CMS 2024 Notice of Benefit & Payment Proposal

Insurers Dislike Limits on Plan Options, Network Adequacy Requirements

- **CMS released the Exchange/ Marketplace (for 2024) proposed rules yesterday afternoon.** The rules enhance access to healthcare services like behavioral & dental health, simplify choice, improve plan selection process for beneficiaries, and make it easier to enroll in coverage, particularly from Medicaid as redeterminations ensue in 2023-24.

- **Health plans (CNC, UNH, MOH, ELV, others) are irked that CMS proposes a limit on non-standardized plans on Exchanges.** The number of non-standardized plan options that issuers of QHPs can offer through Marketplaces on the Federal platform (including SBM-FPs) is limited to two non-standardized plan options per product network type and metal level (excluding catastrophic plans), in any service area, for 2024 and beyond, as a condition of QHP certification. This aims to help patients avoid choice overload when comparing plans.

    - An alternative proposal is to apply a meaningful difference standard in place of these limits for plan year 2024. CMS proposes grouping plans by issuer ID, county, metal level, product network type, and deductible integration type, and then evaluating whether plans within each group are "meaningfully different" based on differences in deductible amounts. In this approach, two plans would need to have deductibles that differ by more than $1,000 to satisfy the new proposed meaningful difference standard.
    - The average number of plans available to consumers on the Marketplace has increased from 26 in 2019 to 113 in 2023. "Having too many plans to choose from can limit consumers' ability to make a meaningful selection when comparing plan offerings," according to CMS.

- **Mental health and substance abuse access is added to QHP's community provider requirements.** To further HHS' goal of expanding access to behavioral health care, the rule proposes to add Substance Abuse Treatment Centers and Mental Health Facilities to the list of essential community provider (ECP) categories. Plans must cover 35% of available providers to two new categories: (1) Federally Qualified Health Centers and (2) Family Planning Providers.

- **Network adequacy requirements and essential community provider standards are boosted, which is a slight negative for plans.** Individual market qualified health plans (QHPs), including stand-alone dental plans (SADPs) and all Small Business Health Option Program (SHOP) plans across all Marketplace-types must use a network of providers that complies with the network adequacy and ECP standards, and to remove the exception that these sections do not apply to plans that do not use a provider network. Requiring all QHPs to use a provider network would better ensure consumer access and would guarantee access to in-network providers.

- **NEW Marketplace five-month special enrollment period (SEP) for those being reverified off Medicaid (CNC, MOH, UNH)**. The proposed rule would give the Marketplaces the option to implement a new rule for the special enrollment period for people losing Medicaid or Children's Health Insurance Program (CHIP) coverage. This would mean that consumers would have 60 days before, or 90 days after, their loss of Medicaid or CHIP coverage to select a Marketplace plan. CMS believes that this new rule would help mitigate coverage gaps when losing Medicaid or CHIP.

- **CMS adds Marketing guidelines, partially in response to the abuses with third parties in Medicare Advantage (MA) program.** QHP and variant plan marketing names are required to (1) include correct information, (2) do not omit material facts, and (3) do not include misleading content.

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CMS would have to collaborate with state partners to review QHP and plan variant marketing names during the annual QHP certification process.

- **CMS puts up guardrails to protect consumers from Marketing abuses.** The rule (1) proposes to require agents, brokers, and web-brokers to provide correct consumer information and document consumer consent, and retain it for 10 years to be produced in case of HHS request, (2) require federal exchanges to accept an applicant's or enrollee's attestation of projected annual household income when IRS data is not available and (3) determine the applicant or enrollee eligible for advance premium tax credit or cost-sharing reductions in accordance with the applicant's or enrollee's attested projected household income. With the new 2-year FTR proposal, if those enrollees that ended their QHP coverage after losing APTC were given another year of APTC eligibility to come into compliance with the requirement to file and reconcile, we estimate that about 102,000 enrollees would have retained coverage with APTC for another coverage year. Expenditures would be increased by $373 M per year beginning in benefit year 2024.

- **Advancing health equity by allowing Navigators to go door-to-door.** Assisters or "navigators" would be able to go door-to-door or use unsolicited means of direct contact to help provide consumers with enrollment assistance. The proposal would also apply to non-Navigator assistance personnel in FFEs and in State Exchanges. Currently, assisters are permitted to go door-to-door to engage in outreach and education activities, but not conduct enrollment assistance.

- **Risk adjustment (RA) program.** For the 2024 benefit year models, CMS proposes to use the 2018, 2019, and 2020 enrollee-level data for model recalibration. One exception would be that for adult models' age-sex coefficients, CMS proposes to blend only the 2018 and 2019 enrollee-level data and to exclude 2020. A market pricing adjustment to the plan liability associated with Hepatitis C drugs in the risk adjustment models for the 2024 benefit year would be applied. A risk adjustment "user fee" for the 2024 benefit year of $0.21 per member per month would be applied. Lastly, states would no longer be able to request a reduction in risk adjustment state transfers starting with the 2025 benefit year. This is estimated to cost approximately $60 M in benefit year 2024. This total cost remains stable with the approximately $60 M estimated for 2023.

- **Recall MA RADV final rules are due in Jan/Feb 2023.** CMS proposes changes to RADV audits (for Marketplace plans).
  - Change the materiality threshold for random and targeted sampling from $15 M in total annual premiums statewide to 30,000 total billable member months statewide.
  - Beginning with the 2021 benefit year, would no longer exempt exiting issuers from adjustments to risk scores and risk adjustment transfers when they are negative error rate outliers in the relevant benefit year's RADV results.
  - CMS is looking for comments on discontinuing the use of the lifelong permanent condition list and the use of Non-EDGE Claims.

- **NEXT UP: This is a proposal for 2024, and we expect modifications between now and final.** We will keep watch for the CMS final rule in the new year or early spring 2023. We are also looking out for MA 2024 rates, and RADV rules (1Q23). The MA & Part D technical rule should be released in the next couple of days.

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