Key Highlights from the 2024 Final Notice of Benefit and Payment Parameters

The 2024 Notice of Benefit and Payment Parameters released by the Centers for Medicare & Medicaid Services (CMS) on April 17, 2023, requires payers offering plans on Federally-Facilitated Exchanges (FFEs) and State-Based Exchanges on the Federal Platform (SBE-FP) to follow a modified set of guidelines for qualified health plans (QHP) to streamline their offerings and reduce disparities.

While this rule intends to ensure consumers can make effective choices about their coverage by reducing the number of options available on the marketplace over the next 2 years, it is not as stringent as originally proposed. With these changes, CMS estimates approximately 17% of nonstandard plans (40% less than originally proposed) will be discontinued in 2024—with many more nonstandard plans to be discontinued for 2025. Next year, the number of plans an average consumer will be able to choose from will drop from 113 to 90 – an improvement, but still far more than the range of 15 seen in other lines of business that promotes easier enrollment decisions, and in turn, higher enrollment rates.

The final rule takes effect 60 days after it is published on the Federal Register and will impact marketplace offerings in Plan Year (PY) 2024 and beyond.

What This Means

- **QHP Portfolio and Membership Shifts as a Result of Standardization.** Payers will need to refine their offerings to meet standardization requirements, and the impact felt will vary by metal level. Smaller payers without dental and vision benefit offerings are likely to face more challenges with developing a competitive stance in the marketplace as larger payers are permitted to maintain more marketplace offerings in general due to their ability to offer dental and vision benefits. However, larger payers will still need to make significant portfolio changes by 2025. Broadly, all payers can expect significant membership shifts in 2024 and 2025 and an increase in shopping between payers. As a result of standardization requirements, approximately 6.6% (over 800,000) of current enrollees will need to be moved to a different plan for PY 2024 as payers update their QHP portfolios. Additional enrollees will be affected when additional limits take hold in 2025. Meanwhile, 15 million individuals are expected to be disenrolled from Medicaid between now and mid-2024, with the resumption of Medicaid redeterminations.[1]
- **Expanded Provider Engagement and Potential Network Gaps.** Many payers will need to contract with additional providers in the different Essential Community Providers (ECPs) categories to meet network adequacy. Based on their current networks, 24% of payers do not meet the new requirement for Federally Qualified Health Centers (FQHCs), while 39% do not meet network adequacy for Family Planning. In general, payers with a shorter history in Medicaid may see greater network adequacy gaps. In some cases, they may have difficulty achieving the 35% contracting rate and plan certification required to offer QHPs in 2024 if they do not begin to address existing gaps in the near term.[2]

1 Additional impacts have been estimated by CMS and are available in the final rule.
2. The changes related to plan standardization specific to QHP offering requirements will not apply to plans offered as stand-alone dental plans (SADPs) or in the Small Business Health Option Program (SHOP).

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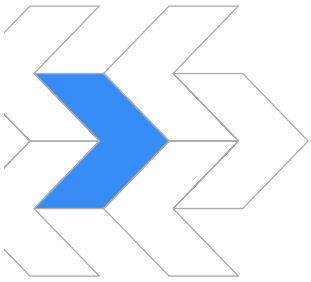
- **Continuity of Care from Medicaid to Marketplace.** For members that are transitioning from Medicaid to QHPs in the coming months, alignment to Medicaid network standards and enhanced participation from ECPs will help to avoid disruptions in care.
- **Risk Adjustment Predictability.** The minor updates to risk adjustment processes will make audit processes more predictable for participating payers and reduce the likelihood of potential exceptions in the future.
- **Internal Process Changes to Accommodate Shortened Timelines.** The shortened 15 calendar-day window may create challenges and an operational burden for disputes that require data extraction or information from clinical staff. Payers may need to consider internal processes and operational changes, including additional staffing, to help ensure thorough yet timely responses to audit findings given reviews must be conducted in half the time.



> "Regardless of their current offerings, payers must focus on coordinating with Medicaid while revisiting their member engagement strategy between now and 2025, when some plans will be allowed to maintain much broader QHP portfolios than others. How payers respond to the final rule today could impact their competitive position for years to come."
> *~ Jade Christie-Maples, Associate Principal, Payer Advisory*

Key Requirements to Follow

Enabling Consumer Choice: Enhancements to Plan Standardization

- **Payers Must Offer Standard Plan Designs.** Payers must have at least one standardized plan option for each product network type and throughout every service area where they offer nonstandardized QHP options. Standard plans must align to the cost-sharing structures for the following metal levels: Expanded Bronze,[3] Standard Silver, each of the 3 income-based Silver Cost Sharing Reduction (CSR) plan variations, Gold, and Platinum. This enables consumers to compare important plan attributes like premium cost and network more directly.
- **Payers May Need to Reduce Nonstandard Plan Offerings.** Payers will be limited to 4 nonstandard QHPs per product network type and metal level in any service area for PY 2024. PY 2025 and subsequent years will further limit the plans to 2 nonstandard offerings.[4] The limitation excludes catastrophic plan offerings as well as any of multiple variations to nonstandard plans for dental and/or vision coverage, providing payers significant flexibility in the size and make-up of their portfolios. Payers without dental and/or vision services will be much more restricted in their number of offerings in the marketplace in general.

3 Expanded Bronze plans have higher actuarial value. Members pay for certain services before a deductible is met. Non-expanded Bronze standard plans will be discontinued for 2024 but may be offered as a nonstandard plan.

4 The following study of consumer behavior demonstrated that a choice of 15 or fewer plans was associated with higher enrollment rates, while a choice of 30 of more plans led to a decline in enrollment:
Chao Zhou and Yuting Zhang, ''The Vast Majority of Medicare Part D Beneficiaries Still Don't Choose the Cheapest Plans That Meet Their Medication Needs.'' Health Affairs, 31, no.10 (2012): 2259–2265.

Building Equitable Access: Enhanced Network Adequacy Requirements

- **Payers Must Contract with 35% of ECPs.** Payers must establish adequate networks, including contracts with at least 35% of FQHCs and Family Planning Providers that qualify as ECPs to increase accessibility. Many payers currently meet or exceed these standards with their current networks; however, gaps will need to be addressed to meet adequacy requirements in 2024. This is in addition to the overall threshold requirement of 35% of available ECPs for the plan's service area. Rural Emergency Hospitals will be included as an ECP provider type due to their participation in Medicare as of January 2023.
- **Payers Must Offer Contracts to Mental Health Facilities and Substance Use Disorder (SUD) Providers.** Mental health facilities and SUD providers will now be included as stand-alone ECP categories. As such, QHPs must offer a contract to at least one SUD treatment center and one mental health facility in every county where they are available in the plan's service area, like with the other ECP categories, to meet adequacy requirements. CMS expects payers may fall short of network adequacy for these providers, so payers will be able to use an ECP write-ins process for providers that would be used to ensure adequate access to care and justify to CMS that their networks should be certified.

Updates to the Risk Adjustment Audit and Transfer Processes

- **Payers Can Expect a Consistent Risk Adjustment Data Validation (RADV) Audit Threshold.** The baseline sample for the RADV model will be 30,000 billable member months for the 2022 benefit year, instead of $15 million in total annual premiums. This will improve the model's consistency, despite premium changes or geographic variations in healthcare costs. Payers falling below the statewide threshold—calculated by combining enrollment in non-catastrophic, catastrophic, small group, and merged markets—will be exempt from annual audits but will still be subject to random and targeted sampling.
- **Exiting Payer Adjustments Must Participate in Transfers.** The current Risk Adjustment program is designed to encourage payers to rate their QHPs based on average population dynamics in their respective markets and stabilize premiums. Payers leaving a market will no longer be exempt from adjustments to risk scores and transfers of funds from lower-than-average risk to higher-than-average risk plans as part of a state risk pool when they are outliers with negative error rates due to underreporting of hierarchical condition category codes. Plan liability risk scores will be adjusted beginning with the 2021 benefit year. As the frequency of exiting payers with negative error rates is low, the impact of this change is expected to be relatively small.
- **Payer Disputes of Audit Findings Must Be Timely.** Payers will have 15 calendar days from the Department of Health and Human Services (HHS) notification (previously 30 days) to confirm or dispute the findings of a Second Validation Audit, beginning with the 2022 benefit year. Disputes must be equal to or greater than $100,000 or 1%, whichever is less, of the total estimated transfers for the issuer in the state market risk pool.

What to Do Now

- **Assess Product Impacts.** Analyze consumer data to understand which plans are the most popular and/or best performing (based on enrollment, impacts of adverse selection, and other factors) and how changes to your plans because of standardization requirements could impact your full membership.
- **Identify Gaps in Your Current Product Offerings.** Determine the changes needed for compliance, including additions to, changes to, and removals from current plan offerings. Identify any network adequacy gaps you must address.
- **Align Product and Membership Strategy.** Coordinate compliant product offerings with product performance, network capabilities, and organizational priorities in a manner that is least disruptive to current membership and positions offerings for growth.
- **Consider Your Competitive Stance.** Analyze your competition and develop strategies to differentiate in the marketplace. Focus on enhancing your unique plan benefits, advancing your price leadership, augmenting networks, and other features to make your plans more attractive to consumers.

Are You Ready?

We can help. Contact us to turn compliance with the Notice of Benefit and Payment 2024 final rule into an opportunity to gain a competitive edge in the marketplace.

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