
Issue Brief

FEDERAL ISSUE BRIEF



Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

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CMS Issues Final Rule of Benefit and Payment Parameters for 2026

This final rule includes payment parameters and provisions related to the HHS operated risk adjustment and risk adjustment data validation (HHS-RADV) programs, as well as 2026 benefit year user fee rates for issuers that participate in the HHS-operated risk adjustment program and the 2026 benefit year user fee rates for issuers offering qualified health plans (QHPs) through Federally facilitated Exchanges (FfEs) and State-based Exchanges on the Federal platform (SBE-FPs).

The rule also includes requirements related to modifications to the calculation of the Basic Health Program (BHP) payment; and changes to the Initial Validation Audit (IVA) sampling approach and Second Validation Audit (SVA) pairwise means test for HHS-RADV. It also addresses HHS' authority to engage in compliance reviews of and take enforcement action against lead agents of insurance agencies for violations of HHS' Exchange standards and requirements; HHS' system suspension authority to address noncompliance by agents and brokers; an optional fixed-dollar premium payment threshold; permissible plan-level adjustment to the index rate to account for cost-sharing reductions (CSRs); reconsideration standards for certification denials; changes to the approach for conducting Essential Community Provider (ECP) certification reviews; a policy to publicly share aggregated, summary-level Quality Improvement Strategy (QIS) information on an annual basis; and revisions to the medical loss ratio (MLR) reporting and rebate requirements for qualifying issuers that meet certain standards.

The rule is effective January 15, 2025. The document is scheduled to be published in the **Federal Register** on January 15, 2025 and a display version is currently available at: <https://federalregister.gov/d/2025-00640>.

Comment

Many of the items being finalized are as proposed. CMS uses "after consideration" to identify most of its final actions in addressing comments and responses. These areas, however, are not emphasized. It would be very helpful if CMS would state at the beginning of each section discussed its final actions with regard to the material being addressed.

Nonetheless, section II B of the rule is very helpful in concisely summarizing and understanding changes being made.

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Summary of Major Provisions (Page 25)

The regulations outlined in the final rule are codified in 42 CFR part 600 and 45 CFR parts 153, 155, 156, and 158.

1. 42 CFR Part 600

CMS is finalizing changes to the methodology regarding the premium adjustment factor (PAF), which is used to calculate the adjusted reference premium (ARP) for Basic Health Program (BHP) payment. CMS is finalizing maintaining the PAF value at 1.188 for States that have fully implemented BHP and are using Second Lowest Cost Silver Plan (SLCSP) premiums from a year in which BHP was fully implemented. As previously clarified, for States in their first year of implementing BHP and choosing to use prior year SLCSP premiums to determine BHP payment, the PAF value will be set to 1.00. CMS is finalizing that if a State is using SLCSP premiums from a year in which BHP was not fully implemented, the PAF is calculated by determining the cost sharing reduction (CSR) adjustment that qualified health plans (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. Additionally, CMS is finalizing a technical clarification for BHP payment rates in cases of multiple SLCSP premiums in an area.

2. 45 CFR Part 153

The HHS-operated risk adjustment program will sequester payments made from fiscal year 2025 resources (that is, funds collected during the 2025 fiscal year) at a rate of 5.7 percent.

CMS is finalizing a risk adjustment user fee for the 2026 benefit year of \$0.20 per member per month (PMPM).

Beginning with the 2025 benefit year of HHS-RADV, CMS is finalizing its proposals to exclude enrollees without hierarchical condition categories (HCCs), which includes adult enrollees with only prescription drug categories (RXC), from the IVA sample, remove the Finite Population Correction (FPC) from the IVA sampling methodology, and replace the source of the Neyman allocation data used for HHS-RADV sampling with the most recent 3 consecutive years of HHS-RADV data. In addition, beginning with the 2024 benefit year of HHS-RADV, CMS is finalizing the proposals to modify the SVA pairwise means test, which tests for statistically significant differences between the IVA and SVA results, to use a bootstrapped 90 percent confidence interval methodology and to increase the initial SVA subsample size from 12 enrollees to 24 enrollees.

3. 45 CFR Part 155

CMS is finalizing revisions at § 155.220(k)(3) to reflect its authority to suspend an agent's or broker's ability to transact information with the Exchange in instances where HHS discovers circumstances that pose unacceptable risk to accuracy of Exchange eligibility determinations, Exchange operations, applicants, or enrollees, or Exchange information technology systems, including but not limited to risk related to noncompliance with the standards of conduct under § 155.220(j)(2)(i), (ii) or (iii) and the privacy and security standards under § 155.260, until the circumstances of the incident, breach, or noncompliance are remedied or sufficiently mitigated to HHS' satisfaction.

CMS is finalizing, in connection with the failure to file and reconcile process at § 155.305(f)(4), that Exchanges are required to send notices to tax filers or their enrollees for the second year in which they have been determined to have failed to reconcile advance payments of the premium tax credit (APTC) explaining that they risk being determined ineligible for APTC.

CMS is finalizing the addition of § 155.400(d)(1) to codify HHS' guidance that requires that, within 60 calendar days after a State Exchange receives a data inaccuracy from an issuer operating in an State Exchange that includes a description of an inaccuracy that meets the requirements at § 156.1210(a) through (c) and all the information that the State Exchange requires or requests to properly assess the inaccuracy, State Exchanges must review and resolve the State Exchange issuer's enrollment data inaccuracies and submit to HHS a description of the resolution of any inaccuracies described by the State Exchange issuer that the State Exchange confirms to be inaccuracies in a format and manner specified by HHS.

CMS is finalizing a provision at § 155.400(g) to allow issuers to adopt a fixed-dollar payment threshold of \$10 or less, to be adjusted for inflation by annual agency guidance, under which issuers would not be required to trigger a grace period or terminate enrollment for enrollees who fail to pay the full amount of their portion of premium owed, provided they do not owe more than the threshold amount. CMS is also finalizing a provision allowing issuers to adopt a gross percentage-based premium threshold of 98 percent or higher, which similarly would not require issuers to trigger a grace period or terminate enrollment for enrollees who fail to pay the full amount of their portion of premium owed, provided they do not owe more than the threshold amount. In addition, CMS is finalizing a provision that permits issuers to set the premium payment threshold based on net premium owed by the enrollee at 95 percent or higher of the net premium, rather than providing for a "reasonable" standard as is currently set forth in regulation.

Further, CMS is finalizing a policy limiting application of the fixed-dollar payment threshold and gross premium percentage-based threshold to premium payments after coverage is effectuated. Issuers will be allowed to apply the fixed-dollar payment threshold and/or one of two percentage-based thresholds (but not both percentage-based thresholds). Issuers will be required to apply all chosen premium payment thresholds uniformly to all enrollees and without regard to their health status.

4. 45 CFR Part 156

CMS is finalizing 2026 the benefit year FFE and SBE-FP user fee rates of 2.5 percent and 2.0 percent of total monthly premiums, respectively. CMS is also finalizing alternative 2026 benefit year FFE and SBE-FP user fee rates of 2.2 percent and 1.8 percent of total monthly premiums, respectively, if enhanced PTC subsidies at the level currently enacted or at a higher level, are extended through the 2026 benefit year by July 31, 2025.

CMS is finalizing amendments to § 156.80(d)(2)(i) to affirm that CSR loading practices that are permitted by State regulators are permissible under Federal law to the extent that they are actuarially justified and provided the issuer does not otherwise receive reimbursement for such CSR amounts.

CMS is finalizing changes to the method for updating the AV Calculator, starting with the 2026 AV Calculator. Under this approach, for a plan year, CMS will only release a single, final version of the AV Calculator.

CMS is finalizing minor updates to the standardized plan option designs for PY 2026 to ensure these plans continue to have AVs 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. In response to comments requesting the expanded bronze metal level designs revert to the 50 percent coinsurance rate used in previous years, CMS has revised this plan design to maintain this consistency, instead of raising it to 60 percent for PY 2026, as proposed. CMS made several additional modifications to both sets of plan designs at the expanded bronze metal.

CMS is finalizing amendments at § 156.201 to require issuers that offer multiple standardized plan options within the same product network type, metal level, and service area to meaningfully differentiate these plans from one another in terms of included benefits, provider networks, included prescription drugs, or a combination of some or all these factors.

CMS is finalizing amendments at § 156.202(b) and (d) to properly reflect the flexibility that issuers have been operationally permitted since these requirements were introduced to vary the inclusion of the distinct adult dental benefit coverage, pediatric dental benefit coverage, and adult vision benefit coverage categories under the non-standardized plan option limit in accordance with § 156.202(c)(1) through (3).

CMS is finalizing conducting ECP certification reviews of plans for which issuers submit QHP certification applications in FFEs in States performing plan management functions, beginning in PY 2026.

CMS is finalizing the proposal to share aggregated, summary-level QIS information publicly on an annual basis beginning on January 1, 2026, with information QHP issuers submit during the PY 2025 QHP Application Period.

CMS is finalizing an amendment to § 156.1220(a) to introduce a new materiality threshold for HHS-RADV appeals, such that CMS will rerun HHS-RADV results and adjust HHSRADV adjustments to State transfers in response to a successful appeal when the impact of that appeal to the filer's HHS-RADV adjustments to State transfers is greater than or equal to \$10,000.

5. 45 CFR Part 158

CMS is finalizing amendments to § 158.140(b)(4)(ii) to allow qualifying issuers to not adjust incurred claims by the net payments or receipts related to the risk adjustment program for Medical Loss Ratios (MLR) reporting and rebate calculation purposes beginning with the 2026 MLR reporting year (reports due in 2027), with certain modifications. Specifically, CMS is finalizing that at the option of 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.

CMS is also finalizing an amendment to § 158.103 to add a definition of "qualifying issuer," with certain clarifications.

CMS is finalizing amendments to § 158.240(c) to add an illustrative example of how qualifying issuers that opt to apply risk adjustment transfer amounts as described in § 158.140(b)(4)(ii) will calculate the amount of rebate owed to each enrollee to accurately reflect how such issuers will incorporate the net risk adjustment transfer amounts into the MLR and rebate calculations differently from other issuers, as well as a conforming amendment to clarify that the current illustrative example in paragraph (c)(2) will apply to issuers that are not qualifying issuers and to qualifying issuers that do not opt to apply risk adjustment transfer amounts as described in § 158.140(b)(4)(ii).