Summary of Provisions of HHS' Proposed 2023 Notice of Benefit and Payment Parameters and Other Key Regulations

Michael Cohen, PhD
Chia Yi Chin, ASA, MAAA
Matt Sauter, ASA, MAAA
Luke Brehmer, ASA, MAAA
Adam Rudin, FSA, MAAA
Van Phan, FSA, MAAA

On December 28, 2021, the Department of Health and Human Services (HHS) released the proposed Notice of Benefit and Payment Parameters (Payment Notice) for 2023 in the Federal Register.[1] The notice includes important proposed rules and parameters for the operation of the individual and small group health insurance markets in 2023 and beyond. This paper summarizes key provisions of the proposed notice, actuarial value calculator, and maximum out of pocket information recently released by HHS. Comments are due within 30 days of filing.

Overview

The following highlights the key changes included in the 2023 proposed Payment Notice. More information on these and other proposed changes follow.

1. **Past Due Premiums:** HHS proposes to rescind the current policy that allows issuers to require enrollees to pay past due premiums from a prior year before enrolling in new coverage.
2. **User Fees:** HHS proposes to maintain user fees at 2.75% for issuers in the Federally-facilitated Exchange (FFE) and 2.25% for issuers in state-based Exchanges operated by HHS (SBE-FPs).
3. **Special Enrollment Period Verification:** HHS proposes to end pre-enrollment special enrollment period (SEP) verification for most types of SEP.
4. **Standard Plans:** HHS proposes to require most issuers operating on the Healthcare.gov platform to offer standard plans. Standardized options would be required in every network type, metal, and throughout every service area they offer a non-standardized product.
5. **Actuarial Value De Minimis Changes:** HHS is proposing to shrink the de minimis thresholds for actuarial values (AVs) for plans subject to EHB requirements. Most notably, HHS proposes to have

[1] Department of Health and Human Services, "Proposed Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023", https://www.federalregister.gov/public-inspection/2021-28317/patient-protection-and-affordable-care-act-benefit-and-payment-parameters-for-2023

de minimis for metal levels at +2/-2, and on-Exchange Silver de minimis levels to +2/0 although leaves the Expanded Bronze de minimis levels in place.

6. **Network Requirements:** HHS proposed to re-impose Federal review of network adequacy for issuers operating on Healthcare.gov Exchanges. Additionally**,** HHS proposes to increase the Essential Community Provider requirements from 20% to 35%.

7. **Risk Adjustment:** HHS has proposed several updates to the risk adjustment model Hierarchical Condition Categories (HCCs), the data used to recalibrate the model, the risk adjustment coefficients, the risk adjustment data validation (RADV) program, and the risk adjustment user fee.

8. **Medical Loss Ratio (MLR) Changes:** HHS proposes to change the definitions of incurred claims and quality improvement as part of MLR submission.

9. **Actuarial Value Calculator:** While not part of the Payment Notice, HHS has proposed changes to the Actuarial Value Calculator that will impact some actuarial values, and thus plan designs, significantly.

Past Due Premiums

HHS proposes to change the current policy that allows issuers to not enroll individuals if the individual owes past due premiums. Currently, issuers can require individuals to repay past due premiums before effectuating their enrollment. HHS believes the current policy, which was put into effect in 2017, creates an unnecessary burden on low-income consumers.

User Fees

HHS proposes to keep user fees for issuers in states that utilize Healthcare.Gov at the current (2022) rates. In particular, HHS proposes charging issuers in FFE 2.75% and charging 2.25% in SBE-FP states.

Enrollment Changes

HHS proposes reducing special enrollment period verification. Starting in 2017, individuals who applied for SEP typically were required to submit additional information to verify that they qualified for an SEP. Until the documentation can be verified, individuals are typically pended (i.e., not effectuated). HHS proposes to end this practice except for SEP involving the loss of minimal essential coverage.

HHS also proposes that HHS would only conduct pre-enrollment verification if the individual is applying for an SEP due to a loss of coverage (e.g., loss of employer coverage). HHS also proposes to relax requirements on all Exchanges (including SBEs) for verification of job-based coverage. Finally, HHS announced that it is considering using different methodologies for determining how to auto-enroll individuals from one year to the next.

Standard Plans

HHS proposes requiring qualified health plan (QHP) issuers operating on the Healthcare.gov platform to offer standard plans. The standardized option rules only apply to states using the federal platform (FFE and SBE-FP), and is not required for state Exchanges. States on the federal platform who already have standardized plan requirements as of January 1, 2020, are exempt (and will use the state rule). Standardized options would be required for every network type, metal, and service area the issuer offers a non-standardized product.

Standardized options are for bronze, expanded bronze, silver (plus CSR variants), gold, and platinum plans. Separate standardized options for Louisiana and Delaware are proposed to accommodate specialty tier drug cost-sharing laws. HHS also proposes that standard plans be differentially displayed on websites (i.e., consumers will be able readily identify plans that are standard plans). HHS published the proposed plan designs.[2] Finally, while not proposing for 2023, HHS raised the potential for limiting non-standard plans in future years as well as reimposing the meaningful difference standard to reduce the number of non-standard plans.

Issuer Requirements

HHS proposes to expand or change issuer requirements in a number of ways. These include changes to actuarial value de minimis, changes to network adequacy requirements, changes to non-discrimination/EHB standards, and changes to quality improvement strategies.

AV De Minimis Thresholds

HHS is proposing to shrink the de minimis thresholds for AV for plans subject to EHB requirements. While expanded bronze plans would maintain a range of +5/-4, most other metal level would have an acceptable range of +2/-2. The exception to this is that Silver QHPs (on-Exchange and the resulting mirror plans) would have a de minimis range of +2/0 (i.e., 70% to 72%). Income based CSR plans would have a de minimis range of +1/0. CMS reminds issuers that QHPs with plan AVs between 71% and 72% would need their corresponding 73% income-based plan variation AV to be at least 2 percentage points above the standard plan's AV.

Network Requirements

HHS is proposing several changes to increase network adequacy standards. HHS is proposing to reintroduce Federal review of network adequacy for QHPs that participate on Healthcare.gov. These include time and distance standards for most specialties, but also wait time standards for other areas. HHS also proposes to increase the Essential Community Provider requirements from 20% to 35%.

[2] https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf

Quality Improvement Strategies

HHS proposes requiring QHP issuers to address health and health care disparities as part of their quality improvement strategy (QIS) reporting requirements. HHS notes that about 40% of QIS submissions for the FFE did not address health care disparities.

Risk Adjustment

HHS proposes several updates to the risk adjustment program in the Payment Notice.

Risk Adjustment Model Recalibration

HHS proposes to use the three most recent consecutive years of data available at the time of the annual NBBP for the draft coefficients. For benefit year 2023 risk adjustment model, HHS will use 2017, 2018, and 2019 enrollee-level EDGE data.

Model Updates to Improve Predictive Power

HHS proposes including a two-stage specification in both the adult and child models, and separately add severity and transplant indicators that would interact with HCC count factors. Limiting the HCC count factor to interact with only severity and transplant indicators seeks to limit the potential for gaming while capturing the compounding costs of multiple HCCs. The current HCC severity interaction terms would be removed as well.

HHS also proposes removing the current 11 enrollment duration factors (EDFs) and replacing them with six EDFs (up to six months) attributable to only those members with one or more payment HCCs.

The preceding changes seek to improve the predictive power of the model for both low- and high-cost enrollees.

Similar to previous benefit years, HHS proposes an adjustment to the Hepatitis C prescription drug class (RXC) to mitigate overprescribing incentives and better reflect the average cost of Hepatitis C treatments in the 2021 benefit year for adult models. HHS proposes to adjust the plan liability associated with Hepatitis C drugs to reflect future market pricing of Hepatitis C drugs before solving for the adult model coefficients.

HHS also proposes to refine its process for mapping RXCs starting with the 2023 model. In particular, HHS proposes to recalibrate the adult model using the fourth quarter RXC mapping for each benefit year of data (except for 2017 enrollee-level EDGE data). HHS also proposes to make changes, should there be significant off-label use or changes in practice patterns. For example, HHS includes the potential need to make changes to Descovy and Hydroxychloroquine in future years.

Finally, HHS is proposing that risk score adjustments for CSR plans will continue for the 2023 benefit year.

State Flexibility Requests

Alabama was the only state to request a reduction of risk adjustment transfers in 2023.[3] HHS proposes to remove the option for state flexibility changes although it does allow for states that are currently approved (Alabama) to maintain its' reduction for 2023.

Additional Data Elements

HHS proposes several additional data elements would be collected as part of EDGE data submission. For the 2023 benefit year, issuers are required to submit zip code, race, ethnicity data, and subsidy indicator. HHS proposes that issuers have the option of submitting individual coverage health reimbursement arrangement (ICHRA) data for 2023, but would be required to do so for 2025.

Risk Adjustment User Fee

HHS estimates the 2023 risk adjustment user fee will be $0.22 per member per month (PMPM), a small decrease from 2022, which was $0.25 PMPM.

Risk Adjustment Data Validation (RADV)

RADV Error Rate Calculations

HHS proposes to change its RADV calculations starting with the 2021 benefit year. In particular, it proposes to apply the same application of super HCC to apply to coefficient estimation group; specify that super HCC will be defined separately via an enrollee's age group model; and constrain any outlier negative failure in a failure rate group to zero.

RADV and MLR

HHS notes that issuers must report RADV adjustments as part of their MLR report in the same way they report traditional risk adjustment payments and charges.

Minimum Loss Ratio (MLR) Changes

HHS proposes several changes to MLR definitions. The first proposed change would require that provider incentives and bonuses may be included in incurred claims for MLR reporting and rebate calculation only if they are tied to clearly defined, objectively measurable, and are well-documented clinical or quality improvement standards that apply to providers.

HHS also proposes that only expenditures directly related to activities that improve health care quality may be included in quality improvement activity (QIA) expenses for MLR reporting and rebate calculations purpose.

Maximum Out of Pocket Updates

HHS no longer publishes maximum out-of-pocket (MOOP) amounts in the Payment Notice, but instead

[3] Alabama requested a 50% reduction in transfers for both Individual and Small Group in 2023.

will finalize those values via guidance. HHS published guidance[4] finalizing the MOOP amounts for Non-CSR plans[5] and cost sharing variations for 2023, which are increasing 4.6% from the 2022 amounts of $8,700/$17,400 (single/family).

- Non CSR Plans: $9,100/$18,200 (single/family)
- 100%-150% FPL: $3,000/$6,000 (single/family)
- 150%-200% FPL: $3,000/$6,000 (single/family)
- 200%-250% FPL: $7,250/$14,500 (single/family)

The catastrophic plan's deductible and MOOP will be set to $9,100/$18,200 (single/family).

The 2023 Actuarial Value Calculator (AVC)

In a separate release,[6] HHS proposes to update the 2023 Actuarial Value Calculator relative to the 2022 version.[7] The draft calculator claims data was based on 2018 data and was trended forward from 2018 to 2023 with differential rates for medical and prescription drug spending. Wakely will be releasing a paper on how the proposed 2023 AVC differs from the 2022 AVC in the near future.

If you have any questions or want to follow up on any of the concepts presented here, please contact any of the following authors:

Michael Cohen, PhD
202.568.0633 • michael.cohen@wakely.com

Adam Rudin, FSA, MAAA
727.259.7483 • adam.rudin@wakely.com

Chia Yi Chin, ASA, MAAA
832.247.6858 • chiayi.chin@wakely.com

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

[5] Standard plans include platinum, gold, silver non-cost sharing variation, bronze metal offerings as well as catastrophic plans.

[6] https://www.cms.gov/cciio/resources/regulations-and-guidance/#plan-management

[7] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-2023-AV-Calculator-Methodology.pdf

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