecutive certification cycle. Requiring notice in a timely manner would allow enrollees to be prepared to participate in the upcoming open enrollment period. We also propose to amend the section title from Non-renewal and decertification of QHPs to Non-certification and Decertification of QHPs, and revise the paragraph headings for § 156.290(a) and (b) to reflect that QHPs are certified on an annual basis rather than renewed. We seek comment on these proposals.

g. Other Considerations

Increasingly, the Exchanges serve as laboratories for innovations through which QHPs develop new ways to provide quality, cost-effective health care that responds to consumers' preferences and needs. We have heard from issuers about innovations around paying for high-quality care, working with health care professionals to encourage coordinated care, standardizing benefits in ways that promote high-value care, and using data analytics to engage with consumers in creative ways that improve their health and bolster retention. We also continue to seek to foster market-driven programs in the Exchanges that can improve the management of costs and care, and that provide consumers with quality, person-centered coverage. As we stated in the 2017 Payment Notice, 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 for 2018 in order to better meet the goals of affordability, quality, and access to care.

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

In the 2017 Payment Notice we established, in § 156.350, that in order to participate in an SBE–FP, a QHP issuer must comply with HHS regulations and guidance pertaining to issuer eligibility and enrollment functions as if the issuer were an issuer of a QHP in an FFE. These regulations and guidance include those requirements specified in paragraphs (a)(1) through (3) of § 156.350, which currently include § 156.285(c)(8)(iii). For the same reasons that we propose to add new paragraph § 155.200(f)(4), we also propose to amend paragraph § 156.350(a)(2) to specify that, in order to participate in an SBE–FP using the Federal platform for SHOP enrollment functions, a QHP issuer would be required to send enrollment reconciliation files on at least a monthly basis according to a process, timeline, and file format established by the FF–SHOPs, consistent with § 156.285(c)(5). Issuers in States operating an SBE–FP for SHOP enrollment functions would be required to follow the process applicable in the FF–SHOPs, as described in § 156.285(c)(5). This amendment would become effective with the effective date of the final rule. We seek comment on this proposal.

5. Reconciliation of the Cost-Sharing Reduction Portion of Advance Payments Discrepancies and Appeals (§ 156.430(h))

As implemented in the regulations at 45 CFR 156.430, HHS reconciles the cost-sharing reduction portion of advance payment amounts by comparing what the enrollee in a cost-sharing reduction plan variation actually paid in cost sharing to what the enrollee would have paid if enrolled in a standard plan. In order to facilitate reconciliation of the cost-sharing reduction portion of advance payments to the actual amount provided for enrollees in cost-sharing reduction variation plans, issuers must report the amount they paid for each eligible medical claim, the amount enrollees paid for the claims, and the amount of cost sharing that would have been paid for the same services under the corresponding standard plan. This information is used to reconcile the actual cost-sharing amounts provided for each policy in a plan variation to the estimated payments that the issuer had been paid in advance. As set forth at § 156.410(d)(3), issuers are not reimbursed for any cost-sharing reductions provided to enrollees who were erroneously assigned to a plan variation more generous than the one for which they are eligible. As set forth at § 155.430(d)(4), any cost-sharing reductions, to the extent thereby or otherwise erroneously provided (such as cost-sharing reductions for non-EHB or non-covered services or cost-sharing reductions provided after a policy has been terminated) must be excluded from the reconciliation process.

In order to ensure the integrity of reconciliation of the cost-sharing reduction portion of advance payments for the 2014 and 2015 benefit years, we implemented automatic system checks that validated data at the time of data submission, for example matching QHP or subscriber IDs to HHS data for a benefit year, and verifying the issuer used the applicable methodology and submitted applicable attestations. This resulted in the rejection of some cost-sharing reduction amounts submitted by issuers. Additionally, some issuers were unable to prepare complete data files in time to meet the cost-sharing reduction data submission deadline. In order to provide issuers with an opportunity to address potential errors that would have directly impacted the calculation of their reconciled cost-sharing reduction amounts, HHS implemented a process for reporting data discrepancies for the 2014 and 2015 benefit year.[58]

We propose adding new paragraph (h)(1) to § 156.430 to require that any issuer that reports a discrepancy and seeks to dispute the notification of the amount of reconciliation of the cost-sharing reduction portion of advance payments, in the manner set forth by HHS, must report the discrepancy to HHS within 30 calendar days of notification of the amount of reconciliation of the cost-sharing reduction portion of advance payments as described in § 156.430(e).

We further propose to codify in § 156.430(h)(2) that an issuer may appeal the amount of reconciliation of the cost-sharing reduction portion of advance payments, under the process set forth in § 156.1220 of this subchapter, only if it has submitted a discrepancy report for its cost-sharing reduction reconciled amounts for the applicable benefit year. We note that irrespective of whether an issuer has filed a discrepancy report under § 156.430, a request for reconsideration under § 156.1220 may only be filed to contest a processing error by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical error, as required under § 156.1220.

We seek comment on these proposals.

[58] On June 23, 2016 CMS released FAQs and technical specifications on the discrepancy resolution process for issuers to follow to report a discrepancy related to reconciliation of the cost-sharing reduction portion of advance payments. The technical specifications are available on the Center for Consumer Information and Insurance Oversight Web site: *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Cost-Sharing-Reduction-Reconciliation-Discrepancy-Resolution-Inbound-Specification.pdf.*

6. Compliance Reviews of QHP Issuers in Federally-Facilitated Exchanges (§ 156.715)

At § 156.715, we previously established that a QHP issuer is subject to compliance reviews to ensure ongoing compliance with Exchange requirements and standards. In § 156.715(b), we require QHP issuers to make available to HHS records that pertain to their activities in an FFE. In the first few years of FFE operations, the vast majority of QHP issuers were responsive and cooperative with the compliance reviews. QHP issuers generally submitted requested documents on time and were responsive to requests for additional information. However, a few QHP issuers were less responsive to HHS, which resulted in unnecessary delays of the compliance reviews. We propose to amend this section to specify HHS's authority to impose remedies authorized under subpart I of part 156 in situations where the QHP issuer is non-responsive or uncooperative with the compliance reviews authorized under this section.

7. Qualified Health Plan Issuer Responsibilities

a. Administrative Appeals (§ 156.1220)

As discussed in the preamble to § 153.630, we propose adding paragraphs (a)(1)(vii) and (viii) to § 156.1220, providing an administrative appeals right to issuers to contest only a processing error by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical error with respect to the findings of a second validation audit as a result of risk adjustment data validation; or the calculation of a risk score error rate as a result of risk adjustment data validation, respectively. Also as discussed in the preamble to §§ 153.630 and 156.430(h), we propose requiring issuers to file a report for discrepancies related to risk adjustment data validation and discrepancies related the reconciliation of the cost-sharing reduction portion of advance payments, if the issue is identifiable, prior to filing a request for reconsideration as set forth at § 156.1220. As such, we propose to amend § 156.1220(a)(4)(ii), to provide that, notwithstanding § 156.1220(a)(1), a reconsideration with respect to a processing error by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical error may be requested only if, to the extent the issue could have been previously identified, the issuer notified HHS of the dispute through the applicable process for reporting a discrepancy set forth in § 153.630(d)(2), § 153.710(d)(2), or § 156.430(h)(1), and the dispute has not been resolved.

Because risk adjustment payments and charges for the 2015 benefit year will not be adjusted as a result of the risk adjustment data validation process, we do not believe an administrative appeal right is necessary for the 2015 benefit year. Therefore, we propose that the first year of risk adjustment data validation appeals would begin with the 2016 benefit year, which is the first year that risk adjustment data validation will affect the amount of risk adjustment payments and charges. As such, we propose to limit the proposed new § 156.1220(a)(1)(vii) and (viii) (specifying that an issuer may file a request for reconsideration under this section to contest a processing error by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical error, with respect to the findings of a second validation audit or the calculation of a risk score error rate as a result of risk adjustment data validation) to administrative appeals with respect to risk adjustment data for the 2016 benefit year and beyond.

We propose to amend § 156.1220(a)(2) regarding the materiality threshold for filing a request for reconsideration to include a reference to the administrative appeals related to the risk adjustment data validation process. We also propose to amend § 156.1220(a)(3)(ii) to add a reference to risk adjustment data validation and to provide that issuers have 30 calendar days to request reconsideration from the date of the notification of the findings of a second validation audit and the calculation of a risk score error rate as a result of risk adjustment data validation. We believe 30 calendar days is sufficient for issuers to review the findings of a second validation audit or the calculation of a risk score error rate as a result of risk adjustment data validation and to submit a request for reconsideration. We seek comment on these timeframes and the appeal proposal.

b. Direct Enrollment With the QHP Issuer in a Manner Considered To Be Through the Exchange (§ 156.1230)

In this rule, we proposed a number of modifications and new requirements in § 155.220 which would apply to web-brokers using the direct enrollment channel. We propose to add a number of these standards to §§ 156.265 and 156.1230(b) so that they also apply to issuers using direct enrollment on a Federally-facilitated Exchange. Specifically, in § 156.1230, we propose to: (1) Specify that HHS may immediately suspend the QHP issuer's ability to transact information with the Exchange if HHS discovers circumstances that pose unacceptable risk to Exchange operations or Exchange information technology systems until the incident or breach is remedied or sufficiently mitigated to HHS's satisfaction; (2) require QHP issuers to demonstrate operational readiness and compliance with applicable requirements prior to their Web sites being used to complete QHP selections; and (3) require QHP issuers to provide consumers with correct information regarding FFEs, QHPs offered through the FFEs and insurance affordability programs, and refrain from marketing or conduct that is misleading, coercive, or discriminatory. A more detailed discussion of these proposed provisions is contained in the preamble discussion regarding § 155.220.

We solicit comments on these proposals and specifically seek comment on whether direct enrollment with a QHP issuer should be permitted for enrollments through all SBE–FPs, or at the option of SBE–FPs.

c. Other Notices (§ 156.1256)

Section 156.1256 requires health insurance issuers offering coverage through an FFE or an SBE–FP to notify enrollees of material plan or benefit display errors under certain circumstances. We propose to change the paragraph cross-referenced in § 156.1256 from § 155.420(d)(4) to § 155.420(d)(12) to reflect our proposal to codify in § 155.420(d)(12) the special enrollment period for material plan or benefit display errors. Since the noticing requirement in § 156.1256 is limited to material plan or benefit display errors and resulting special enrollment periods, proposed § 155.420(d)(12) is a more appropriate reference for this section. We also propose to make some minor non-substantive changes to the regulation text. We seek comments on this proposal.

J. Part 157—Employer Interactions With Exchanges and Shop Participation

For a discussion of the provisions of this proposed rule related to part 157, please see the preamble to § 155.725.

K. Part 158—Issuer Use of Premium Revenue: Reporting and Rebate Requirements

1. Newer Experience (§ 158.121)

a. Deferred Reporting of Newer Business

Section 2718(c) of the PHS Act provides that, subject to the certification of the Secretary, the NAIC is to establish standardized medical loss ratio methodologies that take into consideration (among other things) the

special circumstances of newer plans. Consistent with the NAIC's recommendation to HHS,[59] the MLR December 1, 2010 interim final rule (75 FR 74863) allows issuers to defer reporting of experience of policies newly issued and with fewer than 12 months of experience until the following reporting year, if such policies contribute to 50 percent or more of the issuer's total earned premium for the MLR reporting year. As explained in the interim final rule, the rationale for deferring experience of newly issued policies is that claims experience can be substantially lower than the premium revenue from those policies during the year in which the coverage is issued (although this may occur to a lesser extent in the current environment than prior to introduction of the Affordable Care Act market reforms), and could create a barrier to the entry of new issuers into a market.

However, the NAIC's recommendation was developed in 2010, prior to implementation of many Affordable Care Act market reforms. As a result, the current MLR regulation allows issuers to defer reporting the experience of new policies that were in effect for *fewer than* 12 months, but not for those in effect for the *full* 12 months. This limitation does not account for the fact that beginning in 2014, issuers of non-grandfathered health insurance coverage in the individual and small group markets generally must offer coverage for a consecutive 12-month period (which may be on a calendar year basis or otherwise). Consequently, issuers entering these markets in substantial part in 2014 or later whose policies contribute to 50 percent or more of the issuer's total earned premium for the MLR reporting year are unable to defer reporting of this new business for MLR purposes because such coverage has a full 12 months of experience. Therefore, to align MLR reporting with the requirement that non-grandfathered coverage generally must provide coverage for a consecutive 12-month period, we propose to modify § 158.121 to allow issuers to defer, for MLR purposes, reporting of data for newer experience if 50 percent or more of the issuer's total earned premium for the MLR reporting year is attributable to newly issued policies with 12 full months of experience, rather than policies with less than 12 months of experience. We seek comments on this proposal.

2. Rebating Premium if the Applicable Medical Loss Ratio Standard Is Not Met (§§ 158.232, 158.240)

a. Limit on Rebate Liability

Section 2718(b)(1)(B)(ii) of the PHS Act requires, beginning on January 1, 2014, the MLR to be calculated as an average of 3 consecutive years of experience. When an established issuer's MLR falls below the applicable MLR standard in a given year, the 3-year averaging spreads the actual payment of the rebate over the period of 3 years. This allows issuers to offset low and high MLRs within any 3-year period, enabling issuers to potentially pay a lower overall rebate. However, issuers that newly enter the market in 2014 or later are only able to calculate their first two MLRs based on 1 or 2 years of experience. Consequently, the experience of the first 1 or 2 years can have a disproportionate and overlapping impact on such issuers' average MLRs in their first 3 years in the market, and the 3-year averaging required by section 2718(b)(1)(B)(ii) can lead to distorted MLR calculations and could be a barrier to the entry of new issuers into a market. As a result of the 3-year averaging rule, a new issuer that has an MLR that is initially low but increases within the first 3 years in the market may end up paying a higher total rebate over those initial 3 years than an established issuer with stable enrollment with the same experience in each of those 3 years. In addition, the 3-year averaging rule can have a similar impact on an established issuer that rapidly and significantly expands its presence in the market.

We note that only a narrow subset of issuers are affected in this way by 3-year averaging: Specifically, new issuers and established issuers that experience rapid growth (either by entering a new market or rapidly and significantly expanding their presence in an existing market) and whose MLR falls below the standard in one year and increases within the following 2 years.

Consistent with the requirement under section 2718(c) of the PHS Act to design standardized MLR methodologies that take into consideration (among other things) the special circumstances of smaller and newer plans, we propose to amend §§ 158.240 and 158.232 to mitigate the impact of 3-year averaging on these issuers and thereby reduce barriers to entry and promote competition in health insurance markets. Specifically, we propose to modify § 158.240 by adding a new paragraph (d) and redesignating the existing paragraphs (d) and (e) as paragraphs (e) and (f), respectively, to provide flexibility to limit in appropriate cases an issuer's total rebate liability payable with respect to a given calendar year. We also propose conforming amendments to paragraph (c) to recognize the proposed new flexibility under new paragraph (d). Under this proposal, if an issuer elects this flexibility, the maximum single-year rebate liability attributable to a given calendar year would be limited to no more than the amount determined based on the issuer's MLR calculated using only that year's experience. In these circumstances, we propose to adjust the maximum rebate liability attributable to a given calendar year in each of the two subsequent reporting years to reflect restatement of claims incurred in that calendar year as of March 31 following each of those 2 subsequent reporting years. The restatement of incurred claims would ensure that the rebate liability with respect to the calendar year in question is corrected either upward or downward, as appropriate, in the two subsequent years in order to implement the 3-year averaging requirement. Similarly, we propose that an issuer that elects this option would have to adjust the maximum rebate liability attributable to a given calendar year in the 2 subsequent reporting years to reflect the credibility adjustment applicable in each of those 2 subsequent reporting years. That is, the rebate liability attributable to year 1 would be recalculated in year 2 using a credibility adjustment based on the sum of life-years for years 1 and 2. This approach is consistent with the manner in which the credibility adjustment was applied with respect to all issuers when the MLR requirements were first implemented. We seek comments on this proposal.

We also propose that for an issuer that elects this option, for each reporting year, after the issuer recalculates the maximum rebate liability with respect to each calendar year in the aggregation using restated incurred claims and updated credibility adjustment (as applicable), the outstanding rebate liability with respect to each year in the aggregation would be determined by reducing the maximum rebate liability with respect to that year by any rebate payments made toward it in the two prior years (as applicable). Any rebate payable for a given reporting year would be applied toward the outstanding

[59] 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 athttp://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf.*

rebate liability of the earliest year in the relevant aggregation first. If the rebate calculated for the reporting year based on a multi-year average MLR (2- or 3-year average, as applicable) exceeds the combined outstanding rebate liability for all calendar years included in the aggregation, then under our proposal, the actual rebate payable by the issuer for that reporting year would be limited to the amount of the combined outstanding rebate liability. Conversely, if the total rebate calculated for the reporting year based on a multi-year average MLR is lower than the combined outstanding rebate liability for all years included in the aggregation, then we propose that the actual rebate payable by the issuer for that reporting year be limited to the amount calculated for the reporting year based on a multi-year average MLR. Therefore, our proposal would generally prevent the total rebate amount paid by an issuer with respect to any given calendar year over the course of 3 consecutive years from exceeding the rebate amount resulting from the ratio of the issuer's incurred claims and quality improvement activity expenses to the issuer's after-tax earned premium for that calendar year, with applicable adjustments, falling below the applicable MLR standard. At the same time, our proposal is designed to benefit only new issuers and established issuers that experience rapid growth whose MLR falls below the standard in one year and increases within the following 2 years. This is because the combined outstanding rebate liability for all years included in the aggregation will generally equal or exceed the rebate calculated for the reporting year based on a 3-year average MLR for established issuers that do not experience rapid growth. Therefore, our proposed limit on the rebate liability would not benefit such issuers.

For a simplified illustration of our proposal, suppose that a new, fully-credible individual market issuer reports year 1 incurred claims and quality improvement activity expenses (QIA) of $500,000 and premium adjusted for applicable taxes and fees of $1,000,000 (and no other relevant revenue or expenses relevant to the MLR calculation); year 2 incurred claims and QIA of $700,000 and after-tax premium of $1,000,000; and incurred claims and QIA of $800,000 and after-tax premium of $1,000,000 thereafter. Under our proposal, the rebate liability for year 1 would be calculated as (80% − $500,000/$1,000,000) * $1,000,000 = $300,000; and the issuer would consequently pay a $300,000 rebate for year 1. Suppose that after year 2, the issuer determines that its year 1 incurred claims and QIA were in fact $550,000 rather than $500,000. The issuer's 2-year average MLR would equal ($550,000 + $700,000)/($1,000,000 + $1,000,000) = 62.5% and the corresponding rebate would equal (80% − 62.5%) * $1,000,000 = 175,000. Under our proposal, the issuer's preliminary MLR with respect to year 1 as adjusted by the newer incurred claims and QIA data would be calculated as $550,000/$1,000,000 = 55% and the corresponding rebate liability as (80% − 55%) * $1,000,000 = $250,000. The preliminary MLR with respect to year 2 would be calculated as $700,000/$1,000,000 = 70% and the corresponding rebate liability as (80% − 70%) * $1,000,000 = $100,000. The $300,000 rebate initially paid for year 1 would be applied first against the year 1 rebate liability of $250,000, with the remaining $50,000 applied against the year 2 rebate liability of $100,000, resulting in a combined outstanding rebate liability of $250,000 + $100,000 − $300,000 = $50,000. Because the combined outstanding rebate liability is lower than the rebate based on the 2-year average MLR, the rebate payable for year 2 is limited to the lower amount, or $50,000; whereas under the current MLR regulations, the issuer would be required to pay $175,000 in rebates for year 2. In year 3, the rebate based on the 3-year average MLR would be $116,667, while the combined outstanding rebate liability would be zero, resulting in no rebate payable for year 3.

In recognition of the fact that, as discussed above, only a limited subset of issuers may be disadvantaged by the three-year averaging rule and would be able to benefit from this proposal, we propose to make the use of the rebate liability limit optional for issuers. To further facilitate application of this proposal in the least burdensome manner, as well as to address an existing ambiguity regarding applicability of the credibility adjustment, we additionally propose to clarify § 158.232 by defining the term ''preliminary MLR'' to refer to an MLR calculated without applying any credibility adjustment, and by explicitly specifying instances where § 158.232 is intended to refer to experience of a single year, rather than 3 years. These proposed amendments to § 158.232(d), (e), and (f) will enable issuers that wish to take advantage of the rebate liability limit to rely on the single-year, preliminary MLRs that issuers already calculate as part of determining their credibility adjustment, and minimize the additional reporting associated with calculating the outstanding rebate liability if an issuer elects to exercise the flexibility proposed in § 158.240(d). We seek comments on all aspects of 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 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 16. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this proposed rule that contain ICRs. We generally used data from the Bureau of Labor Statistics to derive average labor costs (including a 100 percent increase for fringe benefits and overhead) for estimating the burden associated with the ICRs.[60]

A. ICRs Regarding Upload of Risk Adjustment Data (§ 153.610)

Under the HHS-operated risk adjustment program, HHS uses a distributed data collection approach for enrollee-level enrollment, claims and encounter data that reside on an issuer's dedicated data environment. Under § 153.710(a), an issuer of a risk adjustment covered plan in a State where HHS is operating the risk adjustment or reinsurance program on behalf of the State, as applicable, must provide HHS, through the dedicated data environment, access to enrollee-

[60] See May 2015 Bureau of Labor Statistics, Occupational Employment Statistics, National Occupational Employment and Wage Estimates at *http://www.bls.gov/oes/current/oes_stru.htm.*

level plan enrollment data, enrollee claims data, and enrollee encounter data, as specified by HHS. Under § 153.610(a), HHS is proposing that an issuer must submit or make accessible all required risk adjustment data for its risk adjustment covered plans in accordance with the risk adjustment data collection approach established by the State, or by HHS on behalf of the State, including any data that is ''protected health information'' as that term is defined at 45 CFR 160.103 for purposes of recalibrating the HHS risk adjustment model, in the form and manner specified by HHS. This proposal entails HHS sending a command to all issuers' EDGE servers that issuers must execute, which would provide HHS a dataset that does not identify the EDGE server, plan, issuer, geographic rating area, State, or enrollee, for purposes of obtaining enrollee-level data upon which we can recalibrate the HHS risk adjustment models. Because this EDGE report requires no new data elements and only requires an issuer to execute the command, we do not believe this provision imposes additional burden on issuers of risk adjustment covered plans described under the information collection currently approved under OMB Control Number 0938–1155.

B. ICRs Regarding Data Validation Requirements When HHS Operates Risk Adjustment (§ 153.630)

Under § 153.630(b), an issuer that offers at least one risk adjustment covered plan in a State where HHS is operating risk adjustment on behalf of the State for the applicable benefit year must have an initial validation audit performed on its risk adjustment data. The cost associated with this requirement is the issuer's time and effort to provide HHS with source claims, records, and enrollment information to validate enrollee demographic information for initial and second validation audits and the issuer's cost to employ an independent auditor to perform the initial validation audit on a statistically valid sample of enrollees. We estimate that each issuer sample will consist of approximately 200 enrollees, and we anticipate that this audit will affect approximately 825 issuers. Beginning with 2018 risk adjustment data validation, HHS proposes to require the review of paid pharmacy claims for all sample enrollees in the initial validation audit. Based on 2015 EDGE reinsurance data, we believe approximately half of all enrollees have pharmacy claims, and of those that do, we would expect approximately six pharmacy claims per enrollee. Therefore, we expect that it would require 30 minutes for an auditor (at a labor cost of $72 per hour) and cost approximately $36 per enrollee to validate paid pharmacy claims. We assume that an initial validation audit would be performed on 165,000 enrollees, with half of them, or 82,500 enrollees, having pharmacy claims. Based on the information above, we estimate that the total additional burden per issuer for initial validation auditors to review and validate paid pharmacy claims would be 50 hours and cost approximately $3,600. Therefore, for 825 issuers, the total annual burden of conducting initial validation audits would be 41,250 hours with an equivalent cost of approximately $2.97 million. We will revise the information collection currently approved under OMB Control Number 0938–1155 with an October 31, 2017 expiration date to account for this additional burden.

C. ICR Regarding the Interim and Final Discrepancy Reporting Processes for Risk Adjustment Data Validation When HHS Operates Risk Adjustment (§ 153.630(d))

Under § 153.630(d)(1), we propose that in the manner set forth by HHS, an issuer must confirm the sample or file a discrepancy report within 15 calendar days to dispute the HHS risk adjustment data validation sample set forth by HHS in the HHS–RADV Final Reports. In § 153.630(d)(2), we propose that in the manner set forth by HHS, an issuer may file a discrepancy report within 30 calendar days to dispute the findings of a second validation audit or the calculation of a risk score error rate.

We estimate that 825 issuers of risk adjustment covered plans would be subject to this requirement, and that issuers would review the HHS-risk adjustment data validation final reports, specifically the initial validation audit sample set for the interim discrepancy reporting process. For the final discrepancy reporting process, set forth in proposed § 153.630(d)(2), issuers would review the results of the second validation audit and the calculation of a risk score error rate. On average, we estimate that it would take a business operations specialist (at an hourly labor cost of $78) approximately 2 hours to respond to an interim report and 6 hours to respond to the interim and final discrepancy reporting process. The total burden for each issuer would be 8 hours with an equivalent cost of $624. Therefore, we estimate an aggregate annual burden of 6,600 hours with an equivalent cost of $514,800 for 825 issuers as a result of these requirements. We will revise the information collection currently approved under OMB Control Number 0938–1155 with an October 31, 2017 expiration date to account for this additional burden.

D. ICR Regarding Standardized Options in SBE–FPs (§ 155.20)

In proposed § 155.20, we propose that an SBE–FP must notify HHS if it wants HHS–designed standardized options to receive differential display, by a date to be specified in guidance. We anticipate that fewer than 10 SBE–FPs would submit this information to HHS annually. Under 5 CFR 1320.3(c)(4), this ICR is not subject to the PRA as it would affect fewer than 10 entities in a 12-month period.

E. ICR Regarding Differential Display of Standardized Options on the Web Sites of Agents and Brokers (§ 155.220) and QHP Issuers (§ 156.265)

We propose to require web-brokers and QHP issuers that utilize the direct enrollment pathway to differentially display standardized options in the 2018 plan year and beyond, consistent with the approach adopted by HHS for display on the Exchange Web site, unless HHS approved a deviation. This policy would require direct enrollment entities to prominently display standardized options in a manner that makes them clear to consumers. We estimate that a total of 160 web-brokers and QHP issuers participate in the FFEs and SBE–FPs and would be required to comply with the standard. We estimate it would take a mid-level software developer (at a rate of $96.82 per hour) approximately 2 hours annually to develop a differential display for standardized options. We estimate an annual cost burden of approximately $193.64 per direct enrollment entity. The total annual burden will be 320 hours with an equivalent cost of approximately $30,982.40.

We anticipate that fewer than 10 web-brokers and issuers would submit a request to deviate from the manner adopted by HHS for display on HealthCare.gov. Under 5 CFR 1320.3(c)(4), this ICR is not subject to the PRA as it would affect fewer than 10 entities in a 12-month period.

F. ICR Regarding Ability of States To Permit Agents and Brokers To Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (§ 155.220)

We propose a number of requirements for web-brokers related to the direct enrollment process such as prominently displaying information regarding consumers' eligibility for APTC, allowing consumers to make attestations regarding APTC, and providing for the

maintenance of electronic records for purposes of audit. At §§ 156.265 and 156.1230, we propose a number of parallel provisions for issuers using the direct enrollment channel. We would provide additional detail regarding the specific requirements under these rules in guidance in the future. At that time, we would estimate the burden associated with these requirements, solicit public comment, and request OMB approval in accordance with the PRA, as may be necessary.

G. ICR Regarding Eligibility Redeterminations (§ 155.330)

We propose to permit an Exchange to choose among three alternatives when the Exchange identifies updated information regarding compliance with the income tax filing and reconciliation requirement under § 155.305. An Exchange may either follow the process described in paragraph (e)(2)(i), a process specified by the Secretary in guidance, or an alternative process proposed by the Exchange and approved by the Secretary. HHS anticipates that it would require Exchanges requesting approval for an alternative process to submit a brief description of the alternative process, and a justification for how the process satisfies the approval criteria outlined in § 155.330(e)(2)(iii)(C). Given the availability of two alternative processes, we anticipate that fewer than 10 Exchanges would submit a proposal. Therefore, under 5 CFR 1320.3(c)(4), this ICR is not subject to the PRA as it would affect fewer than 10 entities in a 12-month period.

We also propose to permit the Exchange to recalculate APTC using the procedure described in § 155.330(g)(1) or an alternate procedure approved by HHS on a transitional basis. HHS anticipates that it would require participating Exchanges to submit a brief description of the alternate procedure and the extent to which the alternate procedure would protect tax filers from an excess APTC repayment. Here too, we anticipate that fewer than 10 Exchanges would submit a proposal. Under 5 CFR 1320.3(c)(4), this ICR is not subject to the PRA as it would affect fewer than 10 entities in a 12-month period.

H. ICR Regarding Termination of Exchange Enrollment or Coverage (§ 155.430(b)(2)(iii))

We are proposing to amend § 155.430(b)(2)(iii) to clarify that when an issuer seeks termination of a QHP purchased on an Exchange via a rescission under § 147.128, it must first demonstrate, to the reasonable satisfaction of the Exchange, that the basis for the rescission is appropriate, if the Exchange requires such a demonstration. This would require the issuer to provide information related to the termination to the Exchange. We do not anticipate that all Exchanges will subject issuers to this requirement. We anticipate that fewer than 10 issuers would be subject to this requirement annually. Under 5 CFR 1320.3(c)(4), this ICR is not subject to the PRA as it would affect fewer than 10 entities in a 12-month period.

I. ICR Regarding QHP Request for Reconsideration (§ 155.1090)

We propose to add § 155.1090 to create a process for an issuer that has applied to an FFE for certification of QHPs and has been denied certification to request reconsideration. We anticipate that fewer than 10 issuers per year would request reconsideration. Under 5 CFR 1320.3(c)(4), this ICR is not subject to the PRA as it would affect fewer than 10 entities in a 12-month period.

J. ICR Regarding Notification by Issuers Denied Certification (§ 156.290)

In proposed § 156.290 we propose that QHP issuers would be required to provide a notification to enrollees within 30 days of the date of HHS's denial of certification for a subsequent, consecutive certification cycle. We anticipate that fewer than 10 issuers would be subject to this requirement annually. Under 5 CFR 1320.3(c)(4), this ICR is not subject to the PRA as it would affect fewer than 10 entities in a 12-month period.

K. ICR Regarding the Discrepancy Reporting Processes for the Reconciliation of the Cost-sharing Reduction Portion of Advance Payments (§ 156.430(h))

Under § 156.430(h)(1), we proposed that, if an issuer files a discrepancy report to dispute the notification of the amount of reconciliation of the cost-sharing reduction portion of advance payments, it must file the discrepancy report within 30 calendar days of notification of the amount of reconciliation of the cost-sharing reduction portion of advance payments as described in § 156.430(e), in the manner set forth by HHS.

We estimate that of approximately 360 QHP issuers that submit cost-sharing reduction reconciliation data, less than ⅓ would file a discrepancy report to dispute the notification of the amount of reconciliation of the cost-sharing reduction portion of advance payments. Issuers would review the notification of the amount of reconciliation of the cost-sharing reduction portion of advance payments for this discrepancy reporting process. On average, we estimate that it would take a business operations specialist (at an hourly labor cost of $78) approximately 6 hours to review the requirements of the discrepancy reporting process, to determine whether the issuer should submit a discrepancy report, to categorize the discrepancy, and to write a description of the discrepancy for submission to HHS. Additionally, we estimate that it would take a computer programmer (at an hourly labor cost of approximately $78) approximately 12 hours to develop the pipe-delimited file for reporting the discrepancy, based on the technical specifications published by HHS, and to submit the discrepancy file to HHS through the electronic file transfer system. Therefore, we estimate that the total burden for each issuer would be approximately 18 hours with an equivalent cost of $1,404. Therefore, assuming that no more than 120 issuers would submit a discrepancy, we estimate a total aggregate annual burden of approximately 2,160 hours with an equivalent cost of $168,480 for issuers as a result of these requirements. We will revise the information collection currently approved under OMB Control Number 0938–1266 with a December 31, 2017 expiration date to account for this additional burden.

L. ICRs Regarding Administrative Appeals (§ 156.1220)

In 45 CFR 156.1220, we established an administrative appeals process to address any issues or errors for advance payment of the premium tax credit, advance payment and reconciliation of cost-sharing reductions, FFE user fees, and the premium stabilization programs, as well as any assessment of a default risk adjustment charge under § 153.740(b). We propose revising § 156.1220 to also address administrative appeals relating to the risk adjustment data validation process.

Under § 153.630(d), an issuer may appeal the findings of a second validation audit or the calculation of a risk score error rate. We propose to amend § 153.630(d) by clarifying the process by which an issuer can appeal the findings of a second validation audit or the calculation of a risk score error rate. We propose requiring issuers to use the administrative appeals process set forth in § 156.1220.

Under § 156.1220(a), we propose to clarify that an issuer may file a request for reconsideration under this section to contest a processing error by HHS,

HHS's incorrect application of the relevant methodology, or HHS's mathematical error with respect to the findings of a second validation audit or the calculation of a risk score error rate.

While the hours involved in a request for reconsideration might vary, for purposes of this burden estimate we estimate that it would take a business operations specialist 1 hour (at an hourly labor cost of $78) to make the comparison and submit a request for reconsideration to HHS. We estimate that 9 issuers, representing approximately 1 percent of issuers of risk adjustment covered plans, subject to risk adjustment data validation, would submit a request for reconsideration, resulting in a total aggregate annual burden of 9 hours with an equivalent cost of approximately $702.

M. ICR Regarding Medical Loss Ratio (§ 158.240)

We are proposing to amend § 158.240 to allow issuers the option of limiting the total rebate payable over the course of a 3-year period with respect to a given calendar year. We anticipate that implementing this proposal would require minor changes to the MLR annual reporting form and we may revise the information collection currently approved under OMB Control Number 0938–1164 to reflect the proposed policy. However, only a small number of issuers would elect the option of additional reporting and we do not expect that the proposed policy would increase the burden.

TABLE 16—ANNUAL REPORTING, RECORDKEEPING AND DISCLOSURE BURDEN

Regulation Section	OMB Control No.	Number of respondents	Responses	Burden per response (hours)	Total annual burden (hours)	Hourly labor cost of reporting ($)	Total labor cost of reporting ($)	Total cost ($)
§ 153.630 Risk Adjustment Data Validation	0938–1155	825	82,500	0.5	41,250	72	2,970,000	2,970,000
§ 153.630(d) Discrepancy Reporting Processes for Risk Adjustment Data Validation	0938–1155	825	1650	4	6,600	78	514,800	514,800
§§ 155.220, 156.265 Differential Display of Standardized Options ...	NEW	160	160	2	320	96.82	30,982	30,982
§ 156.430(h) Discrepancy Reporting for cost-sharing reduction reconciliation	0938–1266	120	1	18	2,160	78	168,480	168,480
§ 156.1220 Administrative Appeals	NEW	9	9	1	9	68	702	702
Total	.....	1,114	84,320	25.5	50,339	392.82	3,684,964	3,684,964

Note: There are no capital/maintenance costs associated with the information collection requirements contained in this rule; therefore, we have removed the associated column from Table 16.

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 2017 and 2018 benefit years, as well as certain modifications to the program that will protect against the potential effects of adverse selection. The Premium Stabilization Rule and previous Payment Notices provided detail on the implementation of this program, including the specific parameters for the 2014, 2015, 2016, and 2017 benefit years applicable to this program. This rule proposes additional standards related to enrollment and eligibility, consumer assistance tools and programs of an Exchange, web-brokers, cost-sharing parameters, qualified health plans, network adequacy, stand-alone dental plans, guaranteed renewability, the rate review program, the medical loss ratio program, the Small Business Health Options Program, and FFE user fees. These proposed standards represent incremental amendments that are intended to continue to strengthen the Exchanges, improve the stability of the market, and enhance the choices available to consumers, while supporting consumers' ability to make informed choices when purchasing health insurance.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995, Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. A regulatory impact analysis (RIA) must be prepared for rules with economically significant effects ($100 million or more in any 1 year).

OMB has determined that this proposed rule is ''economically significant'' within the meaning of section 3(f)(1) of Executive Order 12866, because it is likely to have an annual effect of $100 million in any 1 year. Accordingly, we have prepared an RIA that presents the costs and benefits of this proposed rule.

Although it is difficult to discuss the wide-ranging effects of these provisions in isolation, the overarching goal of the premium stabilization, market standards, and Exchange-related provisions and policies in the Affordable Care Act is to make affordable health insurance available to individuals who do not have access to affordable employer-sponsored coverage. The provisions within this proposed rule are integral to the goal of expanding coverage. For example, the risk adjustment program helps prevent risk selection and decrease the risk of financial loss that health insurance issuers might otherwise expect in 2018 and Exchange financial assistance helps low- and moderate-income consumers and American Indians/Alaska Natives purchase health insurance. The combined impacts of these provisions affect the private sector, issuers, and consumers, through increased access to health care services, decreased uncompensated care, lower premiums, and increased plan transparency. Through the reduction in financial uncertainty for issuers and increased affordability for consumers, these provisions are expected to increase access to affordable health coverage.

HHS anticipates that the provisions of this proposed rule will help further HHS's goal of ensuring that all consumers have access to quality, affordable health care and are able to make informed choices, that Exchanges operate smoothly, that the risk adjustment program works as intended, and that SHOPs are provided flexibility. Affected entities such as QHP issuers would incur costs to comply with the proposed provisions. 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 17 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 a number of effects, including providing consumers with affordable health insurance coverage, reducing the impact of adverse selection, and stabilizing premiums in the individual and small group health insurance markets and in an Exchange. We are unable to quantify certain benefits of this proposed rule—such as improved health outcomes and longevity due to continuous quality improvement, and increased insurance enrollment—and certain costs—such as the cost of providing additional medical services to newly-enrolled individuals. The effects in Table 17 reflect qualitative impacts and estimated direct monetary costs and transfers resulting from the provisions of this proposed rule. The annualized monetized costs described in Table 17 reflect direct administrative costs to health insurance issuers and web-brokers as a result of the proposed provisions, and include administrative costs related to requirements that are estimated in the Collection of Information section of this proposed rule. The annual monetized transfers described in Table 17 include costs associated with the risk adjustment user fee paid to HHS by issuers, and a decrease in MLR rebates to consumers. For 2018, we are proposing to collect a total of $35 million in risk adjustment user fees or $1.32 per enrollee per year from risk adjustment issuers, an increase from $24 million in benefit year 2017 when we established a $1.56 per-enrollee-per-year risk adjustment user fee amount. As in 2017, the risk adjustment user fee contract costs for 2018 include costs for risk adjustment data validation; however, we expect increased enrollment in 2018 HHS risk adjustment covered plans, which decreases the per enrollee amount.

The annual monetized transfers described in Table 17 include a decrease in MLR rebates to consumers.

TABLE 17—ACCOUNTING TABLE

Benefits:

Qualitative:

- Increased enrollment in the individual market leading to improved access to health care for the previously uninsured, especially individuals with medical conditions, which will result in improved health and protection from the risk of catastrophic medical expenditures.
- Improved transparency and shopping experience for consumers due to new, updated standardized options and their differential display; and protections relating to direct enrollment.
- Provide adequate time to newly qualified employees to make informed decisions regarding their coverage in the SHOP.
- Ensure plan choice, allowing individuals to find coverage that fit their needs.

Costs:	Estimate (million)	Year dollar	Discount rate	Period covered
Annualized Monetized ($/year)	$3.68	2016	7	2017–2021
	3.68	2016	3	2017–2021

Costs reflect administrative costs incurred by issuers and web-brokers to comply with provisions in this final rule.

Transfers:	Estimate (million)	Year dollar	Discount rate	Period covered
Annualized Monetized ($/year)	$22.2	2016	7	2017–2021
	22.6	2016	3	2017–2021

- Transfers include risk adjustment user fees for 2018–2021 (assuming that they remain the same during this time period), which are transfers from health insurance issuers to the Federal government; and a reduction in total rebate payments by issuers which is a transfer from enrollees to shareholders or nonprofit stakeholders in individual, small and large group markets, resulting from adjustment in MLR methodology.

Qualitative:

- More accurate risk adjustment charges and payments due to change in risk adjustment methodology.

This RIA expands upon the impact analyses of previous rules and utilizes the Congressional Budget Office's (CBO) analysis of the Affordable Care Act's impact on Federal spending, revenue collection, and insurance enrollment. The temporary risk corridors program and the transitional reinsurance program end after the benefit year 2016. Therefore, the costs associated with those programs are not included in Tables 17 or 18 for fiscal years 2019–2021. Table 18 summarizes the effects of the risk adjustment program on the Federal budget from fiscal years 2017 through 2021, 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 18. We note that transfers associated with the risk adjustment and reinsurance programs were previously estimated in the Premium Stabilization Rule; therefore, to avoid double-counting, we do not include them in the accounting statement for this proposed rule (Table 18).

TABLE 18—ESTIMATED FEDERAL GOVERNMENT OUTLAYS AND RECEIPTS FOR THE RISK ADJUSTMENT, REINSURANCE, AND RISK CORRIDORS PROGRAMS FROM FISCAL YEAR 2017–2021

[In billions of dollars]

Year	2017	2018	2019	2020	2021	2017–2021
Risk Adjustment, Reinsurance, and Risk Corridors Program Payments	10	8	8	9	9	44
Risk Adjustment, Reinsurance, and Risk Corridors Program Collections *	11	7	8	9	9	44

Note 1: Risk adjustment program payments and receipts lag by one quarter. Receipt will fully offset payments over time.

Note 2: The CBO score reflects an additional $2 million in collections in FY 2015 that are outlaid in the FY 2016–FY 2020 timeframe. CBO does not expect a shortfall in these programs.

Source: Congressional Budget Office. Federal Subsidies for Health Insurance Coverage for People Under Age 65: Tables From CBO's March 2016 Baseline *https://www.cbo.gov/sites/default/files/51298-2016-03-HealthInsurance.pdf*.

1. Fair Health Insurance Premiums

The proposed regulations would amend § 147.102(d) to create multiple child age bands rather than a single age band for all individuals aged 0 through 20. Establishing single-year age bands starting at age 15 is likely to result in small annual increases in premiums for children age 15 to 20, which would help mitigate large premium increases attributable to age due to the transition from child to adult age rating.

2. Guaranteed Renewability

This proposed rule would specify the circumstances in which the discontinuation of all coverage currently offered by an issuer in a market in a State would not be considered a market withdrawal subject to the 5-year ban on market re-entry. We believe this proposal is generally consistent with State regulation of health insurance and therefore would not have a material impact on issuers or enrollees. These changes would benefit consumers since imposing the 5-year ban on market re-entry in these situations could result in disruption for consumers and reduced competition in some markets.

3. Risk Adjustment

The risk adjustment program is a program created by the Affordable Care Act in which States, or HHS on behalf of States, collects charges from health insurance issuers that attract lower-risk populations in order to use those funds to provide payments to health insurance issuers that attract higher-risk populations, such as those with chronic conditions, thereby reducing incentives for issuers to avoid higher-risk enrollees. We established standards for the administration of the risk adjustment program, in subparts D and G of part 45 of the CFR. The proposed modifications to the risk adjustment model aims to improve the methodology and would result in more accurate risk adjustment charges and payments and mitigate any residual incentive for risk selection.

A State approved or conditionally approved by the Secretary to operate an Exchange may establish a risk adjustment program, or have HHS do so on its behalf. As described in the 2014, 2015, 2016 and 2017 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 2018 benefit year, we estimate that the total cost for HHS to operate the risk adjustment program on behalf of States for 2018 will be approximately $35 million, and that the risk adjustment user fee would be approximately $1.32 per enrollee per year. The risk adjustment user fee contract costs for 2018 include costs related to 2018 risk adjustment data validation, and are higher than the 2017 contract costs as the result of some contracts that were rebid.

4. SHOP

The SHOPs facilitate the enrollment of eligible employees of eligible small employers into small group market health insurance plans. A qualitative analysis of the costs and benefits of establishing a SHOP was included in the RIA published in conjunction with the Exchange Establishment Rule.[61]

In § 155.230(d)(2), we propose requiring SHOPs to make electronic notices the default method of sending SHOP notices to employers and employees, unless otherwise required by State or Federal law. Electronic notices would provide a more cost effective way for SHOPs to distribute required notices and should decrease the SHOP's costs for notifications.

In § 155.725(g), we propose changes to the enrollment process for newly qualified employees. We believe the proposed amendments would provide newly qualified employees with adequate time to make informed decisions regarding their coverage and are likely to have a negligible impact on plan premiums and would ensure that employers do not exceed the waiting period limits under § 147.116.

5. Direct Enrollment—Standardized Options Differential Display and Privacy/Security and Oversight

We did not require QHP issuers or web-brokers to adhere to differential display requirements of standardized options when using a non-Exchange Web site to facilitate enrollment in a QHP through an Exchange for the 2017 plan year, but we noted that we would consider whether to propose such a standard in the future. We now propose to amend § 155.220(c)(3)(i) by adding

[61] Available at *http://cciio.cms.gov/resources/files/Files2/03162012/hie3r-ria-032012.pdf*.

new paragraph (c)(3)(i)(H) to require web-brokers to differentially display standardized options consistent with the approach adopted by HHS, unless a deviation is approved by HHS and to amend § 156.265(b)(3) by adding new paragraph (b)(3)(iv) to likewise require QHP issuers that conduct direct enrollment to differentially display standardized options in such manner approved by HHS. Requiring web-brokers and QHP issuers using the direct enrollment pathway to make changes to their respective QHP display systems may result a slight increase in administrative costs but would help further our goal of ensuring that all consumers have access to quality and affordable health care and are able to make informed choices.

In §§ 155.220, 156.265, and 156.1230, we propose requirements for web-brokers and issuers related to the direct enrollment process that would provide consumer protections and ensure that consumers have necessary information to select coverage that would best fit their needs. Web-brokers and issuers would incur administrative costs to comply with these requirements.

6. Eligibility and Enrollment Provisions

In § 155.400, we propose to provide Exchanges with the discretion to allow issuers experiencing billing or enrollment problems due to high volume or technical errors to implement a reasonable extension of the binder payment deadlines in § 155.400(e)(1). This proposal aims to retain consumers on the Exchange and to mitigate the problems associated with issuers receiving high-volumes of enrollments in a short timeframe. There would be no added cost to issuers who choose to implement the optional binder payment extensions, while ensuring that they would not lose enrollees who have not paid their binder payments simply because they did not receive their bills due to a processing backlog or a technical error. Consumers would benefit by having a reasonable amount of time to pay their binder payments, which should prevent coverage cancellations due to enrollment irregularities which are not the fault of the consumer.

In § 155.420, we propose to codify several special enrollment periods that are already provided through the Exchange. By codifying these, we seek to ensure that these existing special enrollment periods are applied consistently across Exchanges, and to provide both issuers and consumers with greater certainty in how these special enrollment periods are applied. We believe that this certainty would contribute to greater stability in the market, and in the use of these special enrollment periods, specifically.

We propose to amend § 155.430(b)(2)(iii) to require that when an issuer seeks termination of a QHP on an Exchange via a rescission for fraud or misrepresentation of material fact under § 147.128, it must first demonstrate, to the reasonable satisfaction of the Exchange, that the basis for the rescission is appropriate, if the Exchange requires such a demonstration. This would not restrict issuers' ability to rescind coverage when an individual or a party working on behalf of an individual fraudulently enrolls in coverage, while protecting consumers whose verification and enrollment conform to FFE and SBE–FP rules and guidance.

7. Standardized Options

We are proposing new standardized options for 2018, which are updated versions of the ones finalized in the 2017 Payment Notice. As in 2017, offering standardized options will be voluntary for QHP issuers in 2018. In keeping with the methodology used to design standardized options in 2017, we designed the proposed 2018 standardized plans based on the median cost-sharing features of the most popular 2016 QHPs, based on enrollment to ensure minimal market disruption and impact on premiums. For 2018, we are proposing additional standardized options at each metal level and plan variation with the goal of having at least one option at each metal level that would comply with every State's respective cost-sharing laws as applicable. Each applicable State would have one standardized option at each metal level and plan variation that issuers would then be able to choose to offer. In the 2017 Payment Notice, we attempted to estimate the potential impact that the introduction of standardized options would have on premiums established by QHPs. As we previously estimated, we do not anticipate that standardized options would impact 2018 plan premiums significantly. Rather, the proposed options would allow each applicable State to have a set of standardized options that most closely reflects QHPs in the State while meeting any State cost-sharing mandates. This policy should continue to improve simplicity and transparency for consumers during the shopping experience. To the extent it facilitates consumer shopping, it could put modest downward pressure on premiums.

8. User Fees

To support the operation of FFEs, we require in § 156.50(c) that a participating issuer offering a plan through an FFE must remit a user fee to HHS each month equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year and the monthly premium charged by the issuer for each policy under the plan where enrollment is through an FFE. In this proposed rule, for the 2018 benefit year, we propose a monthly FFE user fee rate equal to 3.5 percent and, for a State-based Exchange that relies on the Federal platform, 3.0 percent of the monthly premium. We had estimated the user fee transfers in the 2017 Payment Notice and there are no additional incremental charges. To avoid double-counting, we do not include the user fee costs in the accounting statement for this rule (Table 17). For the user fee charges assessed on issuers in the FFE and State-based Exchanges using the Federal platform, we intend to seek an exception to OMB Circular No. A–25R, which requires that the user fee charge be sufficient to recover the full cost to the Federal government of providing the special benefit. We seek this exception to ensure that the FFE can support many of the goals of the Affordable Care Act, including improving the health of the population, reducing health care costs, and providing access to health coverage as advanced by § 156.50(d).

9. Levels of Coverage

At § 156.140, we propose to change the de minimis range of bronze plans under certain circumstances. We believe that this policy would not be disruptive to the current bronze plan market as it would allow more bronze plans the flexibility in creating plan designs within the increased de minimis range, as well as allow more options for issuers to leave 2017 cost-sharing structures unchanged. We also believe this policy would allow issuers to continue to offer a range of bronze plans as the AV Calculator is updated in future years, which is good for consumers. Plans are not required to utilize this proposed option, and we do not anticipate any significant impact on average bronze plan premiums from this proposed policy.

10. Provisions Related to Cost Sharing

The Affordable Care Act provides for the reduction or elimination of cost sharing for certain eligible individuals enrolled in QHPs offered through the Exchanges. This assistance will help

many low- and moderate-income individuals and families obtain health insurance—for many people, cost sharing is a barrier to obtaining needed health care.[62]

We set forth in this proposed rule the reductions in the maximum annual limitation on cost sharing for silver plan variations. Consistent with our analysis in previous Payment Notices, we developed three model silver level QHPs and analyzed the impact on their AVs of the reductions described in the Affordable Care Act to the estimated 2018 maximum annual limitation on cost sharing for self only coverage $7,350. We do not believe these changes would result in a significant economic impact. Therefore, we do not believe the provisions related to cost-sharing reductions in this proposed rule would have an impact on the program established by and described in the 2015, 2016, and 2017 Payment Notices.

We also proposed the premium adjustment percentage for the 2018 benefit year. Section 156.130(e) provides that the premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013. The annual premium adjustment percentage sets the rate of increase for three parameters detailed in the Affordable Care Act: The annual limitation on cost sharing (defined at § 156.130(a)), the required contribution percentage used to determine eligibility for certain exemptions under section 5000A of the Code, and the assessable payments under sections 4980H(a) and 4980H(b). We believe that the proposed 2018 premium adjustment percentage of 16.17303196 percent is well within the parameters used in the modeling of the Affordable Care Act, and we do not expect that these proposed provisions would alter CBO's March 2015 baseline estimates of the budget impact.

11. Qualified Health Plan Minimum Standards

In § 156.200(c), we propose to specify that, to satisfy the requirements in these sections, QHPs must be offered through the applicable Exchange at both the silver and gold coverage levels throughout each service area in which the issuer applying for certification offers coverage through the Exchange. Since most issuers are already following these requirements, it is unlikely that there would be any impact on premiums, while ensuring continued plan choice for consumers.

In the 2017 Payment Notice, we finalized a network breadth policy through which we would categorize networks based on their relative size, in addition to other policies. We seek comment regarding how this should apply to ''integrated plans,'' such as staff model HMOs. We expect the policy would continue to improve transparency for consumers and the shopping experience.

Proposed § 156.272 would establish as a condition of certification that QHP issuers must make their QHPs available for enrollment through the Exchanges for the duration of the timeframe for which the plan was certified, unless a basis for suppression under § 156.815 applies. QHP issuers in FFEs and FF–SHOPs that do not comply with this requirement could be subject to CMPs or a two-year ban. This would raise costs or burdens on issuers, who could be forced to remain on the Exchange or face a 2-year ban or CMPs in certain situations. However, we do not believe that violations of the proposed requirement of full year participation under § 156.272 are happening on a wide scale, which minimizes any potential impact.

12. Medical Loss Ratio

In this proposed rule, we propose to amend § 158.121 to align with the requirement that, beginning in 2014, issuers must offer non-grandfathered coverage for a consecutive 12-month period and enable more issuers to defer reporting of the experience of new business in the MLR calculation. In general, deferring reporting of new business effectively enables new and rapidly growing issuers to use a 4-year, rather than a 3-year average MLR. This in turn increases the likelihood that low MLRs in the initial years will be offset by higher MLRs in later years and that only a portion of the rebates generated by the experience of initial years will ultimately be paid. Deferring reporting of new business also eliminates the rebate payment following the first year and instead spreads it over the following 3 years (that is, includes the rebate attributable to year 1 with rebates payable for years 2 through 4). Based on data from the 2013 and 2014 MLR reporting years, we estimate that allowing issuers to defer experience of newly sold policies with full 12 months of experience when 50 percent or more of an issuer's earned premium comes from such policies could reduce total rebate payments from issuers to consumers over a 4-year period by up to a total of $11.6 million.

We additionally propose to amend § 158.240 to allow issuers the option of limiting the total rebate payable over the course of a 3-year period with respect to a given calendar year, as well as to clarify references to single-year and preliminary MLRs in § 158.232. We estimate no impact from the proposed clarifications to § 158.232 because these clarifications are intended to simplify reporting for purposes of calculating the rebate limit proposed in § 158.240 and do not change the manner in which issuers currently calculate the credibility adjustment. Because the proposed amendments to § 158.240 generally would only impact new and rapidly growing established issuers whose MLRs initially fall below the standard and increase in subsequent years, the magnitude of the impact of the proposed limit on the rebate liability would depend on how issuers' enrollment and MLRs change in 2015 and later. Because the majority of new issuers have expanded or intend to expand into new markets in 2014 or later, the 2014 and earlier MLR reports, which are the only data source available at this time, are an insufficient source of data on the types of issuers that would be impacted by this proposal. In addition, significant reporting differences exist between 2011–13 and 2014 and later MLR data, and some rebates that were paid for 2014 are likely to be outliers and may therefore exaggerate estimates. Consequently, while we expect the proposal to decrease the amount of rebates paid by new and rapidly growing issuers to consumers, we are not able to estimate the magnitude of the decrease with a high degree of certainty.

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 proposals in parts 146, 147 and 148, we considered not changing our interpretation of what constitutes a market withdrawal when an issuer transfers all of its products to a related issuer or replaces all of its products with new products with changes that exceed the scope of a uniform modification of coverage. However, this approach could result in fewer product offerings, as issuers would be obligated

[62] 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.*

to leave the market due to the 5-year prohibition on issuing coverage after discontinuing all coverage in a market. This approach could also unnecessarily restrict issuer corporate structuring transactions, reduce market competition and consumer choice, and conflict with States' approaches.

For the proposals in part 147, we considered not changing the uniform child age band. This approach would have maintained the use of a single age band for rating purposes for all individuals age 0 through 20. We determined that creating multiple child age bands more accurately reflects the health risk of children and minimizes the increase in premium attributable to age when an individual attains age 21.

For the proposals in part 153, we considered various approaches to addressing partial year enrollment in the risk adjustment model, including separate models by enrollment duration, and interaction factors of enrollment duration combined with high- and medium-cost conditions. However, based on commenter feedback to the March 31, 2016 White Paper and our analysis of MarketScan® data, HHS determined that the enrollment duration additive factors are preferred and will best address partial year enrollees in the short term.

We considered four different hybrid models for the inclusion of prescription drugs in the HHS risk adjustment methodology: An imputation only model, a prescription drug-dominant model, a flexible model, and a severity only model. Commenters to the White Paper suggested that we use the imputation only model or the flexible model, with constraints to prevent an issuer from being compensated less for recording prescription drug utilization for an enrollee. We have imposed constraints on the flexible model so that the coefficients for the drug terms are greater than zero, preventing such a situation. We are adding two severity-only drug-diagnosis pairs on top of ten imputation/severity drug-diagnosis pairs.

We considered a threshold of $1 million and a coinsurance rate of 80 percent for the proposed high-cost enrollee pool in the risk adjustment proposal, which was supported by commenters to the White Paper. However, many more commenters suggested that the high-cost enrollee pool could be subject to gaming among issuers and would not incentivize cost containment efforts. Therefore, we are proposing a higher threshold of $2 million and a 60 percent coinsurance rate for the high-cost enrollee pool in the risk adjustment model. We also considered a PMPM adjustment to the transfer formula for this high-cost enrollee pool, but we are proposing a percent of per member per month premium adjustment to the transfer formula, to better align with the transfer formula's adjustment at the billable member month premiums.

We considered using only 2014 MarketScan® data for 2018 recalibration. However, commenters to the White Paper preferred to continue using the three-year blended approach. Commenters also supported issuing final coefficients in guidance, which we have proposed to do and are seeking comment on the timing of those final coefficients.

We considered alternative methodologies to recalibrating the 2019 risk adjustment model using EDGE summary level data instead of enrollee level data, as was proposed by one commenter to the White Paper. However, using EDGE summary level data would not enhance the existing risk adjustment models, as the model specifications would need to be known to create the models, and thus would prevent exploratory research and other types of analyses required for research, development and refinement of the risk adjustment models for their continuous improvement. Further, if summary level data were used, quality checks could not be performed on the input data, and additional improvements to address partial year enrollment could not be explored.

For the proposals regarding standardized options, we considered taking no action in designing additional plans per metal level to account for State cost-sharing laws. However, without this proposed change, issuers in States with conflicting cost-sharing laws would not be able to offer standardized options. We believe that it is important for issuers in each State in which an FFE or SBE–FP operates to have the choice to offer standardized options. We also considered designing a set of standardized plans for each State. However, HHS currently lacks the resources to propose this option.

For the proposal at § 155.205(c)(2)(iii), we considered requiring QHP issuers and web-brokers subject to the rule to look only to the LEP populations in the State where the entity is registered or licensed, such as through an issuer's Health Insurance Oversight System (HIOS) ID, when identifying the languages in which taglines must be provided under the rule. However, we believe that using such a definition would not recognize that many insurance companies use a common technology platform for their issuers across multiple States, and would pose difficult operational challenges for many such entities without significantly improving access.

For the proposal at §§ 155.220 and 156.265, we considered not requiring differential display of standardized options by web-brokers or QHP issuers. However, this would have made it less likely that consumers using a non-Exchange Web site would be aware of the standardized options available. We believe that the requirement for differential display of standardized options will help consumers using non-Exchange Web sites more easily compare and choose amongst the available plans. We note that we would not require the manner of differentiation to be identical to the one adopted for displaying standardized options on *HealthCare.gov*, and issuers are not required to offer, and consumers are not required to purchase, standardized options.

For proposals at § 155.400, we considered alternatives to our proposal to allow issuers the option to extend binder payment deadlines when issuers experience volume-related backlogs or technical errors that make it difficult for enrollees to pay their binder payments on time. For example, we considered relying on ad hoc solutions, such as extensions or remedies resembling reinstatements, when problems arise. We believed, however, that codifying the proposed optional extensions will give issuers and consumers alike more certainty and provide for better remedies when consumers experience difficulties during the enrollment process.

For the proposals at § 155.420, we considered not codifying the existing special enrollment periods for consumers who are or were a victim of domestic abuse or spousal abandonment and need to enroll in coverage apart from his or her abuser or abandoner, have been determined ineligible for Medicaid or CHIP, have been impacted by a material plan or benefit display error, or have resolved a citizenship or immigration inconsistency post-expiration, all currently provided through guidance. We also considered not standardizing the availability of the special enrollment period for Indians to non-Indian dependents enrolling at the same time as the Indian. However, we believe that codifying these special enrollment periods provides needed permanence and clarity for these special enrollment periods. This is important to ensure that they continue to be available, are equitably applied across Exchanges, and that consumers, assisters, issuers, and other stakeholders

have a common understanding of the parameters and coverage effective dates associated with each of these special enrollment periods. In this rule, we seek to ensure transparency, stability, and appropriate utilization of special enrollment periods by codifying certain special enrollment periods that we have made available in prior guidance. After weighing our options, we determined that codifying these currently available special enrollment periods is in the best interest of consumers and other Exchange stakeholders.

We considered alternatives to amending § 155.430 in order to protect consumers from having their coverage rescinded for reasons the FFE does not consider reasonable, such as rescissions based on allegations of fraud, despite the disputed information having been verified by the FFE during the enrollment process. One alternative was to issue guidance that would explain to issuers that rescissions based on claims of fraud arising from information provided to and verified by the FFE would not be permissible. Another alternative considered was to work with issuers to prevent rescissions considered unreasonable by the FFE, but to decline to pursue rulemaking. After considering all options, we chose to amend § 155.430(b)(2)(iii) in order to provide more consumer protection.

For the proposals related to SHOPs, we considered maintaining several provisions for the SHOPs. Specifically, we considered maintaining the current requirements at § 155.725(g)(1) and (2), which provide that an employee who becomes a qualified employee outside of the initial or annual open enrollment period must have an enrollment period beginning on the first day of becoming a qualified employee, and require the effective date of coverage to generally be determined in accordance with § 155.725(h). Similarly, we considered maintaining the current requirements at § 155.230(d)(2), which require paper notices to be the default option for SHOPs, so that employers and employees must opt into electronic notices. Finally, we considered maintaining existing requirements in State-based Exchanges using the Federal platform for SHOP eligibility, enrollment, or premium aggregation functions. However, we decided to propose the policies in this proposed rule in order to ensure that employers do not exceed the waiting period limits under § 147.116, to provide SHOPs with more cost-effective alternatives to sending notices, to ensure efficient SHOP operations, and to minimize the potential customization costs that could be associated with permitting State-based Exchanges to use the Federal platform for SHOP functions.

We considered alternative proposals for increasing the de minimis range for bronze plans. We considered simply increasing the de minimis range for bronze plans to extend above 62 percentage points without requiring that plans include certain plan design features in order to qualify for the extended de minimis range. This option could give issuers, and as a result consumers, more flexibility and choice with regards to bronze plan designs. However, we believe that the proposed policy better ensures that bronze plans are not less generous than catastrophic plans.

For the proposals at § 156.200(c)(1), we propose to specify that, to satisfy the requirements in that section, QHPs must be offered through an Exchange at both the silver and gold coverage levels throughout each service area in which the issuer offers coverage through the Exchange. We could have opted not to specify this in regulation; however, issuers could have misinterpreted the policy and not offered a silver and gold plan in the applicable service areas. This could result in fewer silver and gold plans available for consumers to select, and thus less choice for consumers. It also could complicate the calculation of the APTC for an individual market consumer. By revising our regulation, we ensure that consumers have an adequate choice of QHPs at different coverage levels to select from and that we are able to calculate APTC for all eligible individual market consumers.

For the proposals at § 156.272 to require issuer participation for the entirety of the period for which the plan was certified, we considered taking no action. However, we are concerned that inaction could result in limited access for qualified individuals and qualified employees outside of open enrollment periods.

For the proposed changes to § 156.290, we considered not making any changes. However, that could have led to enrollees in plans that are not certified for a subsequent, consecutive certification cycle not knowing as soon as possible that they may have to choose another plan during the annual open enrollment period.

For the proposals in part 158, we considered an alternative proposal for addressing the impact of MLR and rebate calculation on new and rapidly growing issuers. Specifically, we considered allowing new and rapidly growing issuers to include in the MLR calculation rebates they paid within the first 2 years of entering or expanding in a State market, which would be similar to how the 3-year average calculation was phased in for all issuers when the MLR requirements were first implemented. However, in contrast to the initial years of implementation of the MLR requirements, when all issuers had to calculate their first two MLRs using only 1 or 2 years of data, presently, as described in more detail in the preamble to this proposed rule, only a small subset of issuers are affected by the 3-year averaging in a manner that merits an adjustment. We note that inclusion of rebates paid for prior years in the MLR calculation for the current year is generally not appropriate for established and certain new issuers, as it would distort the 3-year average and effectively lower the MLR standards required by section 2718 of the PHS Act. Therefore, the prior year rebate approach would need to be limited to only the new and growing issuers that are adversely affected by the 3-year averaging. In practice, it would be extremely challenging to define enrollment or premium levels, growth rates, and patterns in year-over-year changes in MLRs that would appropriately distinguish new and growing issuers that are disadvantaged by the 3-year averaging from issuers that merely experience ordinary enrollment fluctuations or otherwise would gain an unfair advantage by being able to include prior year rebates in their MLR calculation. Because the proposed approach of limiting the total rebate liability payable with respect to a given calendar year is designed to only benefit new and rapidly growing issuers who are negatively impacted by the 3-year averaging, we believe that the proposed approach is a more effective and objective way to reduce barriers to entry and promote competition in health insurance markets while at the same time preserving the protections promised to consumers by the law.

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 program, 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.

Based on data from MLR annual report submissions for the 2014 MLR reporting year, approximately 118 out of 525 issuers of health insurance coverage nationwide had total premium revenue of $38.5 million or less. This estimate may overstate the actual number of small health insurance companies that may be affected, since almost 80 percent of these small companies belong to larger holding groups, and many if not all of these small companies are likely to have non-health lines of business that would result in their revenues exceeding $38.5 million. Only nine of these 118 potentially small entities, all of them part of larger holding groups, are estimated to experience a decrease in the rebate amount under the proposed amendments to the MLR provisions of this proposed rule in part 158. Therefore, we do not expect the proposed provisions of this rule regarding MLR to affect a substantial number of small entities.

In this proposed rule, we proposed standards for employers that choose to participate in a SHOP Exchange. The SHOPs generally are limited by statute to employers with at least one but not more than 50 employees, unless a State opts to provide that employers with 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 for SHOP eligibility and enrollment 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.

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 State, local, or Tribal governments, in the aggregate, or by the private sector, of $100 million in 1995 dollars, updated annually for inflation. In 2016, that threshold is approximately $146 million. Although we have not been able to quantify all costs, the combined administrative cost and user fee impact on State, local, or Tribal governments and the private sector may be above the threshold. Earlier portions of this RIA constitute our UMRA analysis.

G. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications. Because States have flexibility in designing their Exchanges 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 to operate an Exchange or, risk adjustment program, much of the initial cost of creating these programs were 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. However, HHS anticipates that the Federalism implications (if any) are substantially mitigated because under the statute and our proposals, States have choices regarding the structure, governance, and operations of their Exchanges and risk adjustment program. For example, our proposals relating to binder payment rules and termination of coverage are intended to provide State Exchanges with significant flexibility. Additionally, the Affordable Care Act does not require States to establish these programs; if a State elects not to establish any of these programs or is not approved to do so, HHS must establish and operate the programs in that State. Additionally, States have the option to establish and operate their own SHOP without also establishing and operating their own individual market Exchange. Our proposals requiring SBE–FPs to establish requirements that are consistent with certain Federal requirements when using the Federal platform for certain SHOP functions would not apply should the State decide not to use the Federal platform for these SHOP functions.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have Federalism implications or limit the policy making discretion of the States, HHS has engaged in efforts to consult with and work cooperatively with affected States, including participating in conference calls with and attending conferences of the National Association of Insurance Commissioners, and consulting with State insurance officials on an individual basis.

While developing this proposed rule, HHS has attempted to balance the States' interests in regulating health insurance issuers, and Congress' intent to provide access to Affordable Insurance Exchanges for consumers in every State. By doing so, it is HHS's view that we have complied with the requirements of Executive Order 13132.

States will continue to license, monitor, and regulate agents and brokers, both inside and outside of Exchanges. All State laws related to

agents and brokers, including State laws related to appointments, contractual relationships with issuers, licensing, marketing, conduct, and fraud will continue to apply.

H. Congressional Review Act

This proposed rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801, *et seq.*), which specifies that before a rule can take effect, the Federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and has been transmitted to Congress and the Comptroller for review.

List of Subjects

45 CFR Parts 144, 146, and 147

Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Part 148

Administrative practice and procedure, Health care, Health insurance, Penalties, Reporting and recordkeeping requirements.

45 CFR Part 153

Administrative practice and procedure, Health care, Health insurance, Health records, Organization and functions (Government agencies), Reporting and recordkeeping requirements.

45 CFR Part 154

Administrative practice and procedure, Claims, Health care, Health insurance, Penalties, Reporting and recordkeeping requirements.

45 CFR Part 155

Administrative practice and procedure, Advertising, Brokers, Conflict of interest, Consumer protection, Grant 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, American Indian/Alaska Natives, Conflict of interest, Consumer protection, Cost-sharing reductions, Grant programs—health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Individuals with disabilities, Loan programs—health, Medicaid, Organization and functions (Government agencies), Public assistance programs, Reporting and recordkeeping requirements, State and local governments, Sunshine Act, Technical assistance, Women, Youth.

45 CFR Part 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 144, 146, 147, 148, 153, 154, 155, 156, 157 and 158 as set forth below.

PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

■ 1. The authority citation for part 144 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act, 42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92.

■ 2. Section 144.103 is amended by revising the introductory text of the definition of ''plan'' and by revising the definition of ''product'' to read as follows:

§ 144.103 Definitions.

* * * * *

Plan means, with respect to a product, the pairing of the health insurance coverage benefits under the product with a particular cost-sharing structure, provider network, and service area. The product comprises all plans offered with those characteristics and the combination of the service areas for all plans offered within a product constitutes the total service area of the product. With respect to a plan that has been modified at the time of coverage renewal consistent with § 147.106 of this subchapter—

* * * * *

Product means a discrete package of health insurance coverage benefits that are offered using a particular product network type (such as health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity) within a service area. In the case of a product that has been modified, transferred, or replaced, the new product will be considered to be the same as the modified, transferred, or replaced product when the changes to the modified, transferred, or replaced product meet the standards of § 146.152(f), § 147.106(e), or § 148.122(g) of this subchapter (relating to uniform modification of coverage), as applicable.

* * * * *

PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

■ 3. The authority citation for part 146 continues to read as follows:

Authority: Secs. 2702 through 2705, 2711 through 2723, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg–1 through 300gg–5, 300gg–11 through 300gg–23, 300gg–91, and 300gg–92).

■ 4. Section 146.152 is amended by adding paragraph (d)(3) and revising paragraph (f)(3)(i) to read as follows:

§ 146.152 Guaranteed renewability of coverage for employers in the group market.

* * * * *

(d) * * *

(3) For purposes of this paragraph (d), subject to applicable State law, an issuer is not considered to have discontinued offering all health insurance coverage in a market if—

(i) The issuer or a member of the issuer's controlled group continues to offer and make available in the applicable market in the State at least one product of the issuer that is considered to be the same product as a product the issuer had been offering (as defined in § 144.103 of this subchapter). For purposes of this section, the term controlled group means a group of two or more persons that is treated as a single employer under section 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code of 1986, as amended; or

(ii) The issuer continues to offer and make available at least one product in the applicable market in the State, even if such product is not considered to be the same product as a product the issuer had been offering (as defined in § 144.103 of this subchapter), provided the issuer subjects that product to the rate review requirements under part 154 of this title (to the extent otherwise

applicable to coverage of the same type and in the same market) as if that part applied to that product, and reasonably identifies a discontinued product that corresponds to the new product for purposes of such rate review.

* * * * *

(f) * * *

(3) * * *

(i) The product is offered by the same health insurance issuer (within the meaning of section 2791(b)(2) of the PHS Act), or a member of the issuer's controlled group (as defined in paragraph (d) of this section);

* * * * *

PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

■ 5. The authority citation for part 147 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

■ 6. Section 147.102 is amended by revising paragraphs (d)(1) and (e) to read as follows:

§ 147.102 Fair health insurance premiums.

* * * * *

(d) * * *

(1) *Child age bands.* (i) A single age band for individuals age 0 through 14.

(ii) One-year age bands for individuals age 15 through 20.

* * * * *

(e) *Uniform age rating curves.* Each State may establish a uniform age rating curve in the individual or small group market, or both markets, for rating purposes under paragraph (a)(1)(iii) of this section. If a State does not establish a uniform age rating curve or provide information on such age curve in accordance with § 147.103, a default uniform age rating curve specified in guidance by the Secretary to reflect market patterns in the individual and small group markets will apply in that State that takes into account the rating variation permitted for age under State law.

* * * * *

■ 7. Section 147. 104 is amended by revising paragraph (b)(2) to read as follows:

§ 147.104 Guaranteed availability of coverage.

* * * * *

(b) * * *

(2) *Limited open enrollment periods.* A health insurance issuer in the individual market must provide a limited open enrollment period for the events described in § 155.420(d) of this subchapter, excluding §§ 155.420(d)(3) of this subchapter (concerning citizenship status), 155.420(d)(8) of this subchapter (concerning Indians), 155.420(d)(9) of this subchapter (concerning exceptional circumstances), and 155.420(d)(13) of this subchapter (concerning eligibility for insurance affordability programs or enrollment in the Exchange).

* * * * *

■ 8. Section 147.106 is amended by adding paragraph (d)(3) and revising paragraphs (e)(3)(i) to read as follows:

§ 147.106 Guaranteed renewability of coverage.

* * * * *

(d) * * *

(3) For purposes of this paragraph (d), subject to applicable State law, an issuer is not considered to have discontinued offering all health insurance coverage in a market if—

(i) The issuer or a member of the issuer's controlled group continues to offer and make available in the applicable market in the State at least one product of the issuer that is considered to be the same product as a product the issuer had been offering (as defined in § 144.103 of this subchapter). For purposes of this section, the term controlled group means a group of two or more persons that is treated as a single employer under section 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code of 1986, as amended; or

(ii) The issuer continues to offer and make available at least one product in the applicable market in the State, even if such product is not considered to be the same product as a product the issuer had been offering (as defined in § 144.103 of this subchapter), provided the issuer subjects that product to the rate review requirements under part 154 of this title (to the extent otherwise applicable to coverage of the same type and in the same market) as if that part applied to that product, and reasonably identifies a discontinued product that corresponds to the new product for purposes of such rate review.

(e) * * *

(3) * * *

(i) The product is offered by the same health insurance issuer (within the meaning of section 2791(b)(2) of the PHS Act) or member of the issuer's controlled group (as defined in paragraph (d) of this section);

* * * * *

PART 148—REQUIREMENTS FOR THE INDIVIDUAL HEALTH INSURANCE MARKET

■ 9. The authority citation for part 148 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791 and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

■ 10. Section 148.122 is amended by adding paragraph (e)(4) and revising paragraph (g)(3)(i) to read as follows:

§ 148.122 Guaranteed renewability of individual health insurance coverage.

* * * * *

(e) * * *

(4) For purposes of this paragraph (e), subject to applicable State law, an issuer is not considered to have discontinued offering all health insurance coverage in a market if—

(i) The issuer or a member of the issuer's controlled group continues to offer and make available in the applicable market in the State at least one product of the issuer that is considered to be the same product as a product the issuer had been offering (as defined in § 144.103 of this subchapter). For purposes of this section, the term controlled group means a group of two or more persons that is treated as a single employer under section 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code of 1986, as amended; or

(ii) The issuer continues to offer and make available at least one product in the applicable market in the State, even if such product is not considered to be the same product as a product the issuer had been offering (as defined in § 144.103 of this subchapter), provided the issuer subjects that product to the rate review requirements under part 154 of this title (to the extent otherwise applicable to coverage of the same type and in the same market) as if that part applied to that product, and reasonably identifies a discontinued product that corresponds to the new product for purposes of such rate review.

* * * * *

(g) * * *

(3) * * *

(i) The product is offered by the same health insurance issuer (within the meaning of section 2791(b)(2) of the PHS Act) or member of the issuer's controlled group (as defined in paragraph (e) of this section);

* * * * *

PART 153—STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS, AND RISK ADJUSTMENT UNDER THE AFFORDABLE CARE ACT

■ 11. The authority citation for part 153 continues to read as follows:

Authority: Secs. 1311, 1321, 1341–1343, Pub. L. 111–148, 24 Stat. 119.

§ 153.20 [Amended]

■ 12. Section 153.20 is amended by removing the definition of ''Large employer''.

■ 13. Section 153.320 is amended by revising paragraphs (a)(1) and (b)(1)(i) to read as follows:

§ 153.320 Federally certified risk adjustment methodology.

(a) * * *

(1) The risk adjustment methodology is developed by HHS and published in advance of the benefit year in rulemaking; or

* * * * *

(b) * * *

(1) * * *

(i) Draft factors to be employed in the model, including but not limited to demographic factors, diagnostic factors, and utilization factors, if any, the dataset(s) to be used to calculate final coefficients, and the date by which final coefficients will be released in guidance;

* * * * *

■ 14. Section 153.610 is amended by revising paragraph (f)(2) to read as follows:

§ 153.610 Risk adjustment issuer requirements.

* * * * *

(f) * * *

(2) Remit to HHS an amount equal to the product of its monthly billable enrollment in the risk adjustment covered plan multiplied by the per-enrollee-per-month risk adjustment user fee specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year.

■ 15. Section 153.630 is amended by—

■ a. Redesignating paragraphs (b)(7)(iii) and (iv) as paragraphs (b)(7)(iv) and (v), respectively;

■ b. Adding a new paragraph (b)(7)(iii); and

■ c. Revising paragraph (d).

The addition and revision read as follows:

§ 153.630 Data validation requirements when HHS operates risk adjustment.

* * * * *

(b) * * *

(7) * * *

(iii) Beginning in the 2018 benefit year, validating enrollee health status through review of all relevant paid pharmacy claims;

* * * * *

(d) *Risk adjustment data validation disputes and appeals.* (1) Within 15 calendar days of notification of the initial validation audit sample determined by HHS, in the manner set forth by HHS, an issuer must confirm the sample or file a discrepancy report to dispute the initial validation audit sample determined by HHS.

(2) Within 30 calendar days of notification of the findings of a second validation audit or the calculation of a risk score error rate, in the manner set forth by HHS, an issuer must confirm the audit or error rate, or file a discrepancy report to dispute the findings of a second validation audit or the calculation of a risk score error rate as result of risk adjustment data validation.

(3) An issuer may appeal the findings of a second validation audit or the calculation of a risk score error rate as result of risk adjustment data validation, under the process set forth in § 156.1220 of this subchapter.

* * * * *

PART 154—HEALTH INSURANCE ISSUER RATE INCREASES: DISCLOSURE AND REVIEW REQUIREMENTS

■ 16. 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).

■ 17. Section 154.102 is amended by revising the definition of ''product'' to read as follows:

§ 154.102 Definitions.

* * * * *

Product means a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies offered in a State. The term product includes any product that is discontinued and newly filed within a 12-month period when the changes to the product meet the standards of § 147.106(e)(2) or (3) of this subchapter (relating to uniform modification of coverage).

* * * * *

PART 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

■ 18. 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).

■ 19. Section 155.20 is amended by revising the definition of ''standardized option'' to read as follows:

§ 155.20 Definitions.

* * * * *

Standardized option means a QHP offered for sale through an individual market Exchange that either—

(1) Has a standardized cost-sharing structure specified by HHS in rulemaking; or

(2) Is a high deductible health plan with a standardized cost-sharing structure specified by HHS in rulemaking or in HHS guidance issued solely to modify the cost-sharing structure specified by HHS in rulemaking to the extent necessary to align with high deductible health plan requirements under section 223 of the Internal Revenue Code of 1986, as amended, and HHS actuarial value requirements.

* * * * *

■ 20. Section 155.200 is amended by adding paragraph (f)(4) to read as follows:

§ 155.200 Functions of an Exchange.

* * * * *

(f) * * *

(4) A State Exchange on the Federal platform that utilizes the Federal platform for certain SHOP functions, as set forth in paragraphs (f)(4)(i) through (vii), must—

(i) If utilizing the Federal platform for SHOP eligibility, enrollment, or premium aggregation functions, establish standard processes for premium calculation, premium payment, and premium collection that are consistent with the requirements applicable in a Federally-facilitated SHOP under § 155.705(b)(4);

(ii) If utilizing the Federal platform for SHOP enrollment or premium aggregation functions, require its QHP issuers to make any changes to rates in accordance with the timeline applicable in a Federally-facilitated SHOP under § 155.705(b)(6)(i)(A);

(iii) If utilizing the Federal platform for SHOP enrollment functions, establish minimum participation rate requirements and calculation methodologies that are consistent with those applicable in a Federally-facilitated SHOP under § 155.705(b)(10);

(iv) If utilizing the Federal platform for SHOP enrollment or premium aggregation functions, establish employer contribution methodologies that are consistent with the

methodologies applicable in a Federally-facilitated SHOP under § 155.705(b)(11)(ii);

(v) If utilizing the Federal platform for SHOP enrollment functions, establish annual employee open enrollment period requirements that are consistent with § 155.725(e)(2);

(vi) If utilizing the Federal platform for SHOP enrollment functions, establish effective dates of coverage for an initial group enrollment or a group renewal that are consistent with the effective dates of coverage applicable in a Federally-facilitated SHOP under § 155.725(h)(2); and

(vii) If utilizing the Federal platform for SHOP eligibility, enrollment, or premium aggregation functions, establish policies for the termination of SHOP coverage or enrollment that are consistent with the requirements applicable in a Federally-facilitated SHOP under § 155.735.

■ 21. Section 155.205 is amended by revising paragraphs (c)(2)(iii)(A) and (B) to read as follows:

§ 155.205 Consumer assistance tools and programs of an Exchange.

* * * * *

(c) * * *

(2) * * *

(iii) * * *

(A) For Exchanges and QHP issuers, beginning no later than the first day of the individual market open enrollment period for the 2017 benefit year, this standard also includes taglines on Web site content and any document that is critical for obtaining health insurance coverage or access to health care services through a QHP for qualified individuals, applicants, qualified employers, qualified employees, or enrollees. A document is deemed to be critical for obtaining health insurance coverage or access to health care services through a QHP if it is required to be provided by law or regulation to a qualified individual, applicant, qualified employer, qualified employee, or enrollee. Such taglines must indicate the availability of language services in at least the top 15 languages spoken by the limited English proficient population of the relevant State or States, as determined in guidance published by the Secretary. If an Exchange is operated by an entity operating multiple Exchanges, or relies on an eligibility or enrollment platform that is relied on by multiple Exchanges, the Exchange may aggregate the limited English proficient populations across all the States served by the entity that operates the Exchange or its eligibility or enrollment platform to determine the top 15 languages required for taglines. A QHP issuer may aggregate the limited English proficient populations across all States served by the health insurance issuers within the issuer's controlled group (as defined under § 147.106(d)(3)(i) of this subchapter), whether or not those health insurance issuers offer plans through the Exchange in each of those States, to determine the top 15 languages required for taglines. Exchanges and QHP issuers may satisfy tagline requirements with respect to Web site content if they post a Web link prominently on their home page that directs individuals to the full text of the taglines indicating how individuals may obtain language assistance services, and if they also include taglines on any critical standalone document linked to or embedded in the Web site.

(B) For an agent or broker subject to § 155.220(c)(3)(i), beginning on the first day of the individual market open enrollment period for the 2017 benefit year, or when such entity has been registered with the Exchange for at least 1 year, whichever is later, this standard also includes taglines on Web site content and any document that is critical for obtaining health insurance coverage or access to health care services through a QHP for qualified individuals, applicants, qualified employers, qualified employees, or enrollees. A document is deemed to be critical for obtaining health insurance coverage or access to health care services through a QHP if it is required to be provided by law or regulation to a qualified individual, applicant, qualified employer, qualified employee, or enrollee. Such taglines must indicate the availability of language services in at least the top 15 languages spoken by the limited English proficient population of the relevant State or States, as determined in guidance published by the Secretary. An agent or broker subject to § 155.220(c)(3)(i) that is licensed in and serving multiple States may aggregate the limited English populations in the States it serves to determine the top 15 languages required for taglines. An agent or broker subject to § 155.220(c)(3)(i) may satisfy tagline requirements with respect to Web site content if it posts a Web link prominently on its home page that directs individuals to the full text of the taglines indicating how individuals may obtain language assistance services, and if it also includes taglines on any critical standalone document linked to or embedded in the Web site.

* * * * *

■ 22. Section 155.220 is amended by:

■ a. Revising paragraph (c)(3)(i)(E);

■ b. Removing the word ''and'' at the end of paragraph (c)(3)(i)(F);

■ c. Removing the period at the end of paragraph (c)(3)(i)(G) and adding ''; and'' in its place;

■ d. Adding paragraphs (c)(3)(i)(H) through (M);

■ e. Revising paragraphs (c)(4)(i)(E); and

■ f. Revising paragraph (j)(2)(i).

The additions and revisions read as follows:

§ 155.220 Ability of States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.

* * * * *

(c) * * *

(3)(i) * * *

(E) Maintain audit trails and records in an electronic format for a minimum of ten years and cooperate with any audit under this section;

* * * * *

(H) Differentially display all standardized options in accordance with the requirements under § 155.205(b)(1) in a manner consistent with that adopted by HHS for display on the Federally-facilitated Exchange Web site, unless HHS approves a deviation;

(I) Prominently display information provided by HHS pertaining to a consumer's eligibility for advance payments of the premium tax credit or cost-sharing reductions;

(J) Allow the consumer to select an amount for advance payments of the premium tax credit, if applicable, and make related attestations in accordance with § 155.310(d)(2);

(K) Support post-enrollment activities necessary for the consumer to effectuate his or her coverage or resolve issues related to his or her enrollment, including discrepancies related to eligibility;

(L) Demonstrate operational readiness and compliance with applicable requirements prior to the agent or broker's Internet Web site being used to complete the QHP selection; and

(M) HHS may immediately suspend the agent or broker's ability to transact information with the Exchange if HHS discovers circumstances that pose unacceptable risk to Exchange operations or Exchange information technology systems until the incident or breach is remedied or sufficiently mitigated to HHS's satisfaction.

* * * * *

(4)(i) * * *

(E) Report to HHS and applicable State departments of insurance any potential material breach of the standards in paragraphs (c) and (d) of this section, or the agreement entered into under § 155.260(b), by the agent or

broker accessing the Internet Web site, should it become aware of any such potential breach. An agent or broker that provides access to its Web site or ability to transact information with HHS to another agent or broker Web site is responsible for ensuring that the other agent's or broker's Web site is in compliance with this section; and

* * * * *

(j) * * *

(2)(i) Provide consumers with correct information, without omission of material fact, regarding the Federally-facilitated Exchanges, QHPs offered through the Federally-facilitated Exchanges, and insurance affordability programs, and refrain from marketing or conduct that is misleading (including by having a direct enrollment Web site that HHS determines could mislead a consumer into believing they are visiting *HealthCare.gov*), coercive, or discriminates based on race, color, national origin, disability, age, sex, gender identity, or sexual orientation;

* * * * *

■ 23. Section 155.230 is amended by revising paragraph (d)(2) and adding paragraph (d)(3) to read as follows:

§ 155.230 General standards for Exchange notices.

* * * * *

(d) * * *

(2) Unless otherwise required by Federal or State law, the SHOP must provide required notices electronically or, if an employer or employee elects, through standard mail. If notices are provided electronically, the SHOP must comply with the requirements for electronic notices in 42 CFR 435.918(b)(2) through (5) for the employer or employee.

(3) In the event that an individual market Exchange or SHOP is unable to send select required notices electronically due to technical limitations, it may instead send these notices through standard mail, even if an election has been made to receive such notices electronically.

■ 24. Section 155.330 is amended by revising paragraphs (d)(1)(ii), (e)(2)(i) introductory text, and (g)(1) and adding paragraph (e)(2)(iii) to read as follows:

§ 155.330 Eligibility redetermination during a benefit year.

* * * * *

(d) * * *

(1) * * *

(ii) For an enrollee on whose behalf advance payments of the premium tax credit or cost-sharing reductions are being provided, eligibility determinations for or enrollment in Medicare, Medicaid, CHIP, or the Basic Health Program, if a Basic Health Program is operating in the service area of the Exchange.

* * * * *

(e) * * *

(2) * * *

(i) Except as provided in paragraph (e)(2)(iii) of this section, if the Exchange identifies updated information regarding death, in accordance with paragraph (d)(1)(i) of this section, or regarding any factor of eligibility not regarding income, family size, or family composition, or tax filing status, the Exchange must—

* * * * *

(iii) If the Exchange identifies updated information that the tax filer for the enrollee's household or the tax filer's spouse did not comply with the requirements described in § 155.305(f)(4), the Exchange when redetermining and providing notification of eligibility for advance payments of the premium tax credit must:

(A) Follow the procedures specified in paragraph (e)(2)(i) of this section;

(B) Follow the procedures in guidance published by the Secretary; or

(C) Follow alternative procedures approved by the Secretary based on a showing by the Exchange that the alternative procedures would facilitate continued enrollment in coverage with financial assistance for which the enrollee remains eligible, provide appropriate information about the process to the enrollee (including regarding any action by the enrollee necessary to obtain the most accurate redetermination of eligibility), and provide adequate program integrity protections and safeguards for Federal tax information under section 6103 of the Internal Revenue Code with respect to the confidentiality, disclosure, maintenance, or use of such information.

* * * * *

(g) * * *

(1) When an eligibility redetermination in accordance with this section results in a change in the amount of advance payments of the premium tax credit for the benefit year, the Exchange must:

(i) Recalculate the amount of advance payments of the premium tax credit in such a manner as to account for any advance payments already made on behalf of the tax filer for the benefit year for which information is available to the Exchange, such that the recalculated advance payment amount is projected to result in total advance payments for the benefit year that correspond to the tax filer's total projected premium tax credit for the benefit year, calculated in accordance with 26 CFR 1.36B–3 (or, if less than zero, be set at zero); or

(ii) For benefit years through 2023, recalculate advance payments of the premium tax credit using an alternate method that has been approved by the Secretary.

* * * * *

■ 25. Section 155.400 is amended by adding paragraph (e)(2) to read as follows:

§ 155.400 Enrollment of qualified individuals into QHPs.

* * * * *

(e) * * *

(2) *Premium payment deadline extension.* Exchanges may, and the Federally-facilitated Exchange will, allow issuers experiencing billing or enrollment problems due to high volume or technical errors to implement a reasonable extension of the binder payment deadlines in paragraph (e)(1) of this section.

* * * * *

■ 26. Section 155.420 is amended by:

■ a. Revising paragraphs (b)(2)(iii), (d)(1)(i) and (iii), and (d)(8);

■ b. Removing the period at the end of paragraph (d)(10) and adding a semicolon in its place; and

■ c. Adding paragraphs (d)(10), (11), (12), and (13).

The revisions and additions read as follows:

§ 155.420 Special enrollment periods.

* * * * *

(b) * * *

(2) * * *

(iii) In the case of a qualified individual or enrollee eligible for a special enrollment period as described in paragraph (d)(4), (5), (9), (11), (12), or (13) of this section, the Exchange must ensure that coverage is effective on an appropriate date based on the circumstances of the special enrollment period.

* * * * *

(d) * * *

(1) * * *

(i) Loses minimum essential coverage. The date of the loss of coverage is the last day the consumer would have coverage under his or her previous plan or coverage;

* * * * *

(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)). The date of the loss of coverage is the last day the consumer would have pregnancy-related coverage; or

* * * * *

(8) The qualified individual—

(i) Who gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; or

(ii) Who is or becomes a dependent of an Indian, as defined by section 4 of the Indian Health Care Improvement Act and is enrolled or is enrolling in a QHP through an Exchange on the same application as the Indian, may change from one QHP to another one time per month, at the same time as the Indian;

* * * * *

(10) A qualified individual or enrollee—

(i) Is a victim of domestic abuse or spousal abandonment, as defined by 26 CFR 1.36B–2T, as amended, including 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

(ii) Is a dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim;

(11) A qualified individual or dependent—

(i) Applies for coverage on the Exchange during the annual open enrollment period or due to a qualifying life event, is assessed by the Exchange as potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event; or

(ii) Applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended;

(12) The qualified individual or enrollee, or his or her dependent, adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium influenced the qualified individual's or enrollee's decision to purchase a QHP; or

(13) At the option of the Exchange, the qualified individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a qualified health plan through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period specified in § 155.315 or is under 100 percent of the Federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence.

* * * * *

■ 27. Section 155.430 is amended by revising paragraph (b)(2)(iii) to read as follows:

§ 155.430 Termination of Exchange enrollment or coverage.

* * * * *

(b) * * *

(2) * * *

(iii) The enrollee's coverage is rescinded in accordance with § 147.128 of this subchapter, after a QHP issuer demonstrates, to the reasonable satisfaction of the Exchange, if required by the Exchange, that the rescission is appropriate;

* * * * *

■ 28. Section 155.505 is amended by adding paragraph (h) to read as follows:

§ 155.505 General eligibility appeals requirements.

* * * * *

(h) *Electronic requirements.* If the Exchange appeals entity cannot fulfill the electronic requirements of subparts C, D, F, and H of this part related to acceptance of telephone- or Internet-based appeal requests, the provision of appeals notices electronically, or the secure electronic transfer of eligibility and appeal records between appeals entities and Exchanges or Medicaid or CHIP agencies, the Exchange appeals entity may fulfill those requirements that it cannot fulfill electronically using a secure and expedient paper-based process.

■ 29. Section 155.555 is amended by revising paragraph (b) to read as follows:

§ 155.555 Employer appeals process.

* * * * *

(b) *Exchange employer appeals process.* An Exchange may establish an employer appeals process in accordance with the requirements of this section and §§ 155.505(f) through (h) and 155.510(a)(1) and (2) and (c). Where an Exchange has not established an employer appeals process, HHS will provide an employer appeals process that meets the requirements of this section and §§ 155.505(f) through (h) and 155.510(a)(1) and (2) and (c).

* * * * *

■ 30. Section 155.725 is amended by revising paragraphs (g)(1) and (2) and (j)(2)(i) and adding paragraph (g)(3) to read as follows:

§ 155.725 Enrollment periods under SHOP.

* * * * *

(g) * * *

(1) The SHOP must provide an employee who becomes a qualified employee outside of the initial or annual open enrollment period with a 30-day enrollment period beginning on the date the qualified employer notifies the SHOP about the newly qualified employee. Qualified employers must notify the SHOP about a newly qualified employee on or before the thirtieth day after the day that the employee becomes eligible for coverage.

(2) The effective date of coverage for a QHP selection received by the SHOP from a newly qualified employee is the first day of the month following plan selection, unless the employee is subject to a waiting period consistent with § 147.116 of this subchapter and paragraph (g)(3) of this section, in which case the effective date will be on the first day of the month following the end of the waiting period, but in no case may the effective date fail to comply with § 147.116 of this subchapter. If a newly qualified employee's waiting period ends on the first day of a month and the employee has already made a plan selection by that date, coverage must take effect on that date. If a newly qualified employee makes a plan selection on the first day of a month and any applicable waiting period has ended by that date, coverage must be effective on that date. If a qualified employer with variable hour employees makes regularly having a specified number of hours of service per period, or working full-time, a condition of employee eligibility for coverage offered through a SHOP, any measurement period that the qualified employer elects to use under § 147.116(c)(3)(i) to determine whether an employee meets the applicable eligibility conditions with respect to coverage offered through the SHOP must not exceed 10 months, beginning on any date between the employee's start date and the first day of the first calendar month following the employee's start date.

(3) Waiting periods in a SHOP are calculated beginning on the date the employee becomes eligible for coverage, regardless of when a qualified employer notifies the SHOP about the newly qualified employee, and must not exceed 60 days in length. Waiting periods in a Federally-facilitated SHOP or a State-based SHOP that uses the Federal platform for SHOP eligibility or enrollment functions must be 0, 15, 30, 45 or 60 days in length.

* * * * *

(j) * * *

(2) * * *

(i) Experiences an event described in § 155.420(d)(1) (other than paragraph

(d)(1)(ii)), or experiences an event described in § 155.420(d)(2), (4), (5), (7), (8), (9), (10), (11), or (12);

* * * * *

■ 31. Section 155.740 is amended by revising paragraph (b)(2) to read as follows:

§ 155.740 SHOP employer and employee eligibility appeals requirements.

* * * * *

(b) * * *

(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).

* * * * *

■ 32. Section 155.1090 is added to subpart K to read as follows:

§ 155.1090 Request for reconsideration.

(a) *Request for reconsideration of denial of certification specific to a Federally-facilitated Exchange*—(1) *Request for reconsideration.* The Federally-facilitated Exchanges will permit an issuer that has submitted a complete application to a Federally-facilitated Exchange for certification of a health plan as a QHP and is denied certification to request reconsideration of such action.

(2) *Form and manner of request.* An issuer submitting a request for reconsideration under paragraph (a)(1) of this section must submit a written request for reconsideration to HHS, in the form and manner specified by HHS, within 7 calendar days of the date of the written notice of denial of certification. The issuer must include any and all documentation the issuer wishes to provide in support of its request with its request for reconsideration.

(3) *HHS reconsideration decision.* HHS will provide the issuer with a written notice of the reconsideration decision. The decision will constitute HHS's final determination.

(b) [Reserved]

PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

■ 33. 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).

■ 34. Section 156.80 is amended by revising paragraph (d)(1) to read as follows:

§ 156.80 Single risk pool.

* * * * *

(d) * * *

(1) *In general.* A health insurance issuer must establish an index rate that is effective January 1 of each calendar year for a State market described in paragraphs (a) through (c) of this section.

(i) The index rate must be based on the total combined claims costs for providing essential health benefits within the single risk pool of that State market.

(ii) The index rate must be adjusted on a market-wide basis for the State based on the total expected market-wide payments and charges under the risk adjustment program and Exchange user fees (expected to be remitted under § 156.50(b) or (c) and (d) as applicable plus the dollar amount under § 156.50(d)(3)(i) and (ii) expected to be credited against user fees payable for that State market).

(iii) The index rate must be calibrated on a market-wide basis to correspond to an age rating factor of 1.0, a geographic rating factor of 1.0, and a tobacco use rating factor of 1.0, in a manner specified by the Secretary in guidance.

(iv) The premium rate for all of the health insurance issuer's plans in the relevant State market must use the applicable market-wide adjusted index rate, subject only to the plan-level adjustments permitted in paragraph (d)(2) of this section.

* * * * *

■ 35. Section 156.140 is amended by revising paragraph (c) to read as follows:

§ 156.140 Levels of coverage.

* * * * *

(c) *De minimis variation.* The allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan is ±2 percentage points, except if a health plan under paragraph (b)(1) of this section (a bronze health plan) either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high deductible high plan within the meaning of 26 U.S.C. 223(c)(2), in which case the allowable variation in AV for such plan is −2 percentage points and +5 percentage points.

■ 36. Section 156.200 is amended by revising paragraph (c)(1) to read as follows:

§ 156.200 QHP issuer participation standards.

* * * * *

(c) * * *

(1) At least one QHP in the silver coverage level and at least one QHP in the gold coverage level as described in § 156.140 throughout each service area in which it offers coverage through the Exchange; and,

* * * * *

■ 37. Section 156.235 is amended by revising paragraphs (a)(2)(i) and (b)(2)(i) to read as follows:

§ 156.235 Essential community providers.

(a) * * *

(2) * * *

(i) The network includes as participating practitioners at least a minimum percentage, as specified by HHS, of available essential community providers in each plan's service area. Multiple providers at a single location will count as a single essential community provider toward both the available essential community providers in the plan's service area and the issuer's satisfaction of the essential community provider participation standard; and

* * * * *

(b) * * *

(2) * * *

(i) The number of its providers that are located in Health Professional Shortage Areas or five-digit zip codes in which 30 percent or more of the population falls below 200 percent of the Federal Poverty Line satisfies a minimum percentage, specified by HHS, of available essential community providers in the plan's service area. Multiple providers at a single location will count as a single essential community provider toward both the available essential community providers in the plan's service area and the issuer's satisfaction of the essential community provider participation standard; and

* * * * *

■ 38. Section 156.265 is amended by:

■ a. Removing the word ''and'' at the end of paragraph (b)(3)(ii);

■ b. Removing the period at the end of paragraph (b)(3)(iii) and adding ''; and'' in its place; and

■ c. Adding paragraph (b)(3)(iv).

The addition reads as follows:

§ 156.265 Enrollment process for qualified individuals.

* * * * *

(b) * * *

(3) * * *

(iv) Differentially display all standardized options in accordance with the requirements under § 155.205(b)(1) of this subchapter in a manner consistent with that adopted by HHS for display on the Federally-

facilitated Exchange Web site, unless HHS approves a deviation.

* * * * *

■ 39. Section 156.272 is added to read as follows:

§ 156.272 Issuer participation for full plan year.

(a) An issuer offering a QHP through an individual market Exchange must make the QHP available for enrollment through the Exchange for the full plan year for which the plan was certified, including to eligible enrollees during limited open enrollment periods, unless a basis for suppression applies under § 156.815.

(b) Unless a basis for suppression under section 156.815 applies, an issuer offering a QHP through a SHOP must make the QHP available for enrollment through the SHOP for the full plan year for which the QHP was certified.

(c) An issuer offering a QHP through a Federally-facilitated Exchange or a Federally-facilitated SHOP that does not comply with paragraph (a) or (b) of this section may, at the discretion of HHS, be precluded from offering QHPs in a Federally-facilitated Exchange or Federally-facilitated SHOP for up to the two succeeding plan years.

■ 40. Section 156.290 is amended by revising the section heading and paragraphs (a) introductory text and (b) to read as follows:

§ 156.290 Non-certification and decertification of QHPs.

(a) *Non-certification for a subsequent, consecutive certification cycle.* If a QHP issuer elects not to seek certification for a subsequent, consecutive certification cycle with the Exchange, the QHP issuer, at a minimum, must—

* * * * *

(b) *Notice of QHP non-certification for a subsequent, consecutive certification cycle.* (1) If a QHP issuer elects not to seek certification for a subsequent, consecutive certification cycle with the Exchange for its QHP, the QHP issuer must provide written notice to each enrollee.

(2) If a QHP issuer is denied certification for a subsequent, consecutive certification cycle by the Exchange, it must provide written notice to each enrollee within 30 days of the Exchange's denial of certification.

* * * * *

■ 41. Section 156.350 is amended by revising paragraph (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) * * *

(2) Section 156.285(c)(5) and (c)(8)(iii) regarding the enrollment process for SHOP; and

* * * * *

■ 42. Section 156.430 is amended by adding paragraph (h) to read as follows:

§ 156.430 Payment for cost-sharing reductions.

* * * * *

(h) *Reconciliation of the cost-sharing reduction portion of advance payments discrepancies and appeals.* (1) If an issuer reports a discrepancy and seeks to dispute the notification of the amount of reconciliation of the cost-sharing reduction portion of advance payments, it must report the discrepancy to HHS within 30 calendar days of notification of the amount of reconciliation of the cost-sharing reduction portion of advance payments as described in paragraph (e) of this section, in the manner set forth by HHS.

(2) An issuer may appeal the amount of reconciliation of the cost-sharing reduction portion of advance payments, under the process set forth in § 156.1220.

■ 43. Section 156.715 is amended by adding paragraph (f) to read as follows:

§ 156.715 Compliance reviews of QHP issuer in Federally-facilitated Exchanges.

* * * * *

(f) *Failure to comply.* A QHP issuer that fails to comply with a compliance review under this section may be subject to enforcement remedies under subpart I of this part.

■ 44. Section 156.1220 is amended by—

■ a. Removing the word ''or'' at the end of paragraph (a)(1)(v);

■ b. Removing the period at the end of paragraph (a)(1)(vi) and adding ''; or'' in its place;

■ c. Adding paragraph (a)(1)(vii) and (viii); and

■ d. Revising paragraphs (a)(2), (a)(3)(ii), and (a)(4)(ii).

The revisions and additions read as follows:

§ 156.1220 Administrative appeals.

(a) * * *

(1) * * *

(vii) The findings of a second validation audit as a result of risk adjustment data validation with respect to risk adjustment data for the 2016 benefit year and beyond; or

(viii) The calculation of a risk score error rate as a result of risk adjustment data validation with respect to risk adjustment data for the 2016 benefit year and beyond.

(2) *Materiality threshold.* Notwithstanding paragraph (a)(1) of this section, an issuer may file a request for reconsideration under this section only if the amount in dispute under paragraph (a)(1)(i) through (viii) of this section, as applicable, is equal to or exceeds 1 percent of the applicable payment or charge listed in that paragraph (a)(1)(i) through (viii) payable to or due from the issuer for the benefit year, or $10,000, whichever is less.

(3) * * *

(ii) For a risk adjustment payment or charge, including an assessment of risk adjustment user fees, the findings of a second validation audit, or the calculation of a risk score error rate as a result of risk adjustment data validation, within 30 calendar days of the date of the notification under § 153.310(e) of this subchapter;

* * * * *

(4) * * *

(ii) Notwithstanding paragraph (a)(1) of this section, a reconsideration with respect to a processing error by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical error may be requested only if, to the extent the issue could have been previously identified, the issuer notified HHS of the dispute through the applicable process for reporting a discrepancy set forth in §§ 153.630(d)(2), 153.710(d)(2), and 156.430(h)(1) of this subchapter, it was so identified and remains unresolved.

* * * * *

■ 45. Section 156.1230 is amended by adding paragraphs (b)(1), (2), and (3) to read as follows:

§ 156.1230 Direct enrollment with the QHP issuer in a manner considered to be through the Exchange.

* * * * *

(b) * * *

(1) HHS may immediately suspend the QHP issuer's ability to transact information with the Exchange if HHS discovers circumstances that pose unacceptable risk to Exchange operations or Exchange information technology systems until the incident or breach is remedied or sufficiently mitigated to HHS's satisfaction.

(2) The QHP issuer must demonstrate operational readiness and compliance with applicable requirements prior to the QHP issuer's Internet Web site being used to complete a QHP selection.

(3) The QHP issuer must provide consumers with correct information, without omission of material fact, regarding the Federally-facilitated Exchanges, QHPs offered through the Federally-facilitated Exchanges, and insurance affordability programs, and refrain from marketing or conduct that is misleading (including by having a direct enrollment Web site that HHS

determines could mislead a consumer into believing they are visiting *HealthCare.gov*), coercive, or discriminates based on race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

■ 46. Section 156.1256 is revised to read as follows:

§ 156.1256 Other notices.

As directed by a Federally-facilitated Exchange, a health insurance issuer that is offering QHP coverage through a Federally-facilitated Exchange or a State-based Exchange on the Federal platform must notify its enrollees of material plan or benefit display errors and the enrollees' eligibility for a special enrollment period, included in § 155.420(d)(12) of this subchapter, within 30 calendar days after being notified by a Federally-facilitated Exchange that the error has been fixed, if directed to do so by a Federally-facilitated Exchange.

PART 157—EMPLOYER INTERACTIONS WITH EXCHANGES AND SHOP PARTICIPATION

■ 47. 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.

■ 48. Section 157.205 is amended by revising paragraph (f)(1) to read as follows:

§ 157.205 Qualified employer participation in a SHOP.

* * * * *

(f) * * *

(1) Newly eligible dependents and, on or before the thirtieth day after the day that the employee becomes eligible for coverage, newly qualified employees; and

* * * * *

PART 158—ISSUER USE OF PREMIUM REVENUE: REPORTING AND REBATE REQUIREMENTS

■ 49. 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.

■ 50. Section 158.121 is revised to read as follows:

§ 158.121 Newer experience.

If, for any aggregation as defined in § 158.120, 50 percent or more of the total earned premium for an MLR reporting year is attributable to policies newly issued in that MLR reporting year, then the experience of these policies may be excluded from the report required under § 158.110 for that same MLR reporting year. If an issuer chooses to defer reporting of newer business as provided in this section, then the excluded experience must be added to the experience reported in the following MLR reporting year.

■ 51. Section 158.232 is amended by revising paragraphs (d)(1) and (2) and (e)(1) and (2) and adding paragraph (f) to read as follows:

§ 158.232 Calculating the credibility adjustment.

* * * * *

(d) * * *

(1) Each year in the aggregation included experience of at least 1,000 life-years; and

(2) The issuer's preliminary MLR, as defined under paragraph (f) of this section, for each year in the aggregation was below the applicable MLR standard, as established under §§ 158.210 and 158.211.

(e) * * *

(1) Each year in the aggregation included experience of at least 1,000 life-years; and

(2) The issuer's preliminary MLR, as defined under paragraph (f) of this section, for each year in the aggregation was below the applicable MLR standard, as established under §§ 158.210 and 158.211.

(f) *Preliminary MLR.* Preliminary MLR means the ratio of the numerator, as defined in § 158.221(b) and calculated as of March 31st of the year following the year for which the MLR report required in § 158.110 is being submitted, to the denominator, as defined in § 158.221(c), calculated using only a single year of experience, and without applying any credibility adjustment.

■ 52. Section 158.240 is amended by—

■ a. Revising paragraph (c)(1);

■ b. Redesignating paragraphs (d) and (e) as paragraphs (e) and (f), respectively; and

■ c. Adding a new paragraph (d).

The revision and addition read as follows:

§ 158.240 Rebating premium if the applicable medical loss ratio standard is not met.

* * * * *

(c) * * *

(1) For each MLR reporting year, an issuer must rebate to the enrollee, subject to paragraph (d) of this section, the total amount of premium revenue, as defined in § 158.130, received by the issuer from the enrollee, after subtracting Federal and State taxes and licensing and regulatory fees as provided in §§ 158.161(a) and 158.162(a)(1) and (b)(1), and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance as provided in § 158.130(b)(5), multiplied by the difference between the MLR required by § 158.210 or § 158.211, and the issuer's MLR as calculated under § 158.221.

* * * * *

(d) *Limitation on total rebate payable for each year in the aggregation.* For any State and market, an issuer may elect to limit the amount of rebate payable for the MLR reporting year to the issuer's total outstanding rebate liability with respect to all years included in the aggregation. If an issuer elects this option, the outstanding rebate liability with respect to a specific year in the aggregation must be calculated by multiplying the denominator with respect to that year, as defined in § 158.221(c), by the difference between the MLR required by § 158.210 or § 158.211 for the MLR reporting year, and the sum of the issuer's preliminary MLR for that year, as defined under § 158.232(f), and the credibility adjustment applicable to the current MLR reporting year. The outstanding rebate liability with respect to a specific year must be reduced by any rebate payments applied against it in prior MLR reporting years. A rebate paid for an MLR reporting year must be applied first to reduce the outstanding rebate liability with respect to the earliest year in the aggregation.

* * * * *

Dated: August 11, 2016.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: August 24, 2016.

Sylvia M. Burwell,

Secretary, Department of Health and Human Services.

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