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Preparing for NBPP 2023

New Rules of the Road Expected for Insurers

It's that time of year again. The time of year when the Centers for Medicare and Medicaid Services (CMS) releases their Notice of Benefit and Payment Parameters (NBPP) Proposed Rule for the next plan year (in this case, 2023). This federal regulation, accompanied with the annual "Letter to Issuers," spells out the rules of the road for private insurance plans under the Affordable Care Act (ACA). The Biden Administration used the 2022 NBPP to reverse some of the Trump-era provisions that had undercut patient access and affordability (for instance, eliminating the ability of states to forego using Healthcare.gov). However, given timing, some of the anticipated larger changes had to wait until the 2023 plan year.

Which brings us to the NBPP for 2023. The exact timing of release of the draft rule is unknown, but the rule is currently at the Office of Management and Budget (OMB), the last step before the release of the proposed rule and the beginning of a public notice and comment period. Read on to get a sense of what to watch for in the proposed rule and how CHLPI and other advocates have engaged over the past months to ensure the rule expands patient protections, particularly for individuals living with HIV and other chronic conditions.

CHLPI Laid Advocacy Groundwork for NBPP 2023

- In June 2021, CHLPI, with members of the Chronic Illness and Disability Partnership, held a meeting with the Center for Consumer Information and Insurance Oversight (CCIIO) to ensure that the NBPP for 2023 not only removed Trump-era harmful policies, but set a new, higher standard for patient protections, particularly for those living with chronic conditions and disabilities.
- CHLPI submitted the following advocacy letter to CCIIO following its meeting.

NBPP 2023: What to Watch

Ahead of the proposed rule, here's a rundown of the things that may be included in the NBPP for 2023 that will have the greatest impact on people living with chronic conditions and disabilities:

Standardized Plan Options

Standardized plans are meant to reduce consumer confusion by offering uniform cost sharing within certain market insurance categories (known as metal levels) and providing consumers access to plan options with affordable cost sharing. By standardizing plan cost sharing, consumers are able to focus on other important areas where plans differ, such as provider networks.

The history of standardized plan options is varied across the country. Several states – including Massachusetts and Washington – embraced standardized plan options early to help make it easier for consumers in their states to compare plans. In 2017, under the Obama Administration, issuers selling plans on the federal Marketplace, or Healthcare.gov, were given the option to offer a set of standardized plans known as "simple choice" plans. Simple choice plans offered uniform cost sharing and a set of pre-deductible benefits. However, in 2019, the Trump Administration ended this option. The plot twisted on standardized plans yet again in April 2021 when a federal district court in Maryland issued a decision in *City of Columbus v. Cochran*. That case involved a challenge to several Trump-era ACA changes, including the decision to eliminate the simple choice standardized plan options and the decision to roll back network adequacy protections (more on that below). Following the court decision, these two policy issues were remanded back to CMS for further action. CMS did not have enough time to get these major provisions into the NBPP for the 2022 plan year and announced it would delay action to NBPP 2023.

Standardized Plan Advocacy Priorities

- Prohibit co-insurance (where plans charge a percentage of the cost of a treatment or service instead of a flat dollar amount) and cap monthly prescription drug cost sharing.
- Require certain services – for instance prescription drugs and mental health services – to be covered pre-deductible.
- Allow consumers to smooth cost sharing over 12 months. This would help ensure individuals who have high health care utilization (e.g., those who rely on high-cost brand or specialty drugs) do not have to pay thousands and thousands of dollars as they meet their deductible and out-of-pocket maximum early in the year.

So what's on the table for standardized plan provisions in NBPP 2023? Advocates – including CHLPI – are pushing for standards that recognize the disproportionate costs incurred by people with higher health care utilization and that allow consumers to adequately predict the health care costs they will shoulder. CHLPI and its advocacy partners emphasize that standardized plans must not only be attractive to young, relatively healthy people looking for a good health insurance deal. Plan choices must ensure that individuals with chronic conditions and disabilities have access to affordable coverage and respond to the reality that health status is not static: all beneficiaries must have meaningful protection against high out-of-pocket costs for medical care.

Provider Network Adequacy

The court in *City of Columbus v. Cochran* also vacated a policy that eliminated federal review of provider network adequacy standards. Thus, CMS will also be issuing new standards on network adequacy in NBPP 2023. Advocates have urged CMS to think big when it comes to these protections:

to not only reinstate Obama-era federal review provisions, but to also add protections that strengthen provider availability and accessibility requirements. Advocates ask that these requirements include implementation of specific time and distance standards; transparency requirements that require plans to note specialty and safety net provider designations, race/ethnicity, and other important provider details; stronger Essential Community Provider (ECP) standards (e.g., require plans to cover a higher number of ECPs, which include Ryan White HIV/AIDS Providers and other safety net providers primarily serving low-income communities); and new requirements to ensure that issuers meet network adequacy standards with first tier providers, rather than creating a secondary provider tier (often including specialists) with higher cost sharing.

Prescription Drug Access and Affordability

With a new Administration, there may be opportunities to enhance protections that would benefit people living with chronic conditions who depend on high-cost medications. CHLPI has engaged directly with federal officials in meetings and written comments to advocate for stronger non-discrimination standards and meaningful monitoring and enforcement to ensure compliance. Topline issues to watch (and hope) for in the NBPP are:

- Prohibition on co-pay accumulator policies (plan policies that do not count manufacturer copay card payments toward a beneficiary's deductible or out-of-pocket maximum) when there is no generic equivalent;
- Specific language defining and prohibiting "adverse tiering" or the practice of placing all or substantially all drugs used to treat a certain condition on the highest cost-sharing tiers;
- Prohibition on mid-year formulary changes that remove a drug from a formulary or move it to a higher cost-sharing tier; and
- Stronger requirements for state and federal meaningful review of plan formularies and use of non-discrimination tools to identify discriminatory plan designs.

CHLPI in Court: Upholding Non-Discrimination Protections

- In October 2021, CHLPI submitted an amicus brief in *CVS v. Doe*, a case before the U.S. Supreme Court involving a challenge by CVS to the application of a "disparate impact" analysis under the ACA's Section 1557 non-discrimination protections when determining if plan designs (e.g., specialty pharmacy requirements) discriminate against people with disabilities. Before the case could be heard, CVS withdrew its challenge. CHLPI will continue to monitor and respond to challenges to the ACA's non-discrimination protections, particularly as they apply to plan designs that disproportionately harm people living with chronic conditions and disabilities.
- In November 2021, CHLPI filed another amicus brief in *T.S. v. Heart of CarDon, LLC*, a case before the Seventh Circuit Court of Appeals involving a challenge to the ACA's Section 1557 non-discrimination protections' application to an employer benefit plan offered by a nursing home that receives federal funds. CHLPI and others argued that the letter and spirit of the ACA's non-discrimination protections apply to *any* insurance benefit plan offered by an entity receiving federal funds. A decision is pending.

Even if these provisions don't make it into the initial proposed rule, advocates will have the opportunity to comment on the proposed rule and inform changes before it is finalized.

What Happens Next?

Once the proposed rule is released, a comment period will start running as soon as the proposed rule is published in the Federal Register. Given how late in the year it is, the comment period may be only 30 days. Following release of the proposed NBPP for 2023, the Administration will also publish a draft "Letter to Issuers," which generally reflects the provisions laid out in the NBPP but may provide additional guidance for plans as they prepare for the 2023 plan year. Advocates will also have an opportunity to comment on the Letter to Issuers.

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