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Back to the Future: 2023 Payment Rule Would Revert Nondiscrimination and Guaranteed Availability Provisions to Pre-Trump Forms, Returns Standardized Plan Options

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Today HHS published the Notice of Benefit and Payment Parameters for 2023 proposed rule in the Federal Register. The annual rulemaking details changes to qualified health plans ("QHPs"), QHP issuers, and the ACA's exchanges including:

- Guaranteed Availability
- Nondiscrimination Based on Sexual Orientation and Gender Identity
- Nondiscrimination in Benefit Designs
- Risk Adjustment
- Network Adequacy
- Medical Loss Ratio
- Standardized Plan Options

Some of the proposed changes are intended to advance health equity, consistent with the Biden Administration's Inauguration Day Executive Order. HHS published a Fact Sheet and other resources on December 28, 2021. Comments on the proposed rule are due by January 27, 2022. We touch on a few of the proposals below.

Nondiscrimination

The 2023 NBPP proposed rule would amend 45 C.F.R. § 147.104(e) to explicitly prohibit discrimination on the basis of sexual orientation and gender identity, as had been the case prior to 2020. The rule would prohibit health insurance issuers, their officers, employees, agents, and representatives from:

employing marketing practices or benefit designs that would have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on race, color, national origin, present or predicted disability, age, sex, sexual orientation, gender identity, expected length of life, degree of medical dependency, quality of life, or other health conditions.

The proposed rule explains that the statutory basis for this is independent from ACA Section 1557. Instead, the proposed rule cites ACA Section 1311(c)(1)(A), regarding QHP issuer certification requirements, and ACA Section 1321(a), regarding authority to establish and operate exchanges and the offering of QHPs through such exchanges, as the authorities for amending § 147.104(e) and parallel changes to §§ 155.120(c), 155.220(j), 156.125(b), 156.200(e), and 156.1230(b). This is an important point given the litigation over the scope of Section 1557. The Biden Administration is expected to issue a proposed rule on Section 1557 in April 2022.

The proposed rule also would clarify the nondiscrimination policy for benefit design under 45 C.F.R. § 156.125. As currently drafted, if an issuer's benefit design or its implementation "discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions" then the issuer does not provide an essential health benefit ("EHB"). Similarly, an EHB benchmark plan is prohibited from including discriminatory benefit designs. Industry and stakeholders have struggled to interpret this language. The 2016 Payment Rule provided examples of dubious practices and the 2017 Payment Rule indicated HHS would consider offering more guidance "in the future." The future is now. HHS explains that:

> a nondiscriminatory benefit design that provides EHB is one that is clinically based, that incorporates evidence-based guidelines into coverage and programmatic decisions and relies on current and relevant peer-reviewed medical journal article(s), practice guidelines, recommendations from reputable governing bodies, or similar sources.

The rulemaking lists examples of appropriate and inappropriate sources for evidence and explains the bases for relying on or disregarding such sources. HHS has requested comments on whether to further define the types of acceptable clinical evidence.

Additionally, HHS identifies a non-exhaustive list of presumptively discriminatory benefit designs. Such examples include:

- Limiting hearing aid coverage based on age;
- Autism spectrum disorder coverage limitations based on age;
- Age limits for infertility treatment coverage when treatment is clinically effective for the age group;
- Limiting foot care coverage based on diagnosis (such as diabetes); and
- Limiting coverage for gender-affirming care.

The rulemaking also would address prescription drug benefit tiering as a potentially discriminatory benefit design. HHS's position is that cost alone is an insufficient justification for a discriminatory benefit design. Instead, the prescription drug benefit design must use clinically based, neutral principles applied consistently across types of drugs, especially for drugs in the same class.

Guaranteed Availability

The proposed rule would "reinterpret" guaranteed availability to require insurers to provide coverage to individuals even if they owe past-due premiums to the issuer (or an issuer in the same control group). The proposed rule would redesignate 45 C.F.R. § 147.104(i) as § 147.104(j) and add a new (i) explaining that:

> a health insurance issuer that denies coverage to an individual or employer due to the individual's or employer's failure to pay premium owed under a prior policy, certificate, or contract of insurance, including by attributing payment of premium for a new policy, certificate, or contract of insurance to the prior policy, certificate, or contract of insurance violates guaranteed availability as required by 45 C.F.R. § 147.104(a).

Essentially, this change would restore the interpretation of guaranteed availability that was in effect prior to the 2017 Market Stabilization Rule. This reinterpretation is based, in part, on the rationale that the current policy creates barriers to health coverage that disproportionately affect low-income persons, especially APTC recipients.

Medical Loss Ratio

HHS would make two tweaks to the medical loss ratio rules. First, issuers may only count provider incentive and bonus payments as claims expense if they are "tied to clearly defined, objectively measurable, and well-documented clinical or quality improvement standards." This change is intended to address situations where issuers use provider bonuses or incentives to avoid paying rebates. Second, issuers only may count expenditures directly related to activities that improve healthcare quality. This change would mitigate the inflation of QIA expenses tied to indirect expenses. Issuers will need to better document and review how QIA expenses are calculated and allocated, such as employee salaries when the employee performs QIA only some of the time.

Network Adequacy

HHS would resume federal review of network adequacy of QHPs offered on federally-facilitated exchanges in 2023 (HHS previously had done so from 2015-2017). HHS would apply time and distance standards at the county level and vary by county designation—similar to Medicare Advantage, the designation method would take into account population size and density. The time and distance standards would apply to a specified set of provider and facility specialty types. Additionally, HHS would assess appointment wait-times for behavioral health services, routine primary care, and non-urgent specialty care. The wait-time requirements would be detailed in subsequent guidance.

Standardized Plan Options

The Biden Administration’s proposal revives the Obama-era notion of standardized plan options, which were introduced in the 2017 Payment Rule, with a twist—instead of issuers having the option to offer standardized plans, the Biden rule would require issuers on federally facilitated exchanges and state-based exchanges using the federal platform to offer them. If an issuer offers a non-standardized QHP, then it would be required to offer a standardized plan in the same service area for the same network type and metal level. The cost-sharing, actuarial value, and four-tiered prescription drug benefit are summarized in two charts available here.

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