WHITE PAPER

# SUMMARY OF PROVISIONS OF HHS' PROPOSED 2025 NOTICE OF BENEFIT AND PAYMENT PARAMETERS AND OTHER KEY REGULATIONS

**Michael Cohen**, PhD
202.568.0633 • michael.cohen@wakely.com
**Luke Brehmer,** FSA, MAAA
612.800.6584 • luke.brehmer@wakely.com

*On November 15, 2023, the Department of Health and Human Services (HHS) released the proposed Notice of Benefit and Payment Parameters (Payment Notice) for 2025.[1] The notice includes important proposed rules and parameters for the operation of the individual and small group health insurance markets in 2025 and beyond. This paper summarizes key provisions of the proposed notice, actuarial value calculator[2], and maximum out of pocket information[3] recently released by HHS. Comments are due within 45 days of publishing in the Federal Register.*

## Overview

The following highlights the key changes included in the 2025 proposed Payment Notice. More information on these and other proposed changes follow.

1. **User Fees:** HHS proposes to keep user fees at 2.2% for issuers in the Federally-facilitated Exchange (FFE) and 1.8% for issuers in state-based Marketplaces operated by HHS (SBE-FPs).

2. **Essential Health Benefit Changes:** HHS proposes to expand what can be classified as essential health benefits (EHBs). HHS also proposes to make the process by which states can select the EHB benchmark plan easier.

3. **Enrollment Verification Changes and Enrollment Periods:** HHS proposes several policies to create federal minimum requirements for all Marketplaces in regard to verification standards and special enrollment periods (SEPs). This includes aligning SEP start dates with the first of the month following a selection, setting minimum standards for Open Enrollment start and end dates, and making changes to incarceration verification and failure to reconcile tax verification standards. HHS also proposes to expand the SEP for individuals at or below 150% of the federal poverty level.

4. **Standard Plans:** HHS proposes to continue to require issuers operating on the Healthcare.gov platform to offer standard plans. Standardized options would be required for every network type,

[1] Department of Health and Human Services, "Proposed Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2025", https://www.cms.gov/files/document/cms-9895-p-patient-protection-final.pdf

[2] Draft calculator and the methodology can be accessed here https://www.cms.gov/cciio/resources/regulations-and-guidance/#plan-management

[3] https://www.cms.gov/files/document/2025-papi-parameters-guidance-2023-11-15.pdf

metal, and throughout every service area where an issuer offers a non-standardized product on-Exchange. HHS also proposes an exception process to allow more non-standard plans for issuers on the Healthcare.gov platform. The number of non-standard plans allowed in 2025 is scheduled to decrease compared to 2024.

5. **Network Adequacy Requirements:** HHS proposes to establish a national floor of network adequacy standards and reviews. This would increase the network adequacy standards for issuers in Marketplaces where states operate plan management functions - state-based Marketplaces (SBMs) and federal partnership Marketplaces (SBM-FP). The proposals include requirements to apply quantitative distance and wait time standards in all Marketplaces.
6. **Risk Adjustment:** HHS proposes several updates to the risk adjustment model. This includes updates to the data used to recalibrate the model, the risk adjustment coefficients, and the risk adjustment user fee. It also proposes changes to the cost-sharing reduction (CSR) adjustment factor for American Indian/Alaskan Natives that are enrolled in limited and no cost-sharing CSR variants.
7. **State Marketplace Standards:** HHS proposes to apply a number of operational requirements on SBMs such as operating an enrollment and eligibility platform and live center. HHS also proposes to apply Healthcare.gov standards for online brokers and direct enrollment entities to all Marketplaces.
8. **Maximum Out of Pocket:** The maximum out of pocket decreased 2.6% to $9,200 for an individual.
9. **Actuarial Value Calculator:** While not part of the Payment Notice, HHS proposes changes to the Actuarial Value Calculator, namely using updated data and trending it forward to 2025, which will impact some actuarial values.

The following provides more detail on each of the items summarized above.

## User Fees

HHS proposes to maintain the same level of user fees in 2025 compared to 2024 for issuers in states that utilize Healthcare.Gov. In particular, HHS proposes charging issuers in FFE states 2.2% and charging 1.8% in SBE-FP states.

## Essential Health Benefit Changes

HHS proposes a number of key changes to regulations involving EHBs, both in terms of what is classified as EHB as well as how states can amend their benchmark plan. The proposed new process for updating a EHB benchmark plan would be effective for the 2027 plan year.

### EHB Standards

HHS proposes for prescription drugs in excess of those covered by a state's EHB-benchmark plan to be considered EHB. Secondly, they propose removing the prohibition on allowing routine adult non-dental care from being an EHB. Finally, they raised the potential for changing the drug classification system. Currently issuers must have at least one drug in every category and class under the United State

Pharmacopeia Medicare Model Guidelines (USP MMG). HHS is considering shifting to the USP Drug Classification system (USP DC). USP DC is updated more regularly than USP MMG as well as it potentially includes more expansive drug categories for chronic conditions like obesity. HHS requests comments on the potential financial effects of shifting to the USP DC system.

### Amending the EHB-Benchmark

Secondly, HHS proposes a number of changes that would simplify the process and make it easier to amend a state's EHB-benchmark plan. In particular, states only need to propose a plan whose benefits are higher than the lowest typical employer plan in the state and lower than the highest typical employer plan in the state. This is in contrast to the current typicality and generosity requirements, which are often labor intensive to meet. Additionally, if the proposed rule is finalized as is, state mandated benefits that are covered by EHB benchmark plan no longer need to be defrayed (states must cover the costs for state mandated benefits enacted after December 31, 2011). The rule notes that would not only affect future decisions but could change some defrayals currently occurring due to this circumstance. Finally, HHS proposes that changes to individual/small group market EHB-benchmarks would also apply to Medicaid Alternative Benefit Plans or Basic Health Program standard health plans.

## Eligibility and Enrollment Changes

HHS proposes a number of changes to make it easier for individuals to enroll, both in states in which HHS operates a Marketplace and for state-based Marketplaces. The proposed changes would:

- Require all Marketplaces, including State-based Marketplaces, to have the effective date to receive coverage during a special enrollment period (SEP) to be the first day of the month after the consumer selects a qualified health plan (QHP).
- Require all Marketplaces to accept consumer attestation of incarceration status for purposes of being granted an SEP.
- Require all Marketplaces to check failure to reconcile (FTR) status annually and send reminders to those found to have a FTR issue that would prevent them from being eligible for premium tax credits.
- Remove the limitation that the SEP for individuals under 150% FPL be available only for those individuals with no net premium. This would expand the availability of this SEP to times in which in enhanced subsidies (i.e., due to the Inflation Reduction Act) are not in effect. HHS estimates that this is expected to increase premiums in the future.

## Standard Plans and Limitations on Non-Standard Plans

### Standard Plan Options (SPOs)

HHS proposes to continue requiring 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 Marketplaces. 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 for which the issuer offers a non-standardized product. 2025 SPOs are intended to remain consistent with 2024 SPOs, with minor differences. The exact plan designs can be found in the Notice of Benefit and Payment Parameters (table 12 and 13).

### Non-Standard Plan Limitations

As finalized in the 2024 Payment Notice, for issuers operating on the Healthcare.gov platform, HHS will limit the number of non-standard plans for the 2025 benefit year. Issuers can offer two non-standard plans per product network, metal level, and inclusion of dental/vision coverage in 2025, down from four in 2024. For the 2025 benefit year, HHS is proposing an exception process that would allow issuers to offer a greater number of non-standard plans if these additional plans have reduced cost-sharing of 25% or more on benefits that interact with chronic or high-cost conditions relative to their other non-standardized plan offerings in the same product, network, service area, etc.

## Network Adequacy Requirements

HHS proposes to expand network adequacy requirements, currently in place for federally-facilitated Marketplaces (FFMs), to SBMs and SBM-FPs. For Marketplaces in which states are the primary reviewer, issuers would no longer be allowed to meet network adequacy standards through attestation. SBMs and SBM-FPS would further be required to meet time and distance standards for QHPs that are least as stringent as those in the FFM. As part of QHP certification, all Marketplaces would need to have quantitative network adequacy standards. HHS could take remedial actions if a State Marketplace does not meet network adequacy requirements. HHS also proposes to begin collecting data on telehealth service offerings as part of QHP certification to determine if they may create standards on this topic in the future.

## Risk Adjustment

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

### Sequestration

The risk adjustment program will be sequestered at a rate of 5.7% for funds collected during fiscal year 2024. These sequestered amounts will be available to issuers in fiscal year 2025 (i.e., there's a delay in payment for some risk adjustment payments).

### Risk Adjustment Model Recalibration & Changes

HHS proposes to recalibrate the 2025 benefit year risk adjustment models using the 2019, 2020, and 2021 enrollee-level EDGE data. HHS also proposes to continue to make an adjustment for Hepatitis C drugs to account for the introduction of new and generic Hepatitis C drugs. HHS also introduces new definitions and mapping to a few HCCs, including HCC 70, HCC 71, HCC 122, RXC03, and infant severity indicators.

One significant change proposed is to recalibrate CSR adjustment factors for American Indian (AI) and Alaskan Native (AN) zero and limited cost-sharing plans. HHS is also proposing that any changes to other CSR adjustment factors in the future would be handled via regulatory notice and comment rather than via guidance. As seen below, HHS proposes to dramatically increase the factor for these plans given their analysis of EDGE data which suggests the current coefficients underpredict liability. HHS, in its impact analysis, estimates that the proposed changes would materially increase transfers in states with a significant population in these plans such as Oklahoma, Alaska, and Montana.

| Plan AV | Current Adjustment Factors for the 2024 Benefit Year | Proposed Adjustment Factors for the 2025 Benefit Year and Beyond |
|---|---|---|
| Silver Plan Variant Recipients (and Enrollees in State wrap-around or Medicaid-expansion plans of any metal level, as applicable) | | |
| Plan Variation 94% | 1.12 | 1.12 |
| Plan Variation 87% | 1.12 | 1.12 |
| Plan Variation 73% | 1.00 | 1.00 |
| Standard Plan 70% | 1.00 | 1.00 |
| Zero Cost Sharing Plan Variant Recipients (that is, AI/AN Recipients) | | |
| Platinum (90%) | 1.00 | 1.31 |
| Gold (80%) | 1.07 | 1.39 |
| Silver (70%) | 1.12 | 1.46 |
| Bronze (60%) | 1.15 | 1.51 |
| Limited Cost Sharing Plan Variant Recipients (that is, AI/AN Recipients) | | |
| Platinum (90%) | 1.00 | 1.04 |
| Gold (80%) | 1.07 | 1.10 |
| Silver (70%) | 1.12 | 1.15 |
| Bronze (60%) | 1.15 | 1.19 |

### Risk Adjustment User Fee

HHS proposes a risk adjustment user fee of $0.20 per member per month (PMPM) for the 2025 benefit year.

### Audits and Compliance Review of Risk Adjustment Covered Plans

HHS proposes to require corrective action plans for observations identified through HHS risk adjustment audits beginning with 2020 benefit year audits, which HHS expects to begin in 2024. Currently, the completion, implementation, and submission of documentations of a correction action plan is only required if the audit results in the inclusion of a finding the final report. Under this proposal, covered plans will be required to provide a written correction action plan for any audit findings or observations with evidence of non-compliant to HHS for approval, implement the actions, and provide written documentation of actions taken back to HHS within 45 days of the issuance of the final audit report.

## State Marketplace Changes

HHS is also proposing a number of requirements on current State Marketplaces as well as Marketplaces that wish to transition to becoming state-operated in the future. The proposed changes create minimum operational requirements SBMs must meet. These changes would disallow states from operating a Marketplace in the way Georgia’s 1332 waiver envisioned it would.

### Centralized Eligibility and Enrollment Platforms

HHS proposes to require an SBM to operate a central eligibility and enrollment platform on a website. This would prevent states from only using direct enrollment to enroll individuals.

### Open Enrollment Dates

HHS proposes to require SBMs to provide an annual open enrollment that starts on November 1st and ends no earlier than January 15th. For example, Idaho's SBM has an open enrollment period beginning October 15 and ending December 15, which would need be changed if this requirement is finalized as proposed.

### National Standards for SBMs

HHS proposes a series of national standards that SBMs would be required to meet. In particular, the SBMs would be required to meet certain requirements like a live call center. Additionally, they propose to apply a minimum standard for web-broker and direct enrollment (DE) entities for all Marketplaces, regardless of if a state or the Federal government is operating it.

### Transition Period

HHS proposes to require states transitioning to an SBM from Healthcare.gov to have at least one transition year of operating plan management functioning (SBM-FP) before becoming a full SBM (operating both enrollment and plan management operations). States could no longer transition directly from a FFM state to a SBM state. Earlier this year, CMS declined to approve Georgia's transition to a SBM for plan year 2024, citing readiness concerns which included, among other reasons, that the state was proposing to transition directly from Healthcare.gov to a SBM without transitioning to a SBM-FP first.

### Approval Process

HHS proposes to increase the requirements on states applying to transition to an SBM. For example, states would be required to submit detailed plans around consumer assistance and more general operational functionality.

## Maximum Out of Pocket Updates

HHS no longer publishes maximum out-of-pocket (MOOP) amounts in the Payment Notice, but instead will finalize the values via guidance. HHS published guidance[4] finalizing the MOOP amounts for non-CSR plans[5] and cost-sharing variations for 2025. The MOOP will be **decreasing** 2.6% from the 2024 amounts of $9,450/$18,900 (single/family).

- Non-CSR Plans: $9,200/$18,400 (single/family)

[4] https://www.cms.gov/files/document/2025-papi-parameters-guidance-2023-11-15.pdf

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

- 100%-150% FPL: $3,050/$6,100 (single/family) In 2024 this amount was $3,150 so 2025 represents a decrease relative to last year.
- 150%-200% FPL: $3,050/$6,100 (single/family). Similarly, 2025 represents a decrease relative to 2024 as the 2024 level was $3,150.
- 200%-250% FPL: $7,350/$14,700 (single/family). This amount is also a decrease relative to 2024 as the 2024 level was $7,550.

The catastrophic plan's deductible and MOOP will be set to $9,200/$18,400 (single/family). This is a decrease relative to 2024 when it was set at $9,450.

## The 2024 Actuarial Value Calculator (AVC)

In a separate release, HHS proposes to update the 2025 AVC relative to the 2024 version.[6] The draft calculator claims data is based on 2021 EDGE data. The 2024 AVC was based on claims data from the Health Intelligence Company (HIC), LLC database for calendar year 2018. The 2025 AVC is the first time the methodology includes EDGE data rather than HIC data. The 2021 EDGE data was trended forward from 2021 to 2025 with differential rates for medical and prescription drug spending. Trends were set to align with data collected from the Unified Rate Review Templates. Additionally, HHS proposes to update the AVC to include all current preventative care codes recommended by the US Preventative Services Task Force, Advisory Committee on Immunization, and Health Resources and Services Administration, including COVID-19 vaccines. The totality of changes of the 2025 AVC, relative to the 2024 AVC can have a material effect on actuarial values. Wakely intends to produce a follow-up report on this issue.

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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

**Luke Brehmer,** FSA, MAAA

612.800.6584 • luke.brehmer@wakely.com

[6] https://www.cms.gov/files/document/draft-2025-avc-methodology-508.pdf

## OUR STORY

**Five decades.** Wakely began in 1969 and eventually evolved into several successful divisions. In 1999, the actuarial arm became the current-day Wakely Consulting Group, LLC, which specializes in providing actuarial expertise in the healthcare industry. Today, there are few healthcare topics our actuaries cannot tackle.

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