Published on *The National Law Review* https://natlawreview.com

CMS Releases Notice of Benefit and Payment Parameters for 2024 Final Rule

Article By:

Jason Levy

Ryan A. Lee

On April 17, 2023, the Centers for Medicare & Medicaid Services ("CMS") released the U.S. Department of Health and Human Services ("HHS") Notice of Benefit and Payment Parameters for 2024 Final Rule (the "Notice") that includes standards for issuers and Marketplaces, and requirements for agents, brokers, web-brokers and others. The Notice implements various changes previously proposed by CMS, including (i) requiring provider networks to comply with network adequacy standards and delaying the implementation of appointment wait time standards, (ii) standardizing plan options, (iii) adding special enrollment periods to increase ease of obtaining coverage, (iv) strengthening markets, and (v) bolstering program integrity.

Network Adequacy Standards

CMS now requires all individual market-qualified health plans ("QHPs"), including stand-alone dental plans ("SADPs") and all Small Business Health Option Program plans across all Marketplace-types, to use a network of providers that comply with the standards set out in the network adequacy and essential community provider regulations. Further, the new rules remove the previous exception to the network adequacy standards that allowed plans not using a network provider to avoid compliance with said standards, while creating a new limited exception to the requirement for SADP issuers selling plans in areas where it is "prohibitively difficult" for the issuer to establish a network of dental providers. Determinations for this exception must be made based on attestations from State Departments of Insurance in states with at least 80% of their counties classified as Counties with Extreme Access Considerations that at least one of the following factors exists in the area serviced by the issuer:

- a significant shortage of dental providers;
- a significant number of dental providers unwilling to contract with Marketplace issuers; or
- significant geographic limitations impacting consumer access to dental providers.

Narrowing the exception to compliance with network adequacy standards, and thus requiring the vast majority of plans to ensure they have sufficient hospitals and providers to serve their members, will generate a certain measure of predictability for consumers in evaluating the kind of plans that are available to them and which providers are in-network.

Additionally, CMS has chosen to delay the application of appointment wait time standards until plan year 2025 in order for CMS to develop specific guidelines on how issuers should collect the required data and to allow the public to provide feedback on the proposed rules.

Standardizing Plan Options

As part of its drive to simplify consumer choices regarding health plans, CMS has implemented a number of changes aimed at increasing efficiency and reducing consumer confusion.

First, CMS has removed the standardized plan option for the “non-expanded” bronze metal level. As such, beginning in the plan year 2024, issuers who offer QHPs through Federally Facilitated Marketplaces and State-based Marketplaces on the federal platform must offer standardized QHP options designed by CMS at every product network type, at every metal level except the non-expanded bronze metal level, and in every service area for which that issuer offers non-standardized QHPs.

Additionally, CMS has decreased the amount of non-standardized plan options that issuers who offer QHPs can offer through Marketplaces on the Federal platform: beginning in plan year 2024, the number of non-standardized plan options will be limited to four non-standardized plan options per product network type, metal level (excluding catastrophic plans) and inclusion of dental and/or vision benefit coverage, in any service area. Beginning plan year 2025, the four-option limit will drop to two. CMS’ rationale for this change is to cut down on the large number of plans being offered, and in doing so help to both alleviate the risk of choosing ineffective health plans and to avoid plan choice overload by consumers. However, CMS will permit flexibility for plans that provide a certain amount of additional dental and/or vision benefit coverage. Though, it is important to note that this requirement only applies to plans offered through the federal Marketplace, and not to issuers in State-based Marketplaces, Small Business Health Option Program plans, or SADPs.

CMS also now requires SADP issuers to standardize the method of enrollee age calculation for rating and eligibility purposes by using age on effective date as the sole method of calculation. In removing other, more complex, and less-used calculation methods, CMS hopes to promote certainty in the calculation and streamline the enrollment process. Issuers of SADPs will also need to submit guaranteed rates, beginning plan year 2024, as a condition of Marketplace certification.

CMS has also finalized changes to allow health plans to provide for automatic re-enrollment for enrollees who are eligible for cost-sharing reductions, are currently enrolled in a bronze-level QHP, and would otherwise be automatically re-enrolled in a bronze-level QHP. Starting with plan year 2024, this change would allow such enrollees to be automatically re-enrolled in a silver-level QHP in the same product with the same provider network, with premiums lower or equivalent to the bronze-level QHP into which the enrollee would have otherwise been re-enrolled. CMS will also now require all Marketplaces to incorporate network similarity into auto re-enrollment criteria, for enrollees whose current QHP or health plan will no longer be available in the next year.

Finally, CMS has implemented changes to require that QHP plan and plan variant marketing names include correct information, and not include content that is misleading.

Special Enrollment Periods

CMS has implemented a new rule, beginning January 1, 2024, to prevent consumers from losing Medicaid or Children's Health Insurance Program ("CHIP") coverage which is also considered minimum essential coverage ("MEC"). The new rule requires that consumers be given 90 days after the loss of Medicaid or CHIP coverage to select a plan for Marketplace coverage in a Special Enrollment Period. The Special Enrollment Period now aligns with the Medicaid/CHIP reconsideration period, which is also 90 days and allows consumers to have their coverage requests reconsidered without needing to submit new applications. State-based Marketplaces will have the option to give consumers who are losing Medicaid or CHIP coverage more time to select a QHP and will be able to implement this new rule before January 1, 2024, if they so desire.

The Special Enrollment Period regulations for plan display errors have been adjusted so that consumers will not need to show that they were influenced by a material error related to plan benefits, service area, cost-sharing, or premium. This will make it easier for consumers to correct errors in plan selection and move to a more appropriate QHP.

Strengthening Markets

CMS has also finalized a number of administrative changes in the Notice. For the 2024 plan year, CMS has implemented a user fee rate of 2.2% of premium for QHPs sold on the Federally Facilitated Marketplaces and a user fee rate of 1.8% of premium for QHPs sold on the State-based Marketplaces on the Federal platform. These fee rates have been lowered from the previous rates and should help to lower premiums for consumers.

Regarding the 2024 plan year risk adjustment models, CMS has finalized the use of 2018, 2019, and 2020 enrollee-level EDGE data for model recalibration for all coefficients without exceptions. These are the most recent consecutive years for recalibration regarding risk adjustment models, and this data will allow stabilization of risk scores with regard to differences in the population behind the dataset and have the most up-to-date claims experience available. CMS has also finalized a proposal to collect and extract a new data element from EDGE servers: the Qualified Small Employer Health Reimbursement Arrangement. Additionally, CMS has finalized a risk adjustment user fee of $0.21 per member per month for the 2024 plan year, and has repealed the ability of prior participant states to request a reduction in risk adjustment state transfers under the state payment transfer formula in all state market risk pools beginning with the 2025 plan year.

The HHS Risk Adjustment Data Validation no longer exempts issuers who exit the Marketplace from adjustments to risk scores and risk adjustment transfers when they are an outlier with respect to negative error rates in the applicable plan year's results. The materiality threshold for random and targeted sampling for HHS-RADV participation is now $15 million in total annual premiums Statewide to 30,000 total billable member months Statewide, which begins with the 2022 plan year of data.

Bolstering Program Integrity

In order to prepare for a smoother roll-out in advance of the audits required under the Payment Integrity Information Act of 2019 ("PIIA"), CMS has finalized the Improper Payment Pre-Testing and Assessment ("IPPTA") program to initiate pre-audit activities designed to prepare State Marketplaces for compliance with the PIIA. Under the IPPTA, State Marketplaces will have their pre-testing and assessment period extended to two years, and the periods will begin in either 2024 or

2025. The IPPTA will test processes and procedures that support the review of determinations of the advance payments of premium tax credits.

HHS will now have additional time to review evidence submitted by agents, brokers, or web-brokers to rebut allegations leading to suspension of Marketplace agreements, or to request reconsideration of termination of Marketplace agreements. The additional time amounts to 15 additional calendar days, or up to 45 calendar days, to review such evidence and to come to a new decision regarding suspension of Marketplace agreements, and 30 additional calendar days, or up to a total of 60 calendar days, to review evidence and to come to a new decision regarding termination of Marketplace agreements. The review process often involves time-consuming items such as reviewing complex technical information and revisiting consumer complaints, so additional time will help effectively resolve issues regarding incorrect suspension or termination.

Finally, CMS imposed two new requirements regarding the activities of agents, brokers, and web brokers. Agents, brokers, or web brokers are now required to document that eligibility application information for consumers has been reviewed by and confirmed to be accurate by the consumer or a representative. They must also document the consent of a consumer or a representative to receiving assistance prior to providing such assistance. Both items of documentation must be retained for at least 10 years in order to assist with audit and enforcement activities and must be produced upon request.

Conclusion

The 2024 Notice of Benefit and Payment Parameters final rule aims to enhance affordability, accessibility, and choice for consumers, strengthen consumer protections, improve program integrity, and support state innovation in implementing the Affordable Care Act. These goals are accomplished through the various provisions in the final rule that provide guidance and flexibility to states, insurers, and consumers while ensuring that the Marketplace operates in a transparent and efficient manner. Health insurance stakeholders should carefully review and comply with the regulations outlined in the Notice to ensure compliance with the requirements for the upcoming plan year.

National Law Review, Volume XIII, Number 114