SUMMARY OF PROVISIONS OF HHS' PROPOSED 2024 NOTICE OF BENEFIT AND PAYMENT PARAMETERS AND OTHER KEY REGULATIONS

Wakely
An HMA Company

Michael Cohen, PhD
202.568.0633 • michael.cohen@wakely.com

Chia Yi Chin, ASA, MAAA
832.247.6858 • chiayi.chin@wakely.com

On December 12, 2022, the Department of Health and Human Services (HHS) released the proposed Notice of Benefit and Payment Parameters (Payment Notice) for 2024.[1] The notice includes important proposed rules and parameters for the operation of the individual and small group health insurance markets in 2024 and beyond. This paper summarizes key provisions of the proposed notice, actuarial value calculator, and maximum out of pocket information recently released by HHS. Comments are due within 45 days of filing.

Overview

The following highlights the key changes included in the 2024 proposed Payment Notice. More information on these and other proposed changes follow.

1. **User Fees:** HHS proposes to reduce user fees to 2.50% for issuers in the Federally-facilitated Exchange (FFE) and 2.00% for issuers in state-based Exchanges operated by HHS (SBE-FPs).

2. **Auto-Enrollment Changes:** HHS proposes a number of changes to its re-enrollment hierarchy to shift more enrollment from bronze to silver plans.

3. **Enrollment Verification Changes and Special Enrollment Periods:** HHS proposes several policies to decrease the burden for consumers to enroll and stay enrolled. In particular, it proposes to make changes to requirements on failure to reconcile, standards for accepting income related attestations, and special enrollment period changes for those who lose Medicaid coverage.

4. **Standard Plans and Limitations on Non-Standard Plans:** HHS proposes to continue to require issuers operating on the Healthcare.gov platform to offer standard plans. Standardized options would be required in every network type, metal, and throughout every service area they offer a non-standardized product. HHS also proposes to limit the number of non-standard plans for issuers on the Healthcare.gov platform.

[1] Department of Health and Human Services, "Proposed Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024", https://www.cms.gov/files/document/cms-9899-p-patient-protection-nprm.pdf

5. **Network Requirements:** HHS proposes to increase the network adequacy standards for issuers in states that HHS operates. This includes proposals to apply wait time standards and increase requirements on contracting with essential community provider (ECPs).

6. **Risk Adjustment:** HHS proposes several updates to the risk adjustment model. This includes updates and considerations for the data used to recalibrate the model, the risk adjustment coefficients, and the risk adjustment user fee. It also includes potential inclusion of an additional hierarchical condition category (HCC).

7. **Risk adjustment data validation (RADV):** HHS proposes to make changes to the RADV program including: changes to exemptions, adjustments to exiting issuers, limitations on usage of non-EDGE data, and other changes.

8. **Maximum Out of Pocket:** The maximum out of pocket increased 3.8% to $9,450 for an individual.

9. **Actuarial Value Calculator:** While not part of the Payment Notice, HHS proposes changes to the Actuarial Value Calculator that will impact some actuarial values.

The following provides more detail on each of the items summarized above.

User Fees

HHS proposes to reduce user fees for issuers in states that utilize Healthcare.Gov relative to 2023 levels. In particular, HHS proposes charging issuers in FFE states 2.50% (down from 2.75%) and charging 2.00% (down from 2.25%) in SBE-FP states.

Auto-Enrollment Changes

During Open Enrollment HHS will automatically enroll (e.g., re-enroll) currently enrolled consumers into plans for the following year. Re-enrollment placement follows specific prescribed rules (or hierarchies). HHS proposes several changes to its auto-enrollment hierarchies. First, HHS proposes to modify their re-enrollment hierarchies such that enrollees who are eligible for cost-sharing reductions (CSRs) could be automatically re-enrolled (i.e., they currently have coverage) into a new plan as part of Open Enrollment. In particular CSR-eligible members could automatically re-enrolled in a silver-level QHP (with income-based CSRs) in the same product with a lower or equivalent premium. This would result in more consumers who are currently in bronze plans being shifted to silver. The current subsidy calculations often result in lower income enrollees being able to enroll in a CSR plan without any net premium and HHS proposes to increase this scenario.

The second change to auto-enrollment, HHS proposes to place enrollees into a plan with the same network ID as their current QHP to maintain the most similar network compared to the enrollee's current QHP if their plan is discontinued. Finally, HHS proposes no longer automatically enrolling members at the same metal level if the member’s plan is discontinued. If a member is enrolled in a discontinuing silver

level QHP and another silver level QHP with a comparable network is unavailable, the members will be re-enrolled in a comparable QHP one metal level higher or lower than the enrollee's current QHP, provided certain conditions are met (e.g., net premiums are not higher).

For future modifications, HHS announced that it is considering incorporating net premium and total out-of-pocket cost in the re-enrollment hierarchy. HHS also seeks broad comment on alternative auto-enrollment policies that should be considered in future years.

Enrollment Verification Changes and Special Enrollment Periods

HHS proposes a number of changes to ease eligibility issues and enrollment verification. These proposed changes include:

- Require two consecutive years of failing to reconcile taxes (FTR) to become ineligible for advanced premium tax credits (APTCs).
- Accept enrollee attestation if income data is unavailable as well as giving enrollees more time to resolve data matching issues involving income.
- Allowing qualified individuals who lose coverage mid-month to have coverage retroactive to the beginning of the month in which coverage is lost.
- Expanding the special enrollment period for loss of Medicaid coverage to 60 days before and 90 days after the loss of coverage.

The combined effects the proposed changes to enrollment and eligibility were estimated to increase APTCs by approximately $855 million per year.

Standard Plans and Limitations on Non-Standard Plans

Standard Plan Options (SPOs)

HHS proposes to continue requiring qualified health plan (QHP) issuers operating on the Healthcare.gov platform to offer standard plans. The standardized option rules only apply to states using the federal platform (FFE and SBE-FP) and is not required for state Exchanges. States on the federal platform who already have standardized plan requirements as of January 1, 2020, are exempt (and will use the state rule). Standardized options would be required for every network type, metal, and service area the issuer offers a non-standardized product. 2024 SPOs are intended to remain consistent with 2023 SPOs with minor differences. The exact plan designs can be found in the Notice of Benefit and Payment Parameters.

The key change in terms of standard plans for 2024 is that HHS proposes to no longer include a standardized plan option for the non-expanded bronze metal level, mainly due to actuarial value (AV) constraints. Thus, SPOs would be required in the following metal levels (for metal levels where the issuer offers a non-standard plan): one expanded bronze; one standard silver plan; one version of each of the

three income-based silver CSR plan variations; one gold plan; and one platinum plan. SPOs would continue to be differentially displayed on HealthCare.gov.

Non-Standard Plan Limitations

In addition to HHS requiring standard plans for issuers operating on the Healthcare.gov platform, HHS is also proposing to limit the number of non-standard plans issuers can offer. HHS has outlined two alternative approaches for limiting non-standard plan options (non-SPOs) and is seeking feedback on these options.

The first proposed approach would limit the number of non-SPO plans to two per product, metal level (excluding catastrophic plans), and service area and would be a condition of the QHP certification process. For example, an issuer can offer two gold HMO non-SPO plans, and two gold PPO non-SPO plans in a given service area. In another example, if an issuer currently offers two bronze HMO non-SPO plans statewide and two bronze HMO non-SPO plans in a more limited-service area, the issuer would have to choose one set of bronze plans to offer in this area since the overlapping service area can have no more than two non-SPO bronze plans. This limitation does not apply to off Exchange only plan offerings in states in which HHS operates the Exchange.

HHS estimates that this approach will reduce the number of non-SPO plans by about two-thirds, thereby reducing plan choice overload for consumers. However, since a number of 2023 plans would have to be discontinued because of this requirement, HHS estimates that approximately 27% of enrollees in states where the policy would apply would be affected and would need to be cross-walked into a different plan in 2024.

An alternative approach to limiting the number of plans is through a meaningful difference standard (which was previously codified in 156.298). The standard requires grouping plans by issuer HIOS ID, county (service area), metal level, product network type, and deductible integration type (integrated or separate medical and pharmacy deductible) combination, and then evaluating whether plans within each group are meaningfully different from each other. The ‘meaningful difference’ is defined as deductible amounts varying by more than $1,000. HHS estimates this approach would reduce the total number of plans (SPOs and non-SPOs) by about a half, with 26% enrollees affected in 2024.

HHS is seeking commentary on the two proposed approaches and whether these approaches should be more stringent, more relaxed, or if these would induce an increase in the number of network types filed by the issuers in order to get around the requirements. Additional considerations include imposing limits on the number of product IDs, network IDs, and benefit variation (e.g., plans that include or exclude dental and vision).

Network Requirements

HHS proposes to expand or change issuer requirements surrounding network adequacy for states in which HHS operates the Exchange in several ways.

Apply Standards to Issuers without Networks

HHS proposes to require all QHPs, stand-alone dental plans, and on-Exchange small group (SHOP) plans to meet its network adequacy requirements. Currently plans that do not maintain a provider network are exempt from network adequacy requirements and this proposed change would end that.

Expand Network Adequacy Requirements and ECP Standards

Beginning in 2024, HHS proposes to apply wait time standards to plans that offered in Exchanges operated by HHS. Issuers in these Exchanges must meet minimum appointment wait time standards in order to be certified. Additionally, HHS proposes to make changes to the essential community providers (ECPs) standards. Currently, issuers operating in the Federally-facilitated Exchanges must have 35 percent of ECPs participate in their network. HHS proposes to add two additional ECP categories: Mental Health Facilities and Substance Use Disorder Treatment Centers. HHS is also proposing that issuers contract with at least 35% of Federally Qualified Health Centers and 35% of available family planning providers. HHS is also considering having minimum thresholds for each category of ECP.

Risk Adjustment

HHS proposes several updates to the risk adjustment program in the Payment Notice.

Sequestration

The risk adjustment program will be sequestered at a rate of 5.7% for funds collected during fiscal year 2023. These sequestered amounts will be available to issuers in fiscal year 2024 (i.e., there's a delay in payment for some risk adjustment payments).

Risk Adjustment Model Recalibration & Changes

HHS proposes to recalibrate the 2024 benefit year risk adjustment models using the 2018, 2019, and 2020 enrollee-level EDGE data. However, HHS proposes to only use the 2018 and 2019 EDGE data in the recalibration of the adult age-sex coefficients to account for anomalies in the 2020 EDGE data for older adult enrollees due to the Covid pandemic.

Additional proposed changes include:

- Similar to previous benefit years, HHS proposes an adjustment to the Hepatitis C prescription drug class (RXC).
- HHS is soliciting comments on adding a new payment HCC for gender dysphoria in future years.
- HHS also proposes to continue the CSR risk score adjustment factors for CSR enrollees.
- HHS also propose to continue to use a CSR adjustment factor of 1.12 for all Massachusetts wrap-around plans.

State Flexibility Requests

HHS proposes to repeal the flexibility for States to reduce risk adjustment State transfers for the 2025 benefit year and forward. HHS also requests comments on Alabama's request to reduce risk adjustment transfers by 50% for the 2024 benefit year.

Additional Data Elements

HHS proposes to collect and extract – beginning with the 2023 benefit year – an indicator for Qualified Small Employer Health Reimbursement Arrangements (QSEHRA) if issuers have the data. Issuers would be required starting in 2025 to make a good faith effort to collect this information. Additionally, HHS proposes to add extra rating area and plan identifier data to EDGE data prior to 2021.

Risk Adjustment User Fee

HHS proposes a risk adjustment user fee of $0.21 per member per month (PMPM) for the 2024 benefit year.

Risk Adjustment Data Validation (RADV)

Exemption Threshold

HHS proposes to change the materiality threshold for HHS-RADV audits from $15 million in total annual premiums to 30,000 total billable member months beginning with the 2022 benefit year. This metric will be measured using total membership across a state's individual and small group markets (catastrophic and non-catastrophic) for an issuer in the benefit year being audited.

Exiting Issuers' Adjustments

HHS proposes to no longer exempt exiting issuers from adjustments to risk scores and transfers when they are negative error rate outliers.

Lifelong Permanent Condition and Use of Non-EDGE Claims

HHS solicits comments on discontinuing the lifelong permanent condition list and use of non-EDGE claims in HHS-RADV beginning with the 2022 HHS-RADV benefit year.

Other RADV Changes

HHS proposes to shorten the window to confirm or dispute findings of the secondary validation audit (SVA) to 15 days. HHS also proposes to amend the EDGE discrepancy materiality threshold such that a dispute must be greater than or equal to $100,000 or one percent of total estimate transfers for the issuer.

Maximum Out of Pocket Updates

HHS no longer publishes maximum out-of-pocket (MOOP) amounts in the Payment Notice, but instead will finalize the values via guidance. HHS published guidance[2] finalizing the MOOP amounts for non-CSR plans[3] and cost-sharing variations for 2024. The MOOP will be increasing 3.8% from the 2023 amounts of $9,100/$18,200 (single/family).

- Non-CSR Plans: $9,450/$18,900 (single/family)

[2] https://www.cms.gov/files/document/2024-papi-parameters-guidance-2022-12-12.pdf

[3] Standard plans include platinum, gold, silver non-cost sharing variation, enhanced bronze metal offerings as well as catastrophic plans.

- 100%-150% FPL: $3,150/$6,300 (single/family)
- 150%-200% FPL: $3,150/$6,300 (single/family)
- 200%-250% FPL: $7,550/$51,100 (single/family)

The catastrophic plan's deductible and MOOP will be set to $9,450/$18,900 (single/family).

The 2024 Actuarial Value Calculator (AVC)

In a separate release, HHS proposes to update the 2024 Actuarial Value Calculator relative to the 2023 version.[4] The draft calculator claims data is based on 2018 data and was trended forward from 2018 to 2024 with differential rates for medical and prescription drug spending. Trends are similar to prior years. Additionally, HHS proposes to update the AVC so that it better aligns better with how issuers operationalize their plan design. In particular, copays will not count towards the accumulation of the deducible. The result of this methodological change is lower actuarial value for certain plans, all things equal.

If you have any questions or want to follow up on any of the concepts presented here, please contact any of the following authors:

Matt Sauter, ASA, MAAA

720.627.8669 • matt.sauter@wakely.com

Luke Brehmer, ASA, MAAA

612.800.6584 • luke.brehmer@wakely.com

Ksenia Whittal, FSA, MAAA

720.282.4965 • ksenia.whittal@wakely.com

Jackie Young, ASA, MAAA

727.259.7470 • jacquelyn.young@wakely.com

Michael Cohen, PhD

202.568.0633 • michael.cohen@wakely.com

Chia Yi Chin, ASA, MAAA

832.247.6858 • chiayi.chin@wakely.com

[4] https://www.cms.gov/files/document/draft-2024-av-calculator-methodology.pdf

OUR STORY

Five decades. Wakely began in 1969 and eventually evolved into several successful divisions. In 1999, the actuarial arm became the current-day Wakely Consulting Group, LLC, which specializes in providing actuarial expertise in the healthcare industry. Today, there are few healthcare topics our actuaries cannot tackle.

Wakely is now a subsidiary of Health Management Associates. HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With more than 20 offices and over 400 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

Broad healthcare knowledge. Wakely is experienced in all facets of the healthcare industry, from carriers to providers to governmental agencies. Our employees excel at providing solutions to parties across the spectrum.

Your advocate. Our actuarial experts and policy analysts continually monitor and analyze potential changes to inform our clients' strategies – and propel their success.

Our Vision: To partner with clients to drive business growth, accelerate success, and propel the health care industry forward.

Our Mission: We empower our unique team to serve as trusted advisors with a foundation of robust data, advanced analytics, and a comprehensive understanding of the health care industry.

Learn more about Wakely Consulting Group at www.wakely.com