Issue Brief

FEDERAL ISSUE BRIEF

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

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CMS Proposes Notice of Benefit and Payment Parameters for 2025: Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program

The Centers for Medicare & Medicaid (CMS) have issued a proposed rule that would amend section 1332 Waivers for State Innovation (referred to throughout the proposal as section 1332 waivers) implementing regulations regarding State public notice and comment procedures. The rule proposes changes in 31 CFR part 33 and 45 CFR part 155 that would allow States the flexibility to hold a State public hearing or post-award forum in a virtual format (that is, one that uses telephonic, digital, and/or web-based platforms), or hybrid format (that is, one that provides for both in-person and virtual attendance), which would be considered as the equivalent of holding an in-person meeting.

The proposal is currently on display at the ***Federal Register*** office with a scheduled publication date of November 24. A copy of the 414-page display version is available at: https://public-inspection.federalregister.gov/2023-25576.pdf. A comment period ending January 2, 2024 is provided.

CMS proposes that these changes go into effect upon finalization of this rule. Because these changes would relieve a regulatory restriction, CMS anticipates that they would be made effective immediately upon publication of a final rule.

Comments

The rule provides a table of contents as shown below. We are adding page numbers (in red), except for the collection of information section IV.

The rule's summary of major provisions beginning on page 38 and the accounting table as shown below offer a succinct summary of the proposal.

Questions? Contact Andrew Wheeler, MHA's Vice President of Federal Finance, at 573-893-3700 | ext. 1336 or awheeler@mhanet.com.

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D. 45 CFR Part 155 – Exchange Establishment Standards and Other Related Standards under the Affordable Care Act (Page 91)
E. 45 CFR Part 156 – Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges (Page 219)

IV. Collection of Information Requirements (Page 277)

A. Wage Estimates
B. ICRs Regarding Proposed Amendments to Normal Public Notice Requirements (31 CFR 33.112, 31 CFR 33.120 and 45 CFR Part 155.1312, and 45 CFR 155.1320)
C. ICRs Regarding Basic Health Program Regulations (42 CFR 600.320)
D. ICRs Regarding Election to Operate an Exchange after 2014 (45 CFR 155.106)
E. ICRs Regarding Adding and Amending Language to Ensure Web-brokers Operating in State Exchanges Meet Certain Requirements Applicable in the FFEs and SBE-FPs (45 CFR 155.220)
F. ICRs Regarding Establishing Requirements for DE Entities Mandating HealthCare.gov changes to Be Reflected on DE Entity Non-Exchange Websites within a Notice Period Set by HHS (45 CFR 155.221(b)(6))
G. ICRs Regarding Adding and Amending Language to Ensure DE Entities Operating in State Exchanges Meet Certain Standards Applicable in the FFEs and SBE-FPs (45 CFR 155.221)
H. ICRs Regarding Failure to File and Reconcile Process (45 CFR 155.305(f)(4))
I. ICRs Regarding Verification Process Related to Eligibility for Enrollment in a QHP through the Exchange (45 CFR 155.315(e))
K. ICRs Regarding Eligibility Redetermination During a Benefit Year (45 CFR 155.330(d))
L. ICRs Regarding Establishment of Exchange Network Adequacy Standards (45 CFR 155.1050)
M. ICRs Regarding the State Selection of EHB-benchmark Plans for Plan Years Beginning on or after January 1, 2027 (45 CFR 156.111)
N. ICRs Regarding Non-Standardized Plan Option Limits (45 CFR 156.202)
O. Summary of Annual Burden Estimates for Proposed Requirements
P. Submission of PRA-Related Comments

V. Response to Comments (Page 312)

VI. Regulatory Impact Analysis (Page 313)

Reg Text (Page 383)

CMS provides the following accounting table (Table 16 (Page 315)) which provides a summary of the proposed items and their expected costs.

Table 16: Accounting Table

Benefits:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized ($/year)	$25.79 million	2023	7 percent	2024-2028
	$26.32 million	2023	3 percent	2024-2028

Quantitative:

- Annual cost savings to State Exchanges of approximately $20,317,000 beginning in 2025 associated with the proposal to permit Exchanges to accept consumer incarceration attestations without further verification.
- Annual cost savings to the Federal Government of approximately $570,000 beginning in 2025 due to the proposal to stop generating incarceration data matching issues (DMIs) and thereby stop paying the Prisoner Update Processing System (PUPS) annual maintenance and transaction fees for the purposes of verification incarceration status for qualified health plans (QHP) eligibility.
- Annual cost savings to the Federal Government of approximately $12.5 million associated with the proposal to conduct an additional death periodic data matching (PDM) check annually beginning in 2025.

Qualitative:

- Increased State flexibility with respect to determining the effective date of eligibility for enrollment in a standard health plan for purposes of a basic health program (BHP).
- Improved transparency as a result of the proposal to require States seeking to transition to a State Exchange to provide the public with a notice and copy of its State Exchange Blueprint application at the time of submission to HHS for approval, and conduct periodic public engagements whereby interested parties can learn about the State's intent to transition, as well as a State's progress toward transitioning. Although, historically, States that have transitioned to State Exchanges conducted some level of public engagements that would meet what is being proposed, they have done so voluntarily, so this proposal would set a clear expectation moving forward for all States that intend to establish and operate a State Exchange.
- Improved consumer experience associated with the proposal to require that Exchange call centers must provide consumers with access to a live call center representative during the Exchanges' published hours of operations who must be able to assist consumers with submitting their application for QHP coverage.
- Improved consumer experience and access to accurate insurance information associated with the proposal to require all Exchanges to have a centralized eligibility and enrollment platform on its website. Although all current Exchanges meet this requirement, there may be States transitioning to State Exchanges in the future that would not consider operating a centralized eligibility and enrollment platform in the absence of this proposed amendment. This proposal would set a clear expectation moving forward for all States that intend to establish and operate a State Exchange.
- Increased transparency for agents, brokers, and web-brokers by specifying who will be reviewing their reconsideration request.
- Improved consumer experience on non-Exchange websites by requiring direct enrollment (DE) entities to

Benefits:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized ($/year)	$25.79 million	2023	7 percent	2024-2028
	$26.32 million	2023	3 percent	2024-2028

implement *HealthCare.gov* and State Exchange website display changes that enhance the consumer experience, simplify the plan selection process, and increase consumer understanding of plan benefits, cost-sharing responsibilities and eligibility for financial assistance.

- Reduced burdens and barriers to care for applicants as a result of the proposal to permit Exchanges to accept incarceration attestations without further verification.
- Improved continuity of coverage for enrollees due to the proposal to require Exchanges to automatically re-enroll enrollees in catastrophic coverage into QHP coverage for the coming plan year.
- Reduced consumer confusion and increased consumer access to assisters as a result of the proposal to require State Exchanges to adopt an open enrollment period that begins on November 1 of the calendar year preceding the benefit year and ends no earlier than January 15 of the applicable benefit year, with the option to extend the open enrollment period beyond January 15.
- Reduced consumer confusion and coverage gaps due to the proposal to align the effective dates of coverage after selecting a plan during certain special enrollment periods across all Exchanges.
- Reduced overlaps in coverage and premium payments for Exchange enrollees who retroactively enroll in Medicare Part A or B as a result of the proposal to permit Exchange enrollees to retroactively terminate Exchange coverage back to the date in which they retroactively enroll in Medicare Part A or B.
- Reduced costs for States to perform actuarial analyses to confirm compliance of Essential Health Benefits (EHB)-benchmark plans with scope of benefit requirements at § 156.111(b)(2).

- Reduced coverage barriers to expanding access to adult dental benefits, improved State flexibility to add benefits to improve adult oral health, and promotion of health equity associated with the proposal to remove the prohibition on including routine non-pediatric dental services as an EHB.
- Increased issuer flexibility in plan design as a result of the proposed exceptions process to allow issuers to offer additional non-standardized plan options in excess of the limit of two per product network type, metal level, including of dental and/or vision benefit coverage, and service area, if particular requirements are met.
- Streamlined payments and collections processes and limited administrative burden for operating HHS programs due to the proposal to align netting regulations at § 156.1215 with the policies proposed in the Federal Independent Dispute Resolution (IDR) Process Administrative Fee and Certified IDR Entity Fee Ranges proposed rule.

Costs	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized ($/year)	**$11.41 million**	**2023**	**7 Percent**	**2024-2028**
	$11.37 million	**2023**	**3 percent**	**2024-2028**

Quantitative:

- Cost to issuers being audited for high-cost risk pool payments of approximately $25,078 to complete, submit to HHS, and implement corrective action plans for certain high-cost risk pool audit observations for each benefit year being audited, if required by HHS.
- One-time cost in PY 2025 to web-brokers operating in State Exchanges of approximately $1,071,474 due to the proposal to ensure agents, brokers, and web-brokers operating in these State Exchanges are meeting certain requirements applicable in the Federally-facilitated Exchanges (FFE) and SBE-FPs.
- Costs to States of $2,346,128 associated with the policy that agents, brokers, and web-brokers operating in State Exchanges meet certain requirements applicable in the FFEs and State-based Exchanges on the Federal platform (SBE-FPs).
- Costs to DE entities operating in FFE and SBE-FP States of approximately $240,120 annually beginning in 2025 as a result of the proposal to require that changes adopted by *HealthCare.gov* be reflected on DE entity websites within a notice period set by HHS, unless HHS approves a deviation in advance.
- Costs to DE entities participating in State Exchanges of approximately $1,226,452.50 annually beginning in 2025 associated with implementing display changes and submitting requests to deviate from the standards defined by the State Exchange.
- Costs to DE entities operating in FFE and SBE-FP States of approximately $5,171 to submit a request to deviate from the display approach adopted by *HealthCare.gov* standards defined by HHS annually beginning in 2025.
- Costs to States of $3,353,468 associated with the policy that DE entities operating in State Exchanges meet certain requirements applicable in the FFEs and SBE-FPs, including the costs for States associated with policy surrounding DE entities operating in State Exchanges regarding implementing display changes and reviewing associated deviation requests.
- One-time cost in PY 2025 to DE entities in State Exchanges of approximately $6,762,281 to comply with the proposal to add language to ensure DE entities operating in these State Exchanges are meeting certain requirements applicable in the FFE and SBE-FPs.
- One-time cost in PY 2025 to State Exchanges of $23,770 to conduct an analysis of whether to accept consumer attestation of incarceration status or identify an alternative data source to verify incarceration status and to make changes to their eligibility systems and processes to either accept consumer attestation or use an alternative data source to verify incarceration status.
- One-time cost to HHS of $2.3 million in 2024 to build the structure and set up operations for the purposes of distinguishing costs of accessing CSI data through the VCI Hub service between the State Exchange and State Medicaid agency and annual costs of $1 million starting in 2024 to administer this process.

Costs	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized ($/year)	**$11.41 million**	**2023**	**7 Percent**	**2024-2028**
	$11.37 million	**2023**	**3 percent**	**2024-2028**

- One-time cost to 1 to 3 States with State Exchanges, who currently have one Hub connection shared between the State Exchange and Medicaid, of approximately $3 to 6 million in 2024 (averaged to approximately $4.5 million for purposes of this proposed rule) if they elect to build a second, separate Hub connection for the purposes of distinguishing costs of accessing CSI data through the VCI Hub service between the State Exchange and State Medicaid agency. Should any of these States elect to build a second Hub connection, the State would determine if the State Exchange or Medicaid agency would finance the implementation and operational costs associated with the second Hub connection.
- One-time cost in 2025 of approximately $43,252 to 11 State Exchanges that are not currently meeting the proposed requirement to conduct death PDM at least twice a year.
- Costs to 5 States per year of approximately $18,036 to comply with the proposal regarding the State selection of EHB- benchmark plans.
- Costs to 50 issuers of approximately $95,182 annually to complete the proposed exceptions process in order to offer one additional non-standardized plan option in excess of the non-standardized option plan limit of two for PY 2025 and subsequent years.
- Costs to QHP issuers in State Exchanges and SBE-FPs of approximately $114,992 annually beginning in 2025 associated with the network adequacy proposals in this proposed rule.
- Costs to State Exchanges and SBE-FPs of approximately $1,365,012 annually beginning in 2025 associated with the network adequacy proposals in this proposed rule.
- Costs to interested parties of approximately $136,937 in 2024 to review and interpret this rule.
- Costs to HHS per year of approximately $58,923 to conduct an additional check for deceased enrollees associate with the proposal to require Exchanges to conduct periodic checks for deceased enrollees twice yearly and subsequently end deceased enrollees' QHP coverage beginning with the 2025 calendar year.
- One-time cost in 2025 of $1,540,000 to HHS to modify the Federal platform's current incarceration verification processes for the purposes of verifying eligibility for QHP, and to update the Federal platform's system logic for HHS to stop sending incarceration verification requests to PUPS.

Costs	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized ($/year)	$11.41 million	2023	7 Percent	2024-2028
	$11.37 million	2023	3 percent	2024-2028

Qualitative:

- Increased premium amounts and PTC, to the extent that the proposals to address State-mandated benefits and the process to change EHB-benchmark plans incentivize States to update and modernize the EHB with additional benefits, including routine non-pediatric dental services.
- Increased administrative burden to States and issuers to develop criteria used to select a consumer representative for the P&T committee, to create or revise standard operating procedures for the committee, as well as for any additional training.

Transfers	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized ($/year)	$1.86 billion	2023	7 Percent	2024-2028
	$1.92 million	2023	3 percent	2024-2028

Quantitative:

- Estimated average transfers of costs from the Federal government to Medicaid beneficiaries of approximately $0 million to $538 million per year beginning in 2025 (averaged to $269 million for the purposes of this proposed rule) for additional health care benefits paid by the Medicaid program to new beneficiaries covered under States using the proposed eligibility flexibilities.
- Estimated average transfers of costs from States to beneficiaries of approximately $0 million to $392 million per year beginning in 2025 (averaged to $196 million for the purposes of this proposed rule) for additional health care benefits paid by the Medicaid program to new beneficiaries covered under States using the proposed eligibility flexibilities.

Transfers	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized ($/year)	**$1.86 billion**	**2023**	**7 Percent**	**2024-2028**
	$1.92 million	**2023**	**3 percent**	**2024-2028**

- Estimated transfers of costs from the Federal government to States of approximately $78 million to $122 million per year beginning in 2024 (averaged to $100 million for purposes of this proposed rule) by requiring State Exchanges and State Medicaid agencies to pay for their use of the optional CSI income data accessed through the VCI Hub service.
- Reduction in risk adjustment user fee transfers from issuers to the Federal government of approximately $3.5 million for benefit year 2025 compared to the prior benefit year.
- Estimated increased PTC outlays from the Federal government to issuers of $2 billion to $3 billion (averaged to $2.5 billion for purposes of this proposed rule) annually beginning in 2026 associated with the proposal to remove the limitation that the 150 percent FPL SEP be available only when the applicable taxpayer's applicable tax percentage is set to zero.

Qualitative:

- Provide States additional flexibilities to cover more Medicaid beneficiaries and improve health care for those individuals as a result of the Medicaid proposal in this proposed rule.
- Increase in the overall absolute value of risk adjustment State transfers calculated under the State payment transfer formula of approximately 8 percent in Oklahoma, 2.5 percent in Alaska, 2 percent in Montana, and less than 0.5 percent in South Dakota and North Dakota as a result of the proposal to recalibrate the CSR adjustment factors for AI/AN plan variant enrollees.

Final Thoughts

While the summary provisions and the accounting table offer concise information about the changes being proposed, the preamble is still laced with historical information on how current requirements have been developed. As we continue to say such information is truly unneeded.

All CMS needs to provide is the current state of rules and what changes are being proposed.

Providing a table of contents is very helpful to the reader. Also, CMS appears to be providing more accounting and related tables in its rulemaking. This is welcome.