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CMS Releases Final Rule for 2026 for Health Insurance Marketplaces, Aimed at Safeguarding Consumers, and Improving Transparency and Health Equity

On January 13, 2025, the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) issued the final Notice of Benefit and Payment Parameters for 2026 (CMS-9888-F) with a fact sheet.

This rule includes the following changes:

- Policies related to CMS's authority to undertake compliance reviews and enforcement actions for brokers/agents, as well as other policies impacting brokers/agents,
- Updates to premium payment thresholds to permit fixed or premium-percent thresholds,
- Provides the option for qualified plans to calculate medical loss ratio (MLR) differently to support such plans that are focused on underserved communities,
- Reviews of Qualified Health Plans (QHPs) in FFMs in states performing plan management functions to ensure sufficient provider networks,
- Extension of consumer notification requirements for failure to file federal income taxes and reconcile advance payment of the premium tax credit (APTC),
- Methodological changes to the premium adjustment factor and calculation of Basic Health Plan (BHP) payments,
- Continued current approach to standardized plan options with minor updates and increased pressure on issuers offering indistinguishable plans,
- Use of information and data to increase transparency into Exchange operations and promote performance improvements,
- Changes to risk adjustment policies, including a new pre-exposure prophylaxis (PrEP) factor in Health and Human Services (HHS) risk adjustment models, intended to reduce adverse selection,
- Increase in FFM user fee rates and State-based Marketplace on the Federal platform (SBM-FP) for 2026 to reflect premium tax credits (PTC) subsidy expirations,
- End of publication of the draft Actuarial Value (AV) Calculator,

- Codification of timelines for State Marketplaces on requirements to review and resolve enrollment data inaccuracies received from issuers, and
- Changes to clarify Marketplace authority to deny certification to any plan that does not meet applicable criteria and refine the standards for requests for reconsideration of denials.

CMS also solicited and received public input on ways to reduce the risk of issuer insolvencies adversely impacting the integrity of Federally Facilitated Marketplace (FFMs) and address silver loading by plan issuers as well as input on how assisters in hospitals may refer consumers to programs designed to reduce medical debt.

The rule is effective on January 15, 2025 when it will be published in the Federal Register.

Note that **no policies were proposed or finalized in this rule to address the current copay accumulator policy** which is from the 2020 NBPP rule. This policy permits plans to exclude manufacturer assistance from counting toward patients' out-of-pocket limit for only specific prescription brand drugs that have an available and medically appropriate generic equivalent. **However, in the prior October 2024 proposed NBPP rule, CMS announced an intention of future rulemaking on this topic. A future proposed rule will be issued by HHS and the Departments of Labor and Treasury to address the applicability of drug manufacturer support to the annual limitation on cost-sharing. A timeline for rulemaking has not been announced.** See pages 9-10 in this summary for additional discussion.

CMS FINALIZES ITS PROPOSAL TO STRENGTHEN COMPLIANCE REVIEW AND ENFORCEMENT ACTIONS FOR QHP LEAD AGENT MISCONDUCT

CMS finalizes its proposal to extend its current compliance review and enforcement mechanisms for agents, brokers, and web-brokers to include lead agents within agencies assisting consumers enrolling in QHPs through the Federally Facilitated Exchanges (FFEs) and State-Based Exchanges on the Federal Platform (SBE-FPs). This would allow CMS to investigate and undertake compliance reviews and enforcement actions , holding lead agents accountable for noncompliance or misconduct within their agencies.

To decide whether to pursue a compliance review or enforcement action against a lead agent, CMS would first evaluate if the agency endorses or is involved in noncompliant behavior. This evaluation would involve analyzing compliance metrics, complaints, and patterns of behavior across agents within the agency, as well as system monitoring data to identify potential bad actors. If agency-level involvement is found, CMS would then assess if the agency facilitated the submission of consumer eligibility applications to FFEs or SBE-FPs. This would include reviewing business practices, such as the training resources provided to agents, brokers, or web-brokers, which may indicate the agency's role in supporting noncompliant actions.

CMS EXPANDS AUTHORITY TO SUSPEND MARKETPLACE AGENTS AND BROKERS

To promote information technology system security in FFE and SBE-FPs, CMS has the authority to immediately suspend an agent's or broker's ability to transact information with the Exchange if it identifies circumstances that present an unacceptable risk to Exchange operations or IT systems, until the issue or breach is resolved. In this rule, CMS finalizes its proposal to expand this authority to suspend an agent's or broker's ability to interact with the Exchange if there are concerns about risks to the accuracy of eligibility determinations, operations, or information technology systems.

To monitor compliance, data that may indicate potential misconduct would be reviewed, including transaction volumes, discrepancies in eligibility applications, and enrollee complaints. If misconduct is suspected, a preliminary investigation may be initiated, which could involve providing technical assistance or suspending systems. Agents or brokers may contest these suspensions by presenting evidence showing they have resolved the issues leading to the suspension. If the evidence fails to alleviate the agency's concerns, additional measures may be taken to suspend or terminate their Exchange agreements, barring them from enrollment activities until compliance is verified.

This action seeks to enhance transparency and program integrity by mitigating fraud, protecting personally identifiable information (PII), and ensuring compliance with standards in response to increasing complaints about unauthorized enrollments and inaccurate submissions by agents and brokers that threaten consumer data and efficient Exchange management.

REVISIONS TO MODEL CONSENT FORM AIM TO STRENGTHEN CONSUMER PROTECTION AND IMPROVE ENROLLMENT

In this final rule, CMS makes modifications to the Model Consent Form, which was established in the 2024 Payment Notice[1] to help agents, brokers, and web-brokers document consent from consumers to assist with their Marketplace enrollments and submission of Marketplace eligibility applications. There is currently no specific form to document consumer review and confirmation of the accuracy of eligibility information as required by statute[2]. To address this, CMS finalized modifications to the Model Consent Form to include a section for documenting the consumer's review and confirmation of their Exchange eligibility application information as required by statute.

CMS's updates also provide standardized scripts for agents, brokers, and web-brokers to use during audio recordings to demonstrate compliance with the consent and eligibility application review documentation requirements. While the use of the updated form and scripts would not

[1] 88 FR 25809 through 25811
[2] § 155.220(j)(2)(ii)(A)(1)

be mandatory, CMS's intent is to offer clearer guidance for compliance, ultimately reducing the likelihood of unauthorized enrollments and the associated financial risks to consumers.

CMS RECEIVED PUBLIC INPUT ON HOW TO LOWER RISK OF ISSUER INSOLVENCY AND ADDRESS SILVER LOADING

In response to concerns about issuer insolvencies destabilizing State markets, CMS solicited comments on how HHS could partner with State regulators to lower the risks posed by issuer insolvencies. CMS is considering increasing coordination between State Departments of Insurance (DOIs) and the National Association of Insurance Commissioners (NAIC) to better identify issuers that display a high risk of insolvency and issuers that are experiencing enrollment growth that risks exceeding their capitalization rates.

CMS also sought and received public input on addressing allowable "silver loading" by issuers. "Silver loading" refers to the practice generally encouraged by state DOI's where many issuers increase premiums for silver-level QHPs to cover the cost of implementing cost-sharing reduction (CSR) programs for silver plans required by Section 1402 of the ACA. CMS's regulations around this policy are vague, and the Agency receives numerous questions around its permissibility.

Considering comments received, CMS finalizes amendments to § 156.80(d)(2)(i) to specify that the actuarially justified plan-specific factors by which an issuer may vary premium rates for a particular plan from its market-wide index rate include the actuarial value and cost-sharing design of the plan, including, if permitted by the applicable State authority, accounting for CSR amounts provided to eligible enrollees under § 156.410, provided the issuer does not otherwise receive reimbursement for such amounts.

AGENCY TO UPDATE PREMIUM PAYMENT THRESHOLDS TO PERMIT A FIXED-DOLLAR THRESHOLD WITH A PERCENTAGE-BASED THRESHOLD

CMS finalizes changes to allow issuers to implement a fixed-dollar premium payment threshold in tandem with one of the two percentage-based premium payment thresholds. The fixed-dollar threshold would be capped at $10, adjusted annually for inflation, meaning that if a consumer has paid their initial premium but later owes $10 or less after applying their APTC, they would not be placed in a grace period, which typically leads to potential loss of coverage due to non-payment.

CMS finalizes changes to allow issuers to choose between one of two percentage-based thresholds: the net premium threshold, which would require consumers to pay at least 95 percent of their net premium to avoid triggering a grace period, and the gross premium threshold, which would require at least 98 percent of the total premium paid. This action aims

to better accommodate the financial circumstances of consumers while ensuring issuers can effectively manage their premium collection processes.

MLR CALCULATION MAY BE ADJUSTED TO SUPPORT QUALIFYING PLANS THAT ENROLL UNDERSERVED CONSUMERS WITH HIGH HEALTH NEEDS

Effective beginning with the 2026 MLR reporting year, to support plans with unique business models that focus on underserved communities, CMS finalizes changes to allow qualifying issuers to not adjust incurred claims by the net payments or receipts related to the risk adjustment program for Medical Loss Ratio (MLR) rebate calculation and reporting purposes.

CMS finalizes a narrower policy than it initially proposed which applies these MLR changes to only "qualifying issuers" rather than to all issuers. Whether the issuer is a qualifying issuer is based on an issuer's 3-year aggregate ratio of net payments related to the risk adjustment program under section 1343 of the ACA to earned premiums as defined in § 158.130, but prior to and excluding the adjustments in § 158.130(b)(5) that account for the net payments or receipts related to the risk adjustment, risk corridors, and reinsurance programs, in a relevant State and market. CMS narrowed the scope of the policy in response to concerns raised by commenters regarding the need to reduce the possibility of an adverse impact on issuers that owe risk adjustment charges and that may have lower administrative costs and premiums. As CMS estimates that only a very small number of issuers will meet the definition of a "qualifying issuer" and also owe rebates, the agency believes that finalizing the narrower proposal will have minimal possibility of disrupting the market and exacerbating pricing uncertainty. CMS indicates that it plans to monitor and analyze the impact of this provision after it is implemented for the 2026 and later MLR reporting years to evaluate whether it operates as intended and continues to be appropriate.

In terms of the MLR calculation, CMS also finalizes that at the option of these qualifying issuers, earned premium would account for net risk adjustment receipts by simply adding these net receipts to total premium, without subsequently subtracting them from adjusted earned premium, such that these net receipts would impact the MLR denominator rather than MLR numerator. This is optional rather than making this change mandatory for qualifying issuers.

CMS also amends § 158.240(c) to include an illustrative example to demonstrate how qualifying issuers would calculate the rebate amount owed to enrollees. This is to accurately reflect how these issuers would incorporate the net risk adjustment transfer amounts into the MLR and rebate calculations in a different manner from other issuers.

SYSTEM ENHANCEMENTS TO ALLOW CMS TO DIRECTLY PERFORM ECP CERTIFICATION REVIEWS

In past years, HHS has relied on states to conduct Essential Community Provider (ECP) certification reviews for the certification of QHPs in FFEs in States that perform plan management functions due to technical issues with CMS's ability to collect ECP data. However, recent HHS system design enhancements have allowed the Department to collect ECP data directly from issuers. Accordingly, beginning with PY 2026, CMS finalizes its proposal to conduct ECP certification reviews of QHPs in FFEs in States performing plan management functions. CMS believes this change would add more consistency to oversight of ECP data.

CMS TO CHANGE NOTIFICATION REQUIREMENTS FOR ENROLLEES FACING APTC INELIGIBILITY DUE TO FTR STATUS

Currently, an Exchange can only declare an enrollee ineligible for Advance Premium Tax Credits (APTC) due to their Failure to File and Reconcile (FTR) status if the tax filer, or their spouse, has failed to file a federal income tax return and reconcile their APTC for two consecutive years. Exchanges must send direct or indirect notices for the first year in which the tax filer was determined to have failed to file and reconcile. CMS now will require Exchanges to send a direct or indirect notice to enrollees or their tax filers who have not filed their federal income tax return and reconciled their APTC for two consecutive tax years. A direct notice would inform the tax filer that the Exchange has determined that they failed to file and reconcile their APTC for two consecutive tax years, while an indirect notice would inform the consumer that they may be at risk of losing their APTC and educate them about the requirement to file their federal income taxes and reconcile their APTC. This change would ensure that all tax filers or their enrollees with two consecutive years of FTR status receive educational notices at least twice before losing APTC eligibility.

CMS FINALIZES UPDATES TO PREMIUM ADJUSTMENT FACTOR CALCULATION FOR BASIC HEALTH PROGRAM PAYMENTS

CMS finalizes changes to the methodology for calculating the premium adjustment factor (PAF) under the Basic Health Program (BHP).[3] The BHP provides health coverage to individuals who might otherwise qualify for coverage through QHPs on Exchanges, with federal payments being determined by calculating what premium tax credits (PTCs) and cost-sharing reductions (CSRs) would have been provided if these individuals had enrolled in QHPs.

The payment methodology involves determining the value of PTCs and CSRs that would have been paid on behalf of BHP enrollees had they been enrolled in QHPs. The methodology uses several rate cells based on age, geographic area, household size, and income range to calculate the total federal payment for BHP enrollees. Since federal payments for CSRs were

[3] 42 CFR Part 600

discontinued, QHP issuers have increased premiums for silver-level plans to account for the additional costs, particularly in non-BHP states. This variation is factored into the PAF, which adjusts BHP payments accordingly.

CMS finalizes changes to the calculation of the PAF, starting in 2026. The current PAF, set at 1.188, has been used for all program years from 2018 to 2024, and it reflects the 20% premium increase in silver-level plans in non-BHP states after CSR payments were halted. The goal with these changes is to ensure BHP payments are accurate without overcompensating for CSR-related premium adjustments, while minimizing the administrative burden on states and issuers.

CMS finalizes the following changes:

1. **Full Implementation**: If a state fully implements the BHP and uses second-lowest cost silver plan (SLCSP) premiums from a year where the BHP was fully implemented, the PAF remains 1.188.

2. **Partial Implementation**: If a state is using SLCSP premiums from a year in which BHP was not fully implemented, the PAF is calculated by determining the CSR adjustment that QHP issuers included in the SLCSP premiums, reporting the CSR adjustments for the SLCSP for each region in the state to CMS, and then CMS calculating the PAF as 1.20 divided by 1 plus the adjustment.

3. **Exceptions for New BHP States**: For states in their first year of implementing BHP, where they choose to use prior year premiums, the PAF is set at 1.00, assuming CSR adjustments are already accounted for in those premiums.

CMS FINALIZES TECHNICAL CLARIFICATION FOR CALCULATING BHP PAYMENT RATES IN COUNTIES WITH MULTIPLE SILVER PLAN OPTIONS

In this rule, CMS provides a technical clarification regarding the methodology for calculating BHP payment rates when multiple SLCSPs exist within a county. Normally, BHP payment rates are based on the SLCSP premium in each rating area, which serves as the reference premium for determining federal payments. However, issues arise when more than one SLCSP is available within a single county, typically when QHPs operate in only parts of the county, not the entire region.

For cases where more than one SLCSP exists in a county, CMS clarifies that starting in 2026, the BHP payment rate will be based on the premium of the SLCSP that applies to the largest portion of the county, as measured by the total population. CMS posits that this approach ensures consistency in determining reference premiums and avoids discrepancies in BHP payments due to variations in plan availability across smaller sections of a county.

CURRENT APPROACH TO STANDARDIZED PLAN OPTIONS TO BE CONTINUED WITH MINOR UPDATES AND INCREASED PRESSURE ON ISSUERS OFFERING INDISTINGUISHABLE PLANS

For Plan Year (PY) 2026, CMS will generally follow the approach finalized in the 2023,2024, and 2025 Payment Notices concerning standardized plan options. The minor updates included in this Payment Notice include adding a requirement that issuers that offer multiple standardized plan options within the same metal level, product network type, and service area meaningfully differentiate these plans. This differentiation could come from the plan's benefits, provider networks, included prescription drugs, or a combination of some or all these factor. This change comes in response to some issuers offering indistinguishable standardized plan options, and CMS believes it will help consumers make more informed comparisons between plans. CMS would continue to monitor this policy and may consider more strict policies in future rulemaking.

In addition, CMS makes small changes to plan designs for PY 2026 to ensure that plan AVs remain within the permissible de minimis range for each metal level and to maintain a high degree of continuity with the approaches to standardized plan options finalized in the 2023, 2024, and 2025 Payment Notices. Updates to plan designs for PY 2026 are detailed in Tables 1 and 1 of the rule. Regarding non-standardized plan option limits, CMS clarifies the flexibility that issuers have to vary dental and vision benefit coverage.

CMS DROPS PLANS FOR PUBLIC RELEASE OF REPORTED DATA ON STATE EXCHANGES

State Exchanges and SBE-FPs are required to report various activities and performance data to HHS and engage an independent auditing entity to conduct annual financial and programmatic audits. To meet these requirements, State Exchanges and SBE-FPs submit a State-based Marketplace Annual Reporting Tool (SMART) to CMS, which CMS uses to monitor and evaluate State Exchange compliance with Exchange requirements under Title I of the ACA. Additionally, State Exchanges report enrollment and activity data weekly during Open Enrollment and biannually otherwise to help identify program risks and inform policy development.

CMS had initially proposed publicly releasing the annual SMARTs and financial audits from State Exchanges and SBE-FPs to enhance transparency regarding operation of State Exchanges and promote program improvements. However, in response to concerns raised by State Exchanges that such a release would expose Exchange system operations to misuse or could constrain the efficacy of the SMARTs, the agency will not release the SMARTs.

However, CMS notes it anticipates publicly releasing data on State Exchange spending on outreach (including Navigators), Open Enrollment call center metrics (call center volume, average wait time, average call abandonment rate), and website visits and visitors. Also, the agency indicates it will work with States to evaluate the metric definitions and methodologies

and provide technical assistance prior to publishing this data. CMS plans to also publish reasonably comparable customer metrics from Exchanges on the Federal platform if data is available.

NEW QUALITY IMPROVEMENT STRATEGY (QIS) INFORMATION TO BE SHARED TO INCREASE TRANSPARENCY

To promote transparency and drive innovation and quality improvement across Exchanges CMS finalizes plans to share aggregated, summary-level QIS information annually beginning on January 1, 2026. This data would include the following:

1. Value-based payment models used in QHPs offered by the issuer;
2. QIS topic area;
3. QIS market-based incentive types;
4. Clinical areas addressed by QIS;
5. QIS activities; and
6. QRS measures used in QIS.

To mitigate concerns about the sharing of proprietary information, CMS would only share data that was de-identified and aggregated.

COPAY ACCUMULATOR POLICY TO BE ADDRESSED IN FUTURE RULEMAKING

In this final rule, CMS did not address the copay accumulator policy.

However, in the prior October 2024 proposed rule, while CMS did not propose any changes to its existing policies regarding the exclusion of direct drug manufacturer support to enrollees for prescription drugs from the enrollee's annual cost-sharing limits, the agency did announce an intention of future rulemaking on this issue. A future proposed rule will be issued by the Department of Health and Human Services (HHS) and the Departments of Labor and Treasury to address the applicability of drug manufacturer support to the annual limitation on cost-sharing, an issue from the court ruling on *HIV and Hepatitis Policy Institute et al. v. U.S. Department of Health and Human Services et al.*, Civil Action No. 22- 2604 (D.D.C. Sept. 29, 2023).

The policy finalized in the 2021 Notice of Benefit and Payment Parameters final rule had made it easier for plans to adopt "copay accumulator" programs[4] and "copay maximizer" programs[5]

[4] Programs under which plans exclude the value of manufacturer copay assistance from counting toward an enrollee's deductible or annual cost-sharing limit.
[5] Programs under which plans align an enrollee's copay obligation with available copay assistance from manufacturers and then apply manufacturer assistance to the enrollee's copay obligation but not toward the enrollee's deductible or annual cost-sharing limit.

despite concerns raised by patient groups that such programs increase enrollee out-of-pocket costs and make it harder for enrollees to meet required deductibles. However, due to an October 2023 court ruling[6], the 2021 rule was set aside and a prior 2020 policy that permits copay accumulators only for branded drugs with generic equivalents is currently in effect. HHS has previously stated that until the agency engages in future rulemaking, it has no intention of taking any enforcement action against issuers or plans based on their treatment of such manufacturer assistance.

CMS FINALIZES CHANGES IMPACTING RISK ADJUSTMENT FOR HEPATITIS C AND HIV PREP DRUGS, AMONG OTHER RISK ADJUSTMENT PROPOSALS

The HHS risk adjustment model is used to predict plan liability for an average enrollee based on an individual's age, sex, and diagnoses (referred to as hierarchical condition categories (HCCs)). These factors are then used to produce a risk score. For 2026, CMS will recalibrate the 2026 benefit year HHS risk adjustment models using 2020, 2021, and 2022 benefit year enrollee-level External Data Gathering Environment (EDGE) data. The final risk adjustment user fee is $0.20 per member per month.

CMS also makes various changes impacting the HHS Risk Adjustment Data Validation (HHS-RADV), a program used to verify the accuracy of data submitted by health insurance issuers for risk adjustment calculations. Changes impact the Initial Validation Audit (IVA) and Secondary Validation Audit (SVA), both of which are steps in the HHS-RADV process.

The HHS-operated risk adjustment program is subject to sequestration, per the Office of Management and Budget (OMB) Report to Congress on the Joint Committee Reductions for Fiscal Year (FY) 2025. This program will sequester payments made from FY 2025 resources at a rate of 5.7 percent.

In addition to these policies, starting with the 2026 benefit year, CMS will begin phasing out the market pricing adjustment to the plan liability associated with Hepatitis C drugs in the HHS risk adjustment models. Also, for human immunodeficiency virus (HIV) pre-exposure prophylaxis (PrEP), CMS will incorporate PrEP as a separate, new type of factor called an Affiliated Cost Factor (ACF) in the HHS risk adjustment adult and child models starting with the 2026 benefit year.

CMS also sought and received feedback on whether it should incorporate the time value of money into its risk adjustment program.

[6] https://litigationtracker.law.georgetown.edu/wp-content/uploads/2023/04/HIV-AND-HEPATITIS-POLICY-INSTITUTE_2023.09.29_ORDER.pdf

CMS To Model Costs Associated With Hepatitis C Drugs More Consistently With Other Specialty Drugs

Beginning with the 2026 plan year, CMS will phase out the market pricing adjustment for Hepatitis C drugs and trend them consistent with other specialty drugs for the purposes of the annual recalibration of risk adjustment models. Since the 2020 benefit year HHS risk adjustment models, CMS has included a market pricing adjustment to the plan liability associated with Hepatitis C drugs to reflect future market pricing. The adjustment is intended to account for significant pricing changes between the data years used for recalibrating the models and the applicable benefit year of risk adjustment because of the introduction of new and generic Hepatitis C drugs. In its assessment of whether the pricing adjustment was still needed, CMS found that projected costs for Hepatitis C drugs have increased alongside the cost of other specialty drugs, following years of decline and stagnation that resulted from the introduction of new and generic Hepatitis C drugs. Due to this change, CMS believes it is appropriate to phase of the market pricing adjustment for Hepatitis C drugs and begin trending the cost of these dugs consistent with other similar drugs in the HHS risk adjustment model.

The purpose of this change is to align with the current trending approach, as CMS expects the current growth in Hepatitis C drug costs will continue to be similar to growth in specialty drug costs in the future. CMS is finalizing a phased approach, in which it will apply the specialty drug trend to one year of trending Hepatitis C treatment costs (the trend for 2025 to 2026) for all three years of enrollee-level EDGE data used in recalibration. This data would otherwise be trended forward using the lower trend rate reflecting the market pricing adjustment for Hepatitis C treatments through the 2025 benefit year. As such, 2026 benefit year recalibration would reflect one year of growth in the cost of treatment at the same rate as other specialty drugs. Annually, CMS would increase the number of years for which it would use the specialty drug trend and decrease the number of years that would use the unique marketing pricing adjustment, until all enrollee-level EDGE data years used for the recalibration of the HHS risk adjustment models are from benefit year 2025 or later.

Note that in response to comments requesting review of the costs and consideration of market pricing adjustments associated for other drugs such as GLP-1 drugs, gene therapies, or other unique, high-cost drugs, CMS indicated it did not propose to change the treatment of high-cost drugs, such as GLP-1 drugs, sickle cell disease treatments, or other gene and cellular therapies, in the 2026 benefit year HHS risk adjustment models and are therefore not finalizing such updates in this final rule. CMS notes concerns with data availability for sickle cell disease treatments and gene and cellular therapies, and indicated that, upon examination, at the moment, it did not believe GLP-1 drugs warranted changes, but would continue to assess this category.

CMS Finalizes New Method for Incorporating HIV PrEP Into HHS Risk Adjustment Models

CMS currently models the costs of PrEP in its risk adjustment models alongside other preventive services. However, CMS has performed analysis indicating that PrEP's high costs relative to other preventive services can pose a risk of adverse selection, given the extent to which utilization of PrEP varies between plans. CMS has also received feedback from interested parties that PrEP should be incorporated into risk adjustment models differently due to its high cost.

As such, CMS finalizes its proposal to incorporate HIV PrEP as a new, separate factor called an Affiliated Cost Factor (AFC) in risk adjustment models. CMS is excluding generic versions of PrEP from the ACF at this time and are placing the PrEP ACF in the adult models in a hierarchy below prescription drug category 1 (RXC 1 (Anti-HIV Agents)) without defining any hierarchical relationship between the PrEP ACF and HCC 1 (HIV/AIDS). In the child models, which do not contain RXCs, CMS is finalizing the placement of the PrEP ACF in a hierarchy with HCC 1.

This reflects a potential change in the factors used in HHS risk adjustment models to include a factor that is not indicative of an active condition. The change is intended to reduce issuer incentives to restrict coverage and access to care by addressing the potentially high costs associated with PrEP services.

CMS Received Feedback on Whether the Time Value of Money Should Be Incorporated into its Risk Adjustment Program

For the 2023 benefit year, HHS received feedback that issuers of risk adjustment covered plans were impacted more by the time value of money, for the collection and remittance of state transfers occurring eight to 10 months after the end of the benefit year, than in any previous benefit years. Noting that interest rates were highest in 2023 compared to any other year since the passage of the Affordable Care Act (ACA), and the time value of money has changed and is higher than it has been previously, CMS sought and received feedback on the impact the time value of money has on issuers' assessment of actuarial risk and incentives for adverse selection. The agency also sought and received feedback on potential solutions that should be considered for future rulemaking.

HIGHER USER FEE RATES FOR 2026 TO REFLECT PTC SUBSIDY EXPIRATIONS

CMS finalizes FFM and SBM-FP user fee rates that are significantly higher than the 2025 benefit year rates, at 2.5 percent and 2.0 percent of total monthly premiums respectively. This proposed increase is due to the fact that the enhanced PTC subsidies that were extended under IRA, Public Law 117-169 (2022) are scheduled to expire after 2025. As such, if Congress were to extend enhanced PTC subsidies through the 2026 benefit year by July 31, 2025, CMS's finalized alternative user fee rates would be 2.2% of monthly premiums for the FFM user fee rate and 1.8%of total monthly premiums for the SBM-FP user fee rate. These lower user fee

rates account for projected higher consumer enrollment in the Marketplaces due to the continued availability of enhanced PTC subsidies.

CMS finalizes a risk adjustment user fee of $.20 per member per month which is higher than the 2025 benefit year fee of $0.18. These fees cover a broad range of costs related to risk adjustment operations, including model development, data validation, and program integrity.

The 2026 benefit year premium adjustment percentage and related payment parameters would use the same methodology as those in the 2025 benefit year and was published in guidance[7] by October 8, 2024.

CMS TO END PUBLICATION OF DRAFT AV CALCULATOR

Each year CMS releases an AV Calculator for the purposes of determining levels of coverage (bronze, silver, gold, or platinum). In past years, CMS has released a draft version of the calculator that is subject to public comment before releasing the final version. However, the Agency has received comments requesting the final version of the calculator to be released earlier. To allow for an earlier release of the final AV calculator, CMS finalizes its proposal to only release a single, final version of the AV Calculator for a respective plan year beginning with the 2026 benefit year. CMS would still seek feedback on a continuous rolling basis on the following plan year's AV Calculator, rather than the same plan year's AV Calculator, until the following plan year's AV Calculator is released.

TIMELINES FOR STATE EXCHANGES TO REVIEW AND RESOLVE ENROLLMENT DATA INACCURACIES TO BE CODIFIED

CMS codifies HHS guidance[8] requiring State Exchanges to address enrollment data inaccuracies submitted by State Exchange issuers within 60 calendar days after receipt of a complete inaccuracy submission from a State Marketplace issuer. When a State Exchange issuer identifies an inaccuracy that meets specific criteria, the Exchange must review and resolve the issue, then report the resolution to HHS in a specified format. This change is consistent with current requirements for monthly reconciliation of enrollment data and establishes a clear timeline for State Exchanges to address inaccuracies, which may ensure accurate APTC payments.

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[7] Available at https://www.cms.gov/files/document/2026-papi-parameters-guidance-2024-10-08.pdf

[8] CMS. (2024, August 14). Reporting and Reviewing Data Inaccuracy Reports in State-based Exchanges (SBE) Frequently Asked Questions (FAQs). https://www.cms.gov/cciio/programs-and-initiatives/health-insurancemarketplaces/downloads/faqs-SBE-reporting-enrollment-data-inaccuracies.pdf.

CMS CLARIFIES THAT AN EXCHANGE MAY DENY CERTIFICATION OF ANY QHP THAT DOES NOT MEET CERTAIN CRITERIA

Exchanges have the responsibility to certify QHPs that meet certain criteria and are only required to offer health plans which have in effect a certification issued or are recognized as health plans deemed certified for participation in an Exchange as a QHP. However, an Exchange's authority to deny certification of a QHP is not explicitly outlined. To clarify this, CMS revises regulations to state explicitly that an Exchange may deny certification to any QHP that does not meet the general certification criteria outlined in statute[9].

Additionally, CMS establishes clearer standards for an issuer to request the reconsideration of denial of certification as a QHP specific to the FFEs. This change would place the burden of proof on issuers to demonstrate that the denial of certification was erroneous and require them to provide clear and convincing evidence supporting their claims. The change emphasizes that issuers must demonstrate HHS misunderstood or misinterpreted previously submitted information rather than introducing new evidence not previously presented during the certification process.

AGENCY RECEIVED PUBLIC INPUT ON HOW HOSPITAL ASSISTERS CAN CONNECT CONSUMERS TO FINANCIAL AID PROGRAMS FOR MEDICAL DEBT RELIEF

The agency received public feedback on how assisters, particularly those in hospitals and hospital systems, can refer consumers to programs designed to reduce medical debt while complying with existing regulations. Under the ACA, Exchanges must establish Navigator programs to support consumers during the application and enrollment process. Given the $88 billion in medical debt affecting one in five Americans, hospital-based assisters could play a key role in connecting consumers to financial assistance programs, especially for underserved populations. CMS sought and received comments on how these assisters can effectively connect consumers to financial aid programs within hospital systems and their communities.

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This Applied Policy® Summary was prepared by Stephanie Lomas with support from the Applied Policy team of health policy experts. If you have any questions or need more information, please contact her at slomas@appliedpolicy.com or at (202) 558-5272.

[9] § 155.1000(c)