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New Standards for Plans, Networks in Exchange Marketplace for 2023

Changes to plan offerings, new network adequacy standards, including for essential community providers, and tightening up the medical loss ratio calculation are all part of a final rule issued by the federal Department of Health and Human Services (HHS).

Standard Plan Offerings

The new rule requires that if an insurer offers a plan in any of the metal tiers—bronze, silver, gold or platinum—they must also offer a standardized version of the plan in that tier as well. The standard plan deductible, copayments and maximum out-of-pocket costs are set by HHS in the rule. According to HHS, this change is intended to make it easier for consumers to simplify the deductibles and cost sharing so consumers can more easily compare across insurers based on premium, provider networks and plan quality.

Features of the standardized plans designed by HHS included in the rule are:

- Bronze: a $9,100 deductible after which all covered services are available without any additional cost-sharing;
- Silver (without tax credits applied): a $5,800 deductible with $8,900 limit on cost sharing;
- Silver plan for someone who receives the highest amount of tax credits: $0 deductible and $1,700 limit on cost sharing;
- Gold: $2,000 deductible and $8,700 limit on cost sharing; and
- Platinum: $0 deductible and $3,000 limit on cost sharing.

Network Adequacy

The final rule includes provisions intended to strengthen oversight of the adequacy of insurer networks.

Beginning with the 2023 plan year, HHS indicates it will resume its own evaluation of network adequacy for qualified health plans offered in states like Wisconsin that use the federally facilitated exchanges. HHS indicates that it will not conduct its own evaluation only in states that perform plan management functions and want to conduct their own pre-market network adequacy reviews as long as the review includes an actual review of provider networks—not merely accepting an insurer's attestation that they meet the standards.

The standards including quantitative time and distance requirements for 2023, which will be calculated at the county level. The list of time and distance standards and applicable provider types was published separately.

HHS indicates it will include appointment wait times in 2024 for behavioral health services, routine primary care, and non-urgent specialty care. Under these standards, enrollees would have to be able to secure an appointment with an in-network provider within 10 business days for behavioral health, 15 business days for routine primary care and 30 business days for non-urgent specialty care.

With respect to essential community providers (ECPs), the final rule increases the percentage of available ECPs within the plan's service area that must be contracted in the insurer's network from 20% to 35%. Further, the rule specifies that ECPs must be contracted in the network tier that results in the lowest cost-sharing obligation for the plan's enrollees in order for the ECP to count toward the insurer's satisfaction of this requirement.

Medical Loss Ratio

The Affordable Care Act established a medical loss ratio (MLR) for health insurers. Insurers in the individual and small group markets must spend at least 80% of their premium revenues on clinical care and quality improvements, and for the large group market the MLR is 85%. Insurers must provide rebates to enrollees if they do not meet the MLR requirements. Over the years, there have been various policy adjustments intended to clarify the appropriate costs that can count as clinic care and quality for purposes of the medical loss ratio. In this final rule, HHS again seeks to clarify the types of expenses that insurers can include.

In the proposed rule, HHS expresses its concern that MLRs are inflated. In the proposed rule, HHS gives examples of indirect expenses that they believe should not be counted as a quality improvement activity, such as “office space (including rent or depreciation, facility maintenance, janitorial, utilities, property taxes, insurance, wall art), human resources, salaries of counsel and executives, computer and telephone usage, travel and entertainment, company parties and retreats, IT systems, and marketing of issuers’ products.” In the final rule, HHS estimates modifying these provisions to specify that only expenditures directly related to activities that improve health care quality may be included will increase rebates or reduce premiums by about $49.8 million per year.

The provisions included in the final rule will be effective for the 2023 benefit plan year. Open enrollment for 2023 is set to begin Nov. 1.