NovaRest, Inc.

Summary of Final HHS Notice of Benefit and Payment Parameters for 2025

NovaRest
ACTUARIAL CONSULTING

Contents

Disclaimer

This document represents our interpretation of the regulations and is intended for informational purposes only. While we have made every effort to ensure the accuracy of the information presented, the original source data (Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2025 Final Rule) should always be considered the authoritative source. We encourage readers to consult the original source data for the most accurate and up-to-date information.

Executive Summary

The HHS Notice of Benefit and Payment Parameters for 2025 Final Rule (2025 Payment Notice) was recently released[1], and it is accompanied by a summary fact sheet.[2] The lengthy final rule was faithful to the proposed notice, and most proposals were finalized as proposed.

Significant simplifications were made to the state Essential Health Benefit (EHB) benchmark plan revision process, effective January 1, 2026.[3,4] The simplifications reduced the number of options and guardrails states would need to consider, increased the flexibility of options with definitional changes, and reduced the documentation requirements if formulary changes are not made. A reinterpretation gives states more flexibility by allowing the addition of benefits and services categorized as non-pediatric routine dental, which were previously not allowed. Additional clarification regarding defining EHBs and non-EHBs was made to close gaps in understanding surrounding state defrayal requirements.

Similarly, continuity was the emphasized in Standardized Plan Options. While the limitation on non-standardized plan offerings will continue as expected, the exceptions process for plans directed toward chronic and high-cost conditions received much needed clarification.

Network Adequacy time and distance standards were finalized for State Exchanges and State Based Exchange on the Federal Platform (SBE-FPs) with a little extra time, with implementation effective for plan year 2026 instead of plan year 2025 as originally proposed.

A good portion of the Payment Notice was devoted to Exchange standards to improve consumer experience and continuity by extending several minimum standards to State Exchanges.

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[1] https://www.cms.gov/files/document/cms-9895-f-patient-protection-final.pdf

[2] https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2025-final-rule

[3] The initial proposal was for effective date of January 1, 2027, which was revised to January 1, 2026 except for the removal of the exception for non-pediatric routine dental which will remain effective January 1, 2027.

[4] 2. State Selection of EHB-Benchmark Plans for Plan Years Beginning on or after January 1, 2026 (§ 156.111)

Retroactive Termination of Qualified Health Plan (QHP) enrollment for members enrolling in Medicare Parts A or B (even through Medicare Advantage), also received discussion, particularly regarding logistics. There may still be many unanswered questions, not the least being the impact, however, we believe it is unlikely a significant portion of an issuer's population would request retroactive termination.

Risk adjustment underwent few modifications in the latest update. The annual parameters were finalized, and there was a detailed discussion on the risk adjustment model, with the most significant change being the increase in the cost-sharing reduction (CSR) factors for American Indian/Alaska Native (AI/AN) groups. Additionally, the payment notice mentioned potential adjustments in pricing for GLP-1 and gene therapy drugs, hinting that these changes may be part of future regulations.

Enrollees with catastrophic plans who will lose eligibility were added to the auto-enrollment hierarchy to avoid lapses in coverage.

Special enrollment periods (SEP), specifically the 150% Federal Poverty Line (FPL) SEP was made permanent.

Essential Health Benefits (EHB)

EHB Benchmark Plan Revision

The method by which a State chooses an EHB-benchmark plan was simplified from three options, to one: "a State may change its EHB-benchmark plan by selecting a set of benefits that would become the State's EHB-benchmark plan."[5] This was the most flexible option and the most common chosen methodology for States that have previously made EHB-benchmark plan changes.

The generosity provision was removed and replaced by an expanded definition of the typicality provision.[6] Instead of requiring States to demonstrate an EHB-benchmark plan to provide a scope of benefits equal to the scope of benefits of a typical employer plan, the simplification would allow a range such that the State would demonstrate the scope of benefits are between the least generous and most generous typical employer plan.[7]

The supplementation clause was re-written for clarity, although it is already less confusing with the change in the typicality definition.[8]

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[5] The other options were (1) Selecting the EHB-BP that another state used for the 2017 plan year and (2) Replacing one or more categories of EHBs under its EHB-BP used for the 2017 plan year with the same category or categories of EHB from the EHB-BP that another state used for the 2017 plan year.

[6] 2. State Selection of EHB-Benchmark Plans for Plan Years Beginning on or after January 1, 2026 (§ 156.111)

[7] Defined at § 156.111(b)(2)(i)(A) and (B),

[8] 2. State Selection of EHB-Benchmark Plans for Plan Years Beginning on or after January 1, 2026 (§ 156.111)

The typical employer plans for comparison are not changed, and can be one of the 10 comparison plans used in the 2017 plan year EHB-benchmark plan selection or a large group typical employer planning which "must, among other things, belong to a product that has at least 10 percent of the total enrollment of the five largest large group health insurance products in the State and be from a plan year beginning after December 31, 2013." The large group typical employer plan would not be frozen in time like the other comparison plans, so there is potential for States to mandate coverage for large group which in turn could be added to an EHB-benchmark plan. This activity will be monitored.

States intending to change their EHB-benchmark plan would no longer be required to submit a formulary drug list if they are not intending to change their prescription drug EHBs.[9]

States should be aware that altering the Essential Health Benefits (EHB) benchmark plan can modify the benefits considered as EHBs, which in turn can affect their eligibility for cost-sharing limitations and restrictions on annual or lifetime dollar limits.[10] Potentially, this could impact markets such as large group, self-insured, Medicaid Alternative Benefit Plan (ABP), and Basic Health Program (BHP) standard health plans offering benefits and relying on the State's definition of EHB.

Non-Pediatric Routine Dental

States will have the option to add routine non-pediatric dental services as an EHB beginning January 1, 2027.[11] This is a State option and would require State action to change the EHB-benchmark plan, even if the existing EHB-benchmark plan has language regarding routine non-pediatric dental services.

If a State elects to add any routine non-pediatric dental services as an EHB, unlike pediatric dental services, coverage could not be omitted because a Stand Alone Dental Plan (SADP) already provides coverage on the Exchange.[12] Issuers would not be prohibited from contracting with an SADP to provide the benefits.

[9] 2. State Selection of EHB-Benchmark Plans for Plan Years Beginning on or after January 1, 2026 (§ 156.111)
[10] 2. State Selection of EHB-Benchmark Plans for Plan Years Beginning on or after January 1, 2026 (§ 156.111)
[11] 3. Provision of EHB (§ 156.115)
[12] 3. Provision of EHB (§ 156.115)

Defining an EHB vs a non-EHB

A covered benefit in a state's EHB-benchmark plan is considered an EHB.[13] If a state mandates coverage of a benefit included in the EHB-benchmark plan, it would not require defrayal. Any state currently defraying mandates that are included in the EHB-benchmark plan can cease paying starting in plan year 2025, so issuers can make changes to reflect the EHB status. States will not be reimbursed for past defrayal. If a mandate was removed from the EHB-benchmark plan, it would no longer be considered an EHB. HHS will continue their policy of not providing determination of whether a benefit mandate requires defrayal.

While not a change, the Payment Notice codified that any prescription drug covered by an issuer (including in excess of minimum EHB requirements) is considered an EHB unless required by State mandate.[14] As the Payment Notice indicates, this provision was mentioned again as commenters express concern about copay maximizers and alternative funding programs categorizing certain drugs as non-EHBs, as described below:

"For example, a plan might designate certain drugs as "non-EHB," but indicate that the member can obtain coverage of such drugs so long as they enroll into a third-party program. If the member declines to enroll in the program or fills a prescription for a "non-EHB" drug outside of the program, they risk assuming responsibility for cost sharing that does not count towards the member's deductible or annual limitation on cost sharing."

Other

The final Payment Notice also requires Pharmacy and Therapeutics (P&T) Committees to include at least one patient representative and detailed requirements.[15,16]

[13] 3. Additional Required Benefits (§ 155.170)
[14] 4. Prescription Drug Benefits (§ 156.122)
[15] The proposal indicated consumer representative; however, patient was determined to be a more appropriate term.
[16] 4. Prescription Drug Benefits (§ 156.122)

Standardized Plan Options

Standardized Plan Option Requirements

The structure of the standardized plan options was published, without significant changes to the approach used in prior rate cycles.[17] Issuers are not limited in the number of standardized plan options they can offer, so they can vary benefit packages, networks, and formulary variations, so long as they conform to the required cost sharing parameters for these plans. No proposal was included to expand this requirement to the State Exchange.

Non-Standardized Plan Option Limitations and Exceptions

Federally Facilitated Exchange (FFE) and State Based Exchange on the Federal Platform (SBE-FPs) QHP issuers are limited to two[18] non-standardized plan options per network type, metal level,[19] service area, and inclusion of dental and/or vision benefit coverage for PY2025.[20]

Additional non-standardized plan options may be permitted, subject to an exceptions process, if non-standardized plan options have benefits intended to reduce total patient out-of-pocket cost for treatment of a specific chronic and high-cost condition by at least 25%.[21] The exceptions process is described in the final Payment Notice.[22] A written justification (actuarial memorandum and actuary opinion) will be required for each exception. The justification forms would be required by the initial QHP deadline, not the Early Bird deadline discussed in the proposal.

Deductibles, copayments, coinsurance, and annual limitations would be considered in meeting the 25% reduction.[23] Inclusion of additional benefit coverage, different provider networks, different formularies, or reduced cost sharing for benefits provided through the telehealth modality, would not be considered. The reduction in cost sharing would be to the standard variant of the plan, not the CSR or AI/AN variants. Issuers should consider the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements in the plan design.

[17] 6. Standardized Plan Options (§ 156.201)
[18] Down from 4 in PY 2024
[19] Not including Catastrophic
[20] 7. Non-Standardized Plan Option Limits (§ 156.202)
[21] 7. Non-Standardized Plan Option Limits (§ 156.202)
[22] 7. Non-Standardized Plan Option Limits (§ 156.202)
[23] 7. Non-Standardized Plan Option Limits (§ 156.202)

One exception[24] per chronic[25] and high-cost condition[26] would be permitted.[27] For example, an exception could be requested for diabetes and a separate exception can be requested for hepatitis C.[28] As an example, the following were noted as potential chronic and high-cost conditions for PY 2025:

- Alzheimer's disease,
- Cancer,
- Chronic obstructive pulmonary disease (COPD)
- Diabetes,
- Heart disease,
- Hepatitis C virus,
- Human Immunodeficiency Virus (HIV),
- Kidney disease,
- Multiple sclerosis,
- Osteoporosis,
- Rheumatoid arthritis,

As an example, the following would NOT be considered chronic and high-cost in nature for PY 2025.

- Bronchitis,
- Flu,
- Pneumonia,
- Respiratory infections, and
- Strep throat.

Future rulemaking may consider plan marketing name rules for these excepted chronic or high-cost conditions as well as how these plans would be distinguished on HealthCare.gov.

[24] Per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area.
[25] High-cost conditions "are those that account for a disproportionately high portion of total Federal health expenditures."
[26] Chronic conditions were defined as "those that have an average duration of one year or more and require ongoing medical attention or limit activities of daily living, or both."
[27] 7. Non-Standardized Plan Option Limits (§ 156.202)
[28] Subject to meeting all other requirements.

Network Adequacy

Implementation of proposed State Exchange and SBE-FP Network Adequacy Standards were delayed from January 1, 2025, to January 1, 2026.[29] State Exchanges and SBE-FPs would be required to:

1. Impose minimum quantitative time and distance standards at least as stringent as FFE's.[30]
2. Provide an exception request if standards are different than FFEs but with evidence-based data to support a level of access at least as great as the FFE standards.
3. Review network adequacy reviews prior to certifying a QHP, consistent with FFE reviews.
4. Require a justification process for issuers unable to meet specific time and distance standards.[31]
5. Require issuers to report whether providers offer telehealth services. [32]

The provider specialist lists are unchanged from the FFE standards finalized in the 2023 Payment Notice, although future categories were mentioned by commentors that may be considered in future rulemaking.[33]

The limited SADP "prohibitively difficult" exception was also extended to State Exchanges and SBE-FPs.[34] "Under this exception, an area is considered "prohibitively difficult" for an SADP issuer to establish a network of dental providers based on attestations from State Departments of Insurance in States with at least 80% of their counties classified as Counties with Extreme Access Considerations (CEAC), that at least one of the following factors exists in the area of concern:

1. a significant shortage of dental providers,
2. a significant number of dental providers unwilling to contract with Exchange issuers, or
3. significant geographic limitations impacting consumer access to dental providers."

[29] 19. Establishment of Exchange Network Adequacy Standards (§ 155.1050)

[30] Currently, approximately 25 percent of State Exchanges and SBE-FPs do not have any quantitative standard.

[31] Issuers would be required to provide a justification indicated how adequate service is provided and how the network will be strengthened prior to the start of the plan year. Examples of items that may be considered for exceptions included provider supply shortages, topographic barriers, or other barriers beyond an issuer's control.

[32] A simple survey would be completed with answers "Yes," "No," or "Requested information from the provider, awaiting their response," which would not be displayed to consumers.

[33] 19. Establishment of Exchange Network Adequacy Standards (§ 155.1050)

[34] 19. Establishment of Exchange Network Adequacy Standards (§ 155.1050)

Exchange Standards

The 2025 benefit year Exchange User Fee will be 1.5% of "the monthly premium charged by the issuer for each policy under plans where enrollment is through an FFE" and 1.2% for SBE-FP.[35, 36]

State Exchange Implementation

A State will need to operate an SBE-FP for at least one year, including one open enrollment period, prior to operating a State Exchange.[37]

HHS was given the authority to request any evidence that HHS determines is necessary for the State to detail its implementation of the required State Exchange functionality.[38] This codifies an already existing policy.

Rules surrounding the public notification and engagement of the State Exchange Blueprint application were finalized.[39] Comments were received requesting States provide more information, such as enrollment targets or clear metrics toward meeting Blueprint goals, which HHS is expected to consider in future rulemaking.[40]

Minimum standards for call center operations for "all Exchanges other than SBE-FPs and SHOP Exchanges that do not provide for enrollment in Small Business Health Options Program (SHOP) coverage through an online SHOP enrollment platform", were finalized.[41] Currently, all Exchanges meet compliance requirements, so the guidance is aimed at new Exchanges and those that are already operating, moving forward. No minimum standard for staffing levels was proposed. The Department of Health and Human Services (HHS) will collect performance data on an annual basis.

Minimum HHS standards for display information were set for State Exchanges web-broker Non-Exchange website for State Exchanges, such as requiring website display of standardized QHP comparative information, disclaimer language, information on eligibility for Advance premium tax credit (APTC)/ Cost Sharing Reduction (CSR), operational readiness, standards of conduct, and access by web-broker downstream agents and brokers apply to web-brokers across all Exchanges. [42] The information is encouraged to

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[35] Reduced from 2.2% for FFE and 1.8% for SBE-FP initially proposed due to updated enrollment projections.
[36] 1. FFE and SBE-FP User Fee Rates for the 2025 Benefit Year (§ 156.50)
[37] 1. Approval of a State Exchange (§ 155.105)
[38] 2. Election to Operate an Exchange after 2014 (§ 155.106)
[39] 2. Election to Operate an Exchange after 2014 (§ 155.106)
[40] 2. Election to Operate an Exchange after 2014 (§ 155.106)
[41] 4. Consumer Assistance Tools and Programs of an Exchange (§ 155.205)
[42] 7. Adding and Amending Language to Ensure Web-brokers Operating in State Exchanges Meet Certain HHS Standards Applicable in the FFEs and SBE-FPs (§ 155.220)

follow the standards currently in place for FFE and SBE-FP, however, States will have some flexibility in the display information so long as it meets minimum requirements and does not conflict with HHS minimum standards.

Minimum standards for Direct Enrollment (DE) entities operating in FFEs and SBE-FPs were extended to State Exchanges.[43] To date no State Exchanges have implemented DE programs. Standards for marketing, display, omission of fact, disclaimer, training, entities that can assist consumers, and others were detailed. State Exchanges would enforce compliance.

State Exchanges are also tasked with setting standards and determination of web-brokers operation readiness prior to the website being active.[44] State's revising or adding a web-broker program may require changes to the State's approved Exchange Blueprint, which would require HHS approval.

Eligibility and Enrollment Determination

The Exchange website must serve as the centralized platform for eligibility and enrollment, and it must be the only entity authorized to determine eligibility for Qualified Health Plan (QHP) coverage and affordability programs.[45] For FP and SBE-FP this would be Healthcare.gov. Private entities (one or more) with an agreement to operate the Exchange's centralized eligibility and enrollment platform, would be permitted to make determinations. However, those with an agreement outside of operating the centralized platform could not make determinations. The process must also facilitate a single, streamlined application for enrollment by a consumer. Currently, HHS believes all Exchanges are following this guidance.

As the centralized eligibility and enrollment platform, Exchanges must also maintain records of effectuated enrollments in QHPs.[46] DE entity non-Exchange websites assisting FFEs or SBE-FPs must prominently reflect changes made to the HealthCare.gov site within a specified period of time, typically 30-90 calendar days depending on content.[47] This is an existing policy for most DE entities.

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[43] 9. Ensuring DE Entities Operating in State Exchanges Meet Certain Standards Applicable in the FFEs and SBE-FPs (§ 155.221)

[44] 7. Adding and Amending Language to Ensure Web-brokers Operating in State Exchanges Meet Certain HHS Standards Applicable in the FFEs and SBE-FPs (§ 155.220)

[45] 5. Requirement for Exchanges to Operate a Centralized Eligibility and Enrollment Platform on the Exchange's Website (§§ 155.205(b); 155.302(a)(1))

[46] 5. Requirement for Exchanges to Operate a Centralized Eligibility and Enrollment Platform on the Exchange's Website (§§ 155.205(b); 155.302(a)(1))

[47] 8. Establishing Requirements for DE Entities Mandating HealthCare.gov Changes be Reflected on DE Entity Non-Exchange Websites within a Notice Period Set by HHS (§ 155.221(b))

State Exchanges are expected to develop a similar process, requiring DE entities to reflect changes to the State Exchange in a specified time.[48]

Other

Exchanges and State Medicaid and Children's Health Insurance Program (CHIP) agencies will now be required to pay for the use Verify Current Income (VCI) Hub service to support their eligibility verification processes.[49] The purpose of the VCI Hub service is to verify income if the Department of Treasury fails to verify income. HHS would invoice States on a monthly basis for actual use of data,[50] beginning July 1, 2024.[51] State Medicaid and CHIP agencies may be eligible for federal fund matching. HHS will not invoice when the access was initiated by HHS, for instance in SBE-FPs.

Authority was granted to temporarily suspend periodic data-matching (PDM) requirement during situations where the data needed to conduct PDM is limited.[52,53] Example situations that were included were "public health emergency, enrollment or data lags." Similarly, a temporary pause in PDM may occur when enrollees have limited availability of documentation needed to appeal the PDM findings.

All Exchanges must notify tax filers the first year they failed to reconcile their APTC.[54] This would be an initial warning to notify tax filers they could lose eligibility if they fail to reconcile in future years. HHS will provide a sample notice at Marketplace.cms.gov prior to implementation for plan year 2025.

Exchanges are permitted to accept an applicant's attestation of incarceration status without verification to reduce administrative burden and cost.[55] Exchanges will be required to check for and end coverage for QHP enrollees twice per year, beginning with the 2025 calendar year.[56]

The CMS Administrator is the entity deciding on reconsideration requests for agents, brokers, and web-brokers with Exchange agreements terminated for cause in FFEs or SBE-FPs.[57] Previously, this was abstractly labeled "HHS reconsideration entity."

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[48] 8. Establishing Requirements for DE Entities Mandating HealthCare.gov Changes be Reflected on DE Entity Non-Exchange Websites within a Notice Period Set by HHS (§ 155.221(b))

[49] 12. Verification Process Related to Eligibility for Insurance Affordability Programs (§ 155.320)

[50] A prepay option was initially proposed but was removed in the final rule. A commentor also recommended a mixed-option, which HHS believes they are unable to do at this time.

[51] 12. Verification Process Related to Eligibility for Insurance Affordability Programs (§ 155.320)

[52] The proposal indicated when data was unavailable, but was revised to limited.

[53] 13. Eligibility Redetermination During a Benefit Year (§ 155.330(d))

[54] 10. Failure to Reconcile (FTR) Process (§ 155.305(f)(4))

[55] 11. Verification Process Related to Eligibility for Enrollment in a QHP through the Exchange (§ 155.315(e))

[56] 13. Eligibility Redetermination During a Benefit Year (§ 155.330(d))

[57] 6. Ability of States to Permit Agents and Brokers and Web-Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (§ 155.220(h))

Retroactive Termination of QHP Enrollment for Medicare Enrollment

Enrollees would be permitted to retroactively terminate their QHP enrollment through the exchange when they enroll in a Medicare Parts A or B (including enrollment in Parts A or B through a Medicare Advantage plan), if elected to be implemented by HHS for Exchanges on the Federal platform or if implemented by State Exchanges.[58] Prior to full implementation, advance notice would be provided to issuers and other interested parties through interested party webinars and published guidance such as the Federally-facilitated Exchange Enrollment Manual.

The retroactive termination is limited to no earlier than the later of the following:[59]

1. The day before the first day of coverage under Medicare Parts A or B or
2. The day that is 6 months before retroactive termination of QHP coverage is requested.

Enrollees would need to request retroactive termination within 60 days.[60] Retroactive terminations would not be permitted for stand-alone dental plans (SADPs).

If enrollees request and are granted retroactive termination of their Qualified Health Plan (QHP), they would be eligible to reclaim premiums. However, in such cases, the government would be entitled to reclaim the associated tax credits.[61] On the other hand, a member who retroactively enrolls in Medicare but does not seek retroactive QHP termination is not exempt from the premium tax, so they would not be required to repay tax credits.

An important note is that when coverage is retroactively terminated, former QHP enrollees would be required to work with providers to get claims submitted to Medicare.[62] Any cost-sharing differences between the QHP and Medicare would need to be resolved among the enrollee, the provider, and Medicare. If certain claims are not covered by Medicare or a Medicare Advantage plan, the enrollee may be responsible for those costs. This is particularly relevant for dental or prescription drug claims, which might not be covered by Medicare.

Providers not contracted with a Medicare Advantage plan would be required to accept the Medicare reimbursement payment and are prohibited from billing the enrollee the

[58] 18. Termination of Exchange Enrollment or Coverage (§ 155.430)
[59] 18. Termination of Exchange Enrollment or Coverage (§ 155.430)
[60] 18. Termination of Exchange Enrollment or Coverage (§ 155.430)
[61] 18. Termination of Exchange Enrollment or Coverage (§ 155.430)
[62] 18. Termination of Exchange Enrollment or Coverage (§ 155.430)

difference. Claims during the retroactive period would be ineligible for independent disputer resolution under the No Suprises Act.

Issuers may be entitled to recoup claims for a retroactive QHP termination, although HHS acknowledges it may be difficult for issuers to recoup payment and that HHS will not reimburse issuers.[63]

Consumer education is paramount to this decision and will be addressed in future guidance.

Risk Adjustment

No changes were made to the State payment transfer formula finalized in the 2021 Payment Notice for the 2022 benefit year.[64]

The risk adjustment rate is set at $0.18 PMPM for the 2025 Benefit Year.[65] This was reduced from the proposed rate, due to updated enrollment projections.

The high-cost risk pool parameters for the 2025 benefit year will remain at the $1 million attachment point and 60 percent coinsurance rate.[66]

HHS can request issuers complete a corrective action plan as a result of certain risk adjustment (including high-cost risk pool) audit results, within 45 days of the final audit report being issued.[67] The requirements evaluated in the audit are not changing, only to requirement to provide a corrective action plan if there is evidence of non-compliance. This would begin with 2020 benefit year audits, expected to begin in 2024.

Risk Adjustment Model Calibration and Adjustments

The CSR adjustment factors for AI/AN CSR plan variants were adjusted upward, prompted by high expenditures for AI/AN plan variant enrollees than non-CSR silver enrollees.[68] No changes were made to other CSR factors. All factors will continue into future years unless specifically revised in rulemaking.

The 2025 HHS risk adjustment model will be calibrated with 2019, 2020, and 2021 enrollee-level External Data Gathering Environment (EDGE) data.[69] A pricing adjustment will continue to be made for Hepatitis C drugs in the 2025 risk adjustment model.[70]

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[63] 18. Termination of Exchange Enrollment or Coverage (§ 155.430)
[64] 3. Overview of the HHS Risk Adjustment Methodology (§ 153.320)
[65] 4. HHS Risk Adjustment User Fee for the 2025 Benefit Year
[66] c. List of Factors to be Employed in the HHS Risk Adjustment Models (§ 153.320)
[67] 5. Audits and Compliance Reviews of Risk Adjustment Covered Plans (§ 153.620(c))
[68] d. Cost-Sharing Reduction Adjustments
[69] a. Data for HHS Risk Adjustment Model Recalibration for the 2025 Benefit Year
[70] b. Pricing Adjustment for the Hepatitis C Drugs

The HHS Risk Adjustment model factors for the 2025 benefit year were finalized as proposed.[71] No adjustments were made for the introduction of new high-cost drugs, specifically referencing sickle cell gene therapy. This will be studied going forward as new data becomes available. Discussion was also included regarding adjustments for pre-exposure prophylaxis (PrEP), Tepezza, glucagon-like peptide (GLP-1) drugs, and behavioral health Hierarchical condition category (HCC) for autism, although no additional adjustments were included.

The R-squared statistics for the final 2025 benefit year HHS risk adjustment models were published.[72]

Catastrophic Plans

Exchanges (where permitted by State[73]) are expected to re-enroll individuals enrolled in catastrophic plans but who lose catastrophic eligibility into the following unless a State Exchange receive approval for a separate hierarchy.[74]

1. A bronze metal level QHP in the same product, or if not available
2. A bronze metal level QHP in most similar product with the most similar network, or if not available,
3. A QHP with the lowest coverage level in most similar product with the most similar network

State Exchange open enrollment period must continue uninterrupted for at least 11 weeks, and begin November 1 prior to the benefit year and ending no later than January 15 of the benefit year.[75] To minimize disruption for some State Exchanges, any State Exchange that held an open enrollment that began before November 1, 2023, and ended before January 15, 2024, for the 2024 benefit year will be given grandfathered status and can continue in consecutive future benefit years so long as the period is at least 11 weeks long. HHS indicated "Currently, all Exchanges except one, including 18 State Exchanges, begin their annual open enrollment periods on November 1 of the calendar year preceding the benefit year…"

Enrollees in metal plans (Platinum, Gold, Silver, Bronze) would not be auto re-enrolled into catastrophic coverage.[76]

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[71] c. List of Factors to be Employed in the HHS Risk Adjustment Models (§ 153.320)

[72] e. Model Performance Statistics

[73] Connecticut does not permit auto re-enrolling catastrophic coverage enrollees losing eligibility for catastrophic coverage

[74] 14. Incorporation of Catastrophic Coverage into the Auto Re-enrollment Hierarchy (§ 155.335(j))

[75] 16. Initial and Annual Open Enrollment Periods (§ 155.410)

[76] 14. Incorporation of Catastrophic Coverage into the Auto Re-enrollment Hierarchy (§ 155.335(j))

Special Enrollment Periods

A monthly Special Enrollment Period (SEP) for individuals with incomes at or below 150% of the Federal Poverty Level (FPL) will now be made permanent. Previously, this SEP was available for individuals at or below 150% FPL only when the taxpayer's applicable percentage was 0%, which was due to the American Rescue Plan's enhanced subsidies.

Beginning for plan year 2025, Exchanges must require coverage begin the first day of the month following plan selection for a qualifying individual enrolling in a QHP during a special enrollment period (SEP).[77]

Other

Virtual meetings (considered telephonic, digital, and/or web-based) and hybrid meetings (a combination of virtual and in-person) can be used to satisfy Section 1332 required public hearings requirements, outside of emergent circumstances.[78] Two separate hearings are still required, and States must have a process to request in-person meetings.

States are given two new options for setting the effective date of enrollment for a Basic Health Program (BHP), (1) first day of the month following the month BHP eligibility is determined or (2) request HHS approval for their effective date, so long as it is no later than the first day of the second month following the month BHP eligibility is determined.[79] States still have the option to follow a Medicaid[80] or an Exchange standard process.[81] As of the final rule, only Minnesota is implementing a BHP, while Oregon has submitted a blueprint with a July 1, 2024 implementation date.

The proposal regarding greater flexibility to adopt income and/or resource disregards in determining financial eligibility was not finalized.[82] The “reasonable extension” that is afforded to binder payment deadlines, due to issuer billing or enrollment problems due to high volume or technical errors, is extended to other premium payment deadlines.[83]

[77] 17. Special Enrollment Periods
[78] A. 31 CFR Part 33 and 45 CFR Part 155—Section 1332 Waivers
[79] 2. Changes to the Basic Health Program Regulations (42 CFR 600.320)
[80] at 42 CFR 435.915 exclusive of 42 CFR 435.915(a)
[81] at 45 CFR 155.420(b)(1)
[82] 1. Increase State Flexibility in the Use of Income and Resource Disregards for Non-MAGI Populations (42 CFR 435.601)
[83] 15. Premium Payment Deadline Extensions (§ 155.400(e)(2))