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FACT SHEET

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HHS Notice of Benefit and Payment Parameters for 2023 Final Rule Fact Sheet

In the Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2023 Final Rule released today, the Centers for Medicare & Medicaid Services (CMS) is finalizing standards for issuers and Marketplaces, as well as requirements for agents, brokers, web-brokers, and issuers assisting consumers with enrollment through Marketplaces that use the federal platform.

Overall, the final rule seeks to strengthen the coverage offered by qualified health plans (QHPs) on the federal Marketplace. These policies will also ensure consumers can more easily find the right form of quality, affordable coverage for their circumstances.

Enhancing Consumer Options and Choice

Standardized Plan Options
CMS finalizes changes to require issuers in the Federally-facilitated Marketplace (FFMs) and State-based Marketplaces on the Federal Platform (SBM-FPs) to offer standardized plan options at every product network type, at every metal level, and throughout every service area that they offer non-standardized options in PY 2023 and beyond. Under these requirements, if an issuer offers a non-standardized gold health maintenance organization (HMO) QHP in a particular service area, for example, that issuer must also offer a standardized gold HMO QHP throughout that same service area. CMS finalizes two sets of standardized plan options at each of the bronze, expanded bronze, silver, silver cost-sharing reduction (CSR) variations, gold, and platinum metal levels of coverage, with each set tailored to the unique cost-sharing laws in different sets of states. Issuers of QHPs in FFMs and SBM-FPs that are already required to offer standardized plan options under state rules, such as issuers in the State of Oregon, are exempt from these requirements.

CMS will differentially display these standardized options on HealthCare.gov and will resume enforcement of the existing standardized plan option differential display requirements for web-brokers and QHP issuers utilizing a Classic Direct Enrollment (DE) or Enhanced Direct Enrollment (EDE) pathway. These entities will be able to request to deviate from how standardized options are differentially displayed on HealthCare.gov, so

long as the alternate differentiation format provides a similar level of differentiation and clarity as provided on HealthCare.gov.

Network Adequacy
CMS finalizes changes such that CMS will conduct network adequacy reviews in all states with a FFM except for states performing plan management functions that adhere to a standard as stringent as the federal standard and elect to perform their own reviews. Beginning for plan year (PY) 2023, CMS will evaluate QHPs for compliance with quantitative network adequacy standards based on time and distance standards. Beginning for PY 2024, CMS will also evaluate QHPs for compliance with appointment wait time standards. These reviews will occur prospectively during the QHP certification process. Issuers that are unable to meet the specified standards would be able to submit a justification to explain why they are not meeting the standards, what they are doing to work towards meeting them, and how they are protecting consumers in the meantime. CMS also finalizes a requirement that QHPs submit information on whether providers participating in their network offer services through telehealth**.**

Additionally, HHS will review additional specialties for time and distance that are necessary to meet the unique health care needs of QHPs enrollees, such as emergency medicine, outpatient clinical behavioral health, pediatric primary care, and urgent care. OB/GYN parameters will also be aligned with the parameters for primary care.

Changes to Actuarial Value (AV) de Minimis Ranges
CMS finalizes changes to the AV *de minimis* ranges to +2/-2 percentage points for all individual and small group market plans subject to the AV requirements under an EHB package, affecting bronze, silver, gold, and platinum levels of coverage. CMS also finalizes a *de minimis* range of +5/-2 for expanded bronze plans that cover and pay for at least one major service, other than preventive services, before the deductible or meet the requirements to be a high deductible health plan (HDHP). Additionally, CMS finalizes a *de minimis* range of +2/0 percentage points for individual market silver QHPs and a *de minimis* range of +1/0 percentage points for income-based silver CSR plan variations. The narrowing of the de minimis ranges of individual market silver QHPs will influence the generosity of the Second Lowest Cost Silver Plan (SLCSP), the benchmark plan used to determine an individual's Payments of the Premium Tax Credit (PTC). As a result, subsidized enrollees will likely receive increased premium tax credits.

Advancing Health Equity

Refine Essential Health Benefits (EHB) Nondiscrimination Policy for Health Plan Designs
CMS refines its EHB nondiscrimination policy to ensure that benefit designs, particularly benefit limitations and plan coverage requirements for EHB, are based on clinical evidence. CMS provides examples that illustrate presumptive discriminatory plan designs, such as discrimination based on age and health conditions. CMS rules already provide that an issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminate based on an

individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.

In the proposed rule, HHS proposed amendments to certain regulations to explicitly identify and recognize discrimination on the basis of sexual orientation and gender identity as prohibited forms of discrimination based on sex consistent with the Supreme Court's decision in Bostock v. Clayton County, 140 S. Ct. 1731 (2020), and HHS nondiscrimination policy that existed prior to the 2020 regulatory amendments HHS made in conformance with the "Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority" final rule, 85 FR 37160 (June 19, 2020). In connection with discriminatory benefit designs prohibited under § 156.125, HHS also included in the proposed rule an example related to gender-affirming care that was intended to illustrate a health plan design that presumptively discriminates against enrollees based on gender identity.

Currently, HHS is developing a proposed rule that also will address prohibited discrimination in health coverage based on sex under section 1557 of the ACA. Because HHS's proposed rule implementing section 1557 of the ACA will also address issues related to prohibited discrimination based on sex, HHS is of the view that it would be most prudent to address the nondiscrimination proposals related to sexual orientation and gender identity in the 2023 Payment Notice proposed rule at a later time, to ensure that they are consistent with the policies and requirements that will be included in the section 1557 rulemaking. The Department is committed to removing barriers to coverage because it can lead to improved health outcomes in the LGBTQI+ community. In advance of a future rulemaking to address these provisions, HHS will continue to interpret and enforce section 1557 of the ACA and its protections against sex discrimination to prohibit discrimination on the basis of sexual orientation and gender identity in all aspects of health insurance coverage governed by section 1557.

Special Enrollment Period (SEP) Verification

CMS finalizes changes to scale back pre-enrollment SEP verification in the FFMs and SBM-FPs to include only the SEP for loss of minimum essential coverage—the SEP type that comprises the majority of all SEP enrollments on the Marketplaces on the federal platform—and to clarify that Marketplaces maintain the option to verify eligibility for any SEP types and may provide an exception to pre-enrollment SEP verification when verification may cause undue burden, such as during natural disasters or public health emergencies impacting consumers or the Marketplace. Prior to this rule, Marketplaces on the federal platform conducted pre-enrollment verification of eligibility for five SEP types (loss of minimum essential coverage, Medicaid/Children's Health Insurance Program (CHIP) denial, permanent move, marriage, and dependent addition) representing 90% of SEP applications. While pre-enrollment SEP verification can decrease the risk of adverse selection and improve program integrity, it can also deter eligible consumers from enrolling in coverage through an SEP because of the barrier of document verification. Our experience operating the FFMs and the federal platform shows that pre-enrollment SEP verification disproportionately negatively impacts Black and African American consumers who submit acceptable documentation to verify their SEP eligibility at much lower rates than white consumers. We have also found that younger, often healthier consumers submit acceptable documentation to verify their SEP eligibility at much lower rates than older, often less healthy consumers, which can negatively impact the risk pool. Scaling back SEP verification would

mitigate the negative impacts of pre-enrollment SEP verification on populations that have historically faced barriers to accessing health care, and would decrease the overall consumer burden without substantially sacrificing program integrity.

Update Quality Improvement Strategy (QIS) Standards to Require Issuers to Address Health and Health Care Disparities

CMS finalizes changes to update the QIS standards beginning in 2023 to require QHP issuers to address health and health care disparities as a specific topic area within their QIS. Currently, QHP issuers participating in a Marketplace for two or more consecutive years are required to implement and report on a QIS that includes at least one topic area defined in section 1311(g)(1) of the ACA (activities to improve health outcomes, prevent hospital readmissions, improve patient safety and reduce medical errors, promote wellness and health and reduce health and health care disparities). In PY2020, an estimated 60% of QHP issuer QIS submissions across the FFM did address health care disparities. CMS is now finalizing the requirement for QHP issuers to address the topic of reducing health and health care disparities in their QIS submissions in addition to at least one other topic area described in section 1311(g)(1) of the ACA beginning in 2023.

Raise the Essential Community Provider (ECP) Threshold from 20% to 35%

For PY2023 and beyond, CMS finalizes increasing the ECP threshold from 20% to 35% of available ECPs in each plan's service area to participate in the plan's provider network. For PY2021, the percentages of medical and dental QHP issuers on the FFMs that could have satisfied a 35% ECP threshold were 80% and 74%, respectively. CMS anticipates that issuers will be able to meet the 35% threshold with only minimal reliance on our ECP write-in and justification processes, if needed.

Lowering Premiums and Strengthening Markets

FFM and SBM-FP User Fees

For the 2023 benefit year, CMS finalizes an FFM user fee rate of 2.75% of premium and a SBM-FP user fee rate of 2.25% of premium.

Risk Adjustment

CMS finalizes two of the three proposed model specification changes to the risk adjustment models, improving risk prediction for the lowest and highest risk enrollees. Beginning with the 2023 benefit year, CMS finalizes removing the current severity illness factors from the adult models to add an interacted hierarchical condition category (HCC) count model specification to the adult and child models and replacing the current enrollment duration factors in the adult models with HCC-contingent enrollment duration factors to improve prediction for partial-year enrollees. CMS is not finalizing the proposed addition of a two-stage weighted model specification for the adult and child models. CMS believes the model changes finalized in this rule will continue to improve the risk adjustment program's ability to predict and balance payments for risk across the individual and small group markets.

CMS also finalizes the following changes to model recalibration for the 2023 benefit year risk adjustment models: (1) using the 2017, 2018, and 2019 enrollee-level EDGE data for model

recalibration; (2) applying a market pricing adjustment to the plan liability associated with Hepatitis C drugs; and (3) using the fourth quarter (Q4) prescription drug categories (RXC) mapping document for each benefit year of recalibration data, except for 2017 enrollee-level EDGE data.

CMS also finalizes changes to collect and extract through issuers' EDGE servers five new data elements including ZIP code, race, ethnicity, individual coverage health reimbursement arrangement (ICHRA) indicator, and a subsidy indicator as part of the required risk adjustment data that issuers must make accessible to HHS in states where HHS is operating the risk adjustment program. CMS also finalizes changes to extract three new data elements issuers already provide through their EDGE servers as part of the required risk adjustment data submissions (plan ID, rating area, and subscriber indicator), and to expand the permitted uses of the risk adjustment data and reports. Additionally, CMS finalizes a risk adjustment user fee for the 2023 benefit year of $0.22 per member per month.

Finally, CMS repeals the ability for states to request a reduction in risk adjustment state transfers starting with the 2024 benefit year, with an exception for prior participants that previously requested such flexibility. CMS will limit a prior participant's ability to request a reduction in risk adjustment transfers to only those that meet the *de minimis* threshold criteria. In future rulemaking, CMS intends to propose to eliminate the prior participant exception and fully repeal the state flexibility framework beginning with the 2025 benefit year. For the 2023 benefit year, CMS approves Alabama's request to reduce risk adjustment state transfers, but at lower percentages than requested. CMS approves for the 2023 benefit year a 25% reduction in Alabama's individual market (including the catastrophic and non-catastrophic risk pools) transfers and a 10% reduction in Alabama's small group market transfers.

HHS Risk Adjustment Data Validation (HHS-RADV)
CMS finalizes further refinements to the HHS-RADV error rate calculation methodology beginning with the 2021 benefit year and beyond to: (1) extend the application of Super HCCs to also apply coefficient estimation groups throughout the HHS-RADV error rate calculation processes; (2) specify that the Super HCCs will be defined separately according to the age group model to which an enrollee is subject except for where child and adult coefficient estimation groups have identical definitions; and (3) constrain to zero any outlier negative failure rate in a failure rate group, regardless of whether the outlier issuer has a negative or positive error rate. We believe that these changes will better align the calculation and application of error rates with the intent of the HHS-RADV program, thereby enhancing the integrity of HHS-RADV and the HHS-operated risk adjustment program.

Premium Adjustment Percentage and Payment Parameters
CMS issued the 2023 benefit year premium adjustment percentage, the maximum annual limitation on cost-sharing, the reduced maximum annual limitation on cost-sharing, and the required contribution percentage (payment parameters) in guidance on December 28, 2021[1], consistent with policy finalized in the 2022 Payment Notice (86 FR 24140).

[1] https://www.cms.gov/files/document/2023-papi-parameters-guidance-v4-final-12-27-21-508.pdf

Prohibit Inclusion of Indirect Quality Improvement Activity (QIA) Expenses in Medical Loss Ratio (MLR)
CMS finalizes changes to specify that QIA expenses that may be included for MLR reporting and rebate calculation purposes are only those expenses that are directly related to activities that improve health care quality. Some issuers appropriately include only direct QIA expenses, such as salaries of the staff actually performing QIA functions, while others additionally allocate indirect expenses, such as a portion of overhead (including holding group overhead), marketing, office space, IT infrastructure (such as IT mainframes, which are primarily used to process claims), and vendor profits that have no traceable or quantifiable connection to QIA.

Enhancing the Consumer Experience

Advanced Payments of the Premium Tax Credit (APTC) Proration
CMS finalizes the proposed APTC proration methodology for Marketplaces using the federal platform, but does not finalize the requirement for State-based Marketplaces to prorate premium or APTC amounts using the methodology described in the proposed rule. Rather, beginning in the 2023 plan year, State-based Marketplaces will prospectively report to HHS their methodology for preventing payments of excess APTC when an enrollee is enrolled in a particular policy for less than the full coverage month. This reporting requirement will provide implementation flexibility to State-based Marketplaces while helping to prevent APTC overpayment that exceeds an enrollee's premium tax credit, and thus will protect the enrollee from potentially incurring additional income tax liability.

Require the Display of Explanations for QHP Recommendations on Web-Broker Websites
CMS finalizes changes to require web-broker websites to display a prominent and clear explanation of the rationale for explicit QHP recommendations and the methodology for default display of QHPs on their websites (for example, alphabetically based on a plan name, from lowest to highest premium, etc.) to ensure consumers are better able to make informed decisions and shop for and select QHPs that best fit their needs.

Prohibit QHP Advertising on Web-Broker Websites
CMS finalizes changes that will prohibit QHP advertising, or otherwise providing favored or "preferred placement," in the display of QHPs, on web-broker websites based on compensation an agent, broker, or web-broker receives from QHP issuers.

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