Individual & Family Plan Year 2024 CMS Provisions: Takeaways for Agencies & Health Plans

The Centers for Medicare & Medicaid Services (CMS) released the Plan Year (PY) 2024 Notice of Benefit and Payment Parameters final rule. With provisions taking effect June 18, 2023, Agencies and Health Plans need to digest and address what they mean for business operations and strategy. Stride is bringing you this quick guide to the provisions with major takeaways so you're ready for the year ahead.

	Final Rule Category	The Big Headline	The Takeaway
Increasing Access to Health Care Services	*Network Adequacy and Essential Community Providers*	**Network Adequacy Standards are Bolstered Along with Additions to the ECP List**	First and foremost, this provision requires **all individual market Qualified Health Plans (QHPs) across all Marketplace-types to use a network of providers that meets the network adequacy and Essential Community Provider (ECP) standards.** This includes Stand-Alone Dental Plans (SADPs) and all Small Business Health Option Program (SHOP) plans, including SHOP SADPs. One exception is for SADPs where it's prohibitively difficult for the issuer to establish a network of dental providers. Additionally, the final rule includes **two new ECP categories: Substance Use Disorder Treatment Centers and Mental Health Facilities.** Finally, the rule requires plans **to contract with at least 35% of available ECPs in a plan's service area to apply to two individual ECP categories: Federally Qualified Health Centers and Family Planning Providers.** The overall 35% threshold requirement also remains in place.
Simplifying Choice and Improving the Plan Selection Process	*Standardized Plan Options*	**Changes to Standardized Plans at the Bronze Level and Requirements for Health Plans to Offer Standardized Plans**	With respect to standardized plans, CMS confirmed they will no longer include standardized plans at the non-expanded bronze level. Instead, **there will be a single set of standardized plans at the expanded bronze metal level. Additionally, for PY 2024, health plans must offer standardized plans for every product type (EOP, HMO, POS, and PPO) and metal level in every service area where a non-standardized plan is offered.** This change applies to Federally-facilitated Marketplaces (FFMs) and State-based Marketplaces on the Federal Platform (SBMs-FP), but not full State-based Marketplaces (SBMs). CMS opted to hold on proposed changes around health plans' placement of generic and specialty drugs in specific tiers.
	Non-Standardized Plan Option Limits	**There are New Restrictions on Non-Standardized Plans**	CMS finalized the ruling limiting the number of non-standardized plans a carrier can offer, a change from what was proposed. This is also a significant change from today as up to this point, health plans have been allowed an unlimited number of non-standardized plans, or in other words, there have been no restrictions prior to this ruling. In the final rule, **health plans can offer up to four non-standardized plan options per product type, metal level (excluding catastrophic plans), and inclusion of dental and/or vision benefit coverage, in any service area, for PY 2024.** Initially, the proposed limit was two. However, CMS is taking a step-down approach to get to that level. The final rule makes clear that beginning in PY 2025 and for all subsequent years, health plans can only offer up to two non-standardized plan options per product type, metal level, and dental and/or vision benefit.

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Simplifying Choice and Improving the Plan Selection Process	*Stand-Alone Dental Plans (SADPs)*	**Age on Effective Date is the Sole Method for Rating and Eligibility of SADPs, plus New Requirements on Submissions of Guaranteed Rates**	For PY 2024, **issuers of Stand-Alone Dental Plans (SADPs) must use age on effective date as the sole method to calculate an enrollee's age for rating and eligibility purposes.** Previously, issuers could use more complex age calculation methods. With this change, CMS is aiming to reduce consumer confusion. Additionally, issuers of SADPs must submit guaranteed rates beginning with, and as a condition of, Marketplace certification for PY 2024. Both requirements apply to Marketplace-certified SADPs, whether they are sold on- or off-Marketplace.
	Re-enrollment Hierarchy	**Marketplaces are Allowed to Modify Re-enrollment Hierarchies to Automatically Re-enroll Members in Silver Plans**	This provision **allows all Marketplaces (on the Federal platform and State-based Marketplaces (SBMs)) to modify their re-enrollment hierarchies so that Cost-Sharing Reduction (CSR)-eligible enrollees who would otherwise be automatically re-enrolled into a bronze plan without CSRs would instead be re-enrolled into silver-level plans with income-based CSRs.** There is a specification that re-enrollment will be limited to the same product (at the silver level) with the same issuer and with a premium after the application of Advanced Premium Tax Credit (APTC) that is lower or equivalent to the premium of the bronze level. This is referred to as the "bronze to silver crosswalk policy."
	Establish Requirements for Qualified Health Plan and Plan Variant Marketing Names	**Plan Names and Variant Marketing Names Must Not be Misleading**	This policy requires that **QHP plan and plan variant names include correct information, without omission of material fact, and do not include content that is misleading.** The agency will assess plan names and variant marketing names to prevent misleading information.
Making it Easier to Enroll in Coverage	*Special Enrollment Periods*	**Marketplaces Can Extend a Special Enrollment Period to Individuals Losing Medicaid or CHIP Coverage**	**Marketplaces are allowed the option of extending a SEP of up to 90 days to individuals losing Medicaid or Children's Health Insurance Program (CHIP) coverage to select a plan for Marketplace coverage.** The intention is to help mitigate coverage gaps when consumers lose health insurance coverage while allowing for a more seamless transition into alternative coverage through the Marketplace. Additionally, CMS confirmed it finalized the change allowing Marketplaces the option of offering earlier coverage effective dates for individuals attesting to a future loss of Minimum Essential Coverage (MEC).
	Income Data Matching Issues	**Enrollee's Income Attestation will be Accepted When IRS Data is Not Available**	When a consumer reports an annual income to the Marketplace and their income cannot be verified from a trusted source like tax return data from the Internal Revenue Service, the consumer experiences an income data matching issue. With this provision, **CMS will now accept the household's income attestation when they cannot get that data. Additionally, enrollees with income inconsistencies will have a total of 150 days (an automatic 60-day extension in addition to the 90 days currently provided) to provide documentation to verify household income.**

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Making it Easier to Enroll in Coverage	*Allow Door-to-Door Enrollment by Navigators and Other Assisters*	**Navigators and Assisters are Permitted to Conduct Door-to-Door Enrollment Assistance**	Navigators were created by the Affordable Care Act to provide helpers for people to enroll in coverage through the health insurance exchange and refer or assist with Medicaid enrollment, while Assisters help consumers navigate coverage transitions from Medicaid into QHPs through the Federally-facilitated Marketplace (FFM). Previously, navigators and assisters were prohibited from providing enrollment assistance upon an initial interaction at an individual's residence. **With this final rule, that policy is repealed, allowing Navigators and Assisters to conduct direct door-to-door enrollment assistance with no barriers around first access.**
	Failure to File and Reconcile Process	**APTC Will Be Denied to Consumers Who Have Failed to File Taxes and Reconcile Tax Credits for Two Consecutive Years**	Starting on the day that the final rule goes into effect, **a consumer must fail to file a federal income tax return and reconcile past APTCs two years in a row before Affordable Care Act marketplace plans can deny them eligibility.** Previously, consumers could be deemed ineligible after only one tax year; however, CMS found that data lags in IRS reporting were likely leading to inappropriate coverage loss. This change was made to help avoid that and increase Marketplace retention. The rule also noted that Marketplaces on the Federal platform will continue to send notices to consumers for any year in which they have failed to reconcile APTC. The notice serves to educate and inform consumers of their responsibility and warn them of their risk of being determined ineligible if they fail to do so for a second consecutive tax year. CMS recommends that SBMs take similar action.
Strengthening Markets	*FFM and SBM-FP User Fees*	**The Final Rule Tacks on Even Greater Reductions in FFE and SBM-FP User Fees**	For the PY 2024, **user fees have been reduced to 2.2% in FFE states (from 2.75% in PY 2023) and to 1.8% in SBM-FP states (from 2.25% in PY 2023).** This final rule from CMS has been amended even greater than the proposal, which suggested a reduction of 2.5% and 2.0%, respectively. CMS noted that the further reduction from the proposed rule was due to the record volume of enrollments for PY 2023 Open Enrollment as well as the enactment of the Consolidated Appropriations Act, which provided certainty around the timing of Medicaid Unwinding. Larger projected enrollment means that CMS can spread costs over a larger enrollment base and, in turn, lower the user fee.
	HHS-Operated Risk Adjustment Program	**The Risk Adjustment Program Moves Forward with No Exceptions to Data**	**For the 2024 benefit year risk adjustment models, CMS finalized that it will use 2018, 2019, and 2020 data with no exceptions.** This is an alteration from its proposal as initially, CMS proposed to exclude some enrollees' data as HHS previously concluded that healthcare utilization due to COVID-19 had anomalously reduced estimates of those enrollees. **CMS will continue to make a downward adjustment to plan spending on Hepatitis C drugs,** which is intended to capture price reductions spurred by the entry of competing Hepatitis C drugs not fully reflected in the three years of data it will use. HHS assesses a user fee on individual and small group issuers to cover the costs of operating the risk adjustment program. With the final rule, **CMS confirmed a risk adjustment user fee of $0.21 per member per month for the 2024 benefit year, down slightly from $0.22 for the previous year.**

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Strengthening Markets	*HHS Risk Adjustment Data Validation*	**CMS Makes Further Refinements to the HHS Risk Adjustment Data Validation (HHS-RADV)**	**The policy exempting health plans that were exiting a state's market and found to be negative error rate outliers (generally meaning it understated its enrollees' risk scores) from the RADV process will officially end.** Previously, HHS exempted those plans; however, with this final rule and beginning with the 2021 benefit year of HHS-RADV, those issuers will be included in the results. Additionally, CMS finalized changing the materiality threshold for random and targeted sampling for HHS-RADV participation. **Beginning with the 2022 benefit year of HHS-RADV, the threshold will be set at 30,000 total billable member months across a state's individual and small group markets** rather than the previously set threshold of $15 million in total annual premiums Statewide. Further, CMS is discontinuing the use of the lifelong permanent condition list and the use of non-EDGE claims in HHS-RADV beginning with the 2022 benefit year of HHS-RADV.
Strengthening Markets	*Premium Adjustment Percentage and Payment Parameters*	**No Proposed Changes to the Methodology to Calculate the Premium Adjustment Percentage or Related Parameters, and thus HHS has Issued the 2024 Payment Parameters**	HHS issued guidance that lays out payment parameters for the 2024 benefit year. Here are the 2024 payment parameters: • The premium adjustment percentage for 2024 will be 1.4899877401. • The maximum annual out-of-pocket limit on cost-sharing for 2024 will be $9,450 for self-only coverage and $18,900 for other than self-only coverage. This increases these limits by approximately 3.8 percent over 2023, when the limits were $9,100 for self-only coverage and $18,200 for other than self-only coverage. • The amounts above will be reduced by cost-sharing reductions (CSRs) to a $3,150 cost-sharing limit for self-only coverage and a $6,300 cost-sharing limit for other than self-only coverage for individuals with incomes less than or equal to 200 percent of the federal poverty level (FPL), and to $7,550 and $15,100 cost-sharing limits for individuals and families, respectively, with incomes greater than 200 and less than or equal to 250 percent of the FPL. States could have requested state-specific datasets for use as the standard population to calculate actuarial value. HHS also provided information on CSR plan variations to ensure that these plans continue to meet their specific Actuarial Value (AV) levels. • The required contribution percentage will be 7.97 percent, down from 8.17 percent for 2023.
Bolstering Program Integrity	*Establish Improper Payment Pre-Testing and Assessment for State Marketplaces*	**State Marketplaces Must Participate in the Improper Payment Pre-Testing and Assessment (IPPTA) Program**	The Payment Integrity Information Act of 2019 (PIIA) requires federal agencies to report information related to improper payments. To prepare State Marketplaces for compliance with the PIIA, **CMS has finalized the rule requiring State Marketplaces to participate in the Improper Payment Pre-Testing and Assessment (IPPTA) program.** The program is designed to prepare State Marketplaces for compliance with the PIIA. With this rule, 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 APTC.

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Bolstering Program Integrity

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Provisions Related to Agents, Brokers, or Web-brokers	**Extended Time for HHS Review of Rebuttal Evidence in Suspension and Termination Cases**	**With this provision, CMS is now allowed up to 45 calendar days to review evidence submitted by agents, brokers, or web-brokers to rebut allegations that may lead to suspension of their Marketplace agreements and up to 60 calendar days to review such evidence in cases involving termination of their Marketplace agreements. This provides CMS an additional 15 calendar days to review evidence for suspension or 30 calendar days for termination.**
	Confirmation and Documentation of Correct Information by Consumer or Authorized Representative and Consumer Consent is Now Required	**Agents, brokers, and web-brokers assisting individuals applying for APTCs and cost-sharing reductions (CSRs) will now be required to document that the eligibility application information has been reviewed and confirmed by the consumer or their authorized representative,** as directed by this final rule from CMS. The purpose of this provision is to confirm the accuracy of the information entered into the application and remind consumers that the information they include on an application to determine financial support is a legal, binding contract. This rule was borne in response to inaccurate information in applications and consumer complaints. The provision also **requires documentation to be created by the agent, broker, or web-broker confirming receipt of consent from the consumer or the consumer's authorized representative.** While the final rule doesn't specify a method for documentation, it does specify that the consent documentation must include specific elements including date, consumer's name, agent's name, scope, purpose and duration of consent, and process for rescinding consent. Additionally, documentation must **be maintained by the agent/ broker or web-broker for a minimum of 10 years** and be produced upon request in response to monitoring, audit, and enforcement activities.

Agencies and Health Plans are used to operating in a changing healthcare landscape, but navigating the volume and its impact on operations, strategy, and member engagement can be challenging. Stride is here to help. You can also explore how partnering with a technology provider like Stride can help you easily comply with CMS regulations and industry standards by contacting Christie Helvey at christie.helvey@stridehealth.com.

About Stride

Since 2013, Stride has combined innovative SaaS technology, health insurance expertise and a customer-first approach resulting in an insurance recommendation and enrollment platform utilizing proprietary decision support tools to modernize the healthcare market. This customizable and configurable solution enables health plans, agents, and consumers to confidently navigate complex health insurance decisions. Our seamless, secure, and end-to-end solutions combine an intuitive shopping and quoting experience, eligibility verification, and Phase 3 Enhanced Direct Enrollment (EDE) integration. Stride offers peace of mind when making one of life's most important decisions so individual consumers are confident their family is protected with insurance that fits their health care needs and budget.

Source: https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2024-final-rule

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