2025 Payment Notice Webinar

Centers for Medicare & Medicaid Services (CMS)
Center for Consumer Information & Insurance Oversight (CCIIO)

April 25, 2024

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Disclaimer

The information provided in this presentation is intended only as a general, informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, and formal policy guidance that it is based upon. This presentation summarizes current policy and operations as of the date it was presented. Links to certain source documents have been provided for your reference. We encourage audience members to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information about the requirements that apply to them. The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

This document generally is not intended for use in the State-based Marketplaces (SBMs) that do not use HealthCare.gov for eligibility and enrollment. Please review the guidance on our Agent and Broker Resources webpage (http://go.cms.gov/CCIIOAB) and Marketplace.CMS.gov to learn more.

Unless indicated otherwise, the general references to "Marketplace" in the presentation only include Federally-facilitated Marketplaces (FFMs) and State-based Marketplaces on the Federal Platform (SBM-FPs).

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Housekeeping Reminders

- **If called upon during the Live Question & Answer session, please ask only one (1) question.**
- **To capture links posted in the Zoom Chat, please click on the desired link and bookmark it for future reference.**
- **Webinar and Audio Access Tips have been shared in the Zoom Chat and are listed in the email access details you received from *REGTAP Registration Support*.**

Discussion and Questions

At the end of today's webinar, we will have a live discussion and question and answer session. You will be able to ask your questions verbally or by written submission in the Q&A tab.

To ask a verbal question:

- If you are listening via the Zoom application, click "**Raise Hand**" in the webinar controls.
- If you are listening via phone, dial **star (*) nine (9)** to raise your hand.
  - Once your hand is raised, the facilitator will call on the **last three (3)** digits of your phone number.
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Agenda

1. Network Adequacy
2. Marketplace Open Enrollment Period Standardization
3. Simplifying Choice and Improving the Plan Selection Process
4. 150% SEP Extension
5. Essential Health Benefits
6. Failure to File and Reconcile Process

Opening Remarks

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Reminder: Documenting Consumer Consent Requirement

Consent Documentation Requirements

- Agents, brokers, and web-brokers are required to document the receipt of consent from the consumer or their authorized representative.
  - The consumer or their authorized representative must take an action to produce the documentation;
  - The documentation must contain, at a minimum, the following information:
    - A description of the scope, purpose, and duration of the consent provided by the consumer or their authorized representative;
    - The date the consent was given;
    - The name of the consumer or their authorized representative;
    - The name of the agent, broker, web-broker, or agency being granted consent;
    - A process through which the consumer or their authorized representative may rescind the consent.
  - The agent, broker, or web-broker must maintain the documentation for **a minimum of 10 years.**

For more information on these requirements, view these FAQs here: https://www.cms.gov/files/document/2024-pn-ab-faq-9823.pdf **and webinar slides here:** https://www.cms.gov/files/document/marketplace-compliance-2024-payment-notice-updates-webinar-slides.pdf**.**

Reminder: Documenting Application Review Requirement

Review Documentation Requirements

- Agents, brokers, and web-brokers are required to document that eligibility application information has been reviewed by and confirmed to be accurate by the consumer or their authorized representative prior to application submission.
  - The consumer or their authorized representative must take an action to produce the documentation;
  - The documentation must contain, at a minimum, the following information:
    - The date the information was reviewed;
    - The name of the consumer or their authorized representative;
    - An explanation of the attestations at the end of the eligibility application; and
    - The name of the assisting agent, broker, or web-broker.
  - The agent, broker, or web-broker must maintain the documentation for **a minimum of 10 years.**

For more information on these requirements, view these FAQs here: https://www.cms.gov/files/document/2024-pn-ab-faq-9823.pdf **and webinar slides here:** https://www.cms.gov/files/document/marketplace-compliance-2024-payment-notice-updates-webinar-slides.pdf**.**

Reminder: Changing NPNs on Marketplace Applications

Review Requirements for Changing National Producer Numbers (NPNs) on a Consumer's Application

- Documented consent must be obtained from the consumer when an NPN on a Marketplace application is being changed from one agent or broker to another.
- Consent must be documented prior to assisting the consumer with applying for or enrolling in coverage.
- If a consumer has granted agency-wide consent, the agency will not be required to obtain new consent when the NPN on the consumer's application changes, provided:
  - The consumer's consent has not expired or been rescinded; and
  - The new NPN belongs to an agent or broker of the agency to whom the consumer granted consent.

Agents, brokers, and web-brokers may never make any changes to a consumer's eligibility application without obtaining and documenting that the consumer has consented to this change and reviewed and confirmed this new eligibility application information.

For more information on these requirements, view these FAQs here: https://www.agentbrokerfaq.cms.gov/s/article/How-do-the-consent-requirements-adopted-in-the-2024-Payment-Notice-relate-to-NPNs-being-changed-on-Marketplace-applications **and webinar slides here:** https://www.cms.gov/files/document/marketplace-compliance-2024-payment-notice-updates-webinar-slides.pdf.

Network Adequacy

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Network Adequacy

- To help ensure that Marketplace enrollees in all states have reasonable and timely access to health care providers, the final rule creates more consistent nationwide standards on **how far and how long a consumer must travel to see various types of providers** in State Marketplaces (SBMs) and State-based Marketplaces on the Federal Platform (SBM-FPs).
- SBMs and SBM-FPs must also conduct quantitative network adequacy reviews prior to certifying any plan as a qualified health plan (QHP), consistent with the reviews conducted by the Federally-facilitated Marketplaces (FFMs). This policy is effective for plan years beginning on or after January 1, 2026.
- In the 2024 Payment Notice, CMS established standards for appointment wait times for QHP issuers in the Federally-facilitated Exchanges but delayed the implementation until plan year (PY) 2025. The 2025 Letter to Issuers describes the quantitative standards for appointment wait times for all QHP issuers in FFMs.
- Additionally, medical QHP issuers must **contract with a third party to conduct secret shopper surveys** of their primary care (routine) and behavioral health providers to assess compliance with the appointment wait time standards. The third-party entity must conduct secret shopper surveys while presenting as a new patient.

Marketplace Open Enrollment Period Standardization

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Marketplace Open Enrollment Period Standardization

- **Standardizing the dates of Open Enrollment periods across almost all Marketplaces** to generally begin on November 1 and end no earlier than January 15, with the option to extend the Open Enrollment period beyond January 15.
- This rule aims to ensure a more streamlined consumer experience across Federally-facilitated and State-based Marketplaces, with policies such as **requiring Marketplaces to have live call center representatives** available during call center hours of operation to assist consumers with QHP application submission and enrollment.

Marketplace Open Enrollment Period Standardization (continued)

- These representatives **must assist consumers with their Marketplace application** during the Marketplace's hours of operation, which includes:
  - providing consumers information on their advance payment of the premium tax credit (APTC) and cost-sharing reduction (CSR) eligibility
  - helping consumers understand their QHP options
  - facilitating a consumer's comparison of QHPs, and
  - helping consumers submit QHP enrollment applications to the Marketplace.
- Issuers are now required to **automatically re-enroll people who are enrolled in a catastrophic plan** for the next year, including those who will lose eligibility for catastrophic coverage, in order to prevent gaps in coverage.

Simplifying Choice and Improving the Plan Selection Process

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Simplifying Choice and Improving the Plan Selection Process

- Like in previous years, FFM and SBM-FP issuers must offer the **Standardized Plan Options** in all service areas in which they sell on-Exchange plans.
  - CMS made minimal changes to the plan designs. We modified the maximum out of pocket limits (MOOPs) and deductibles for several metal levels but did not otherwise modify the cost sharing in these plan designs.
- **Limitation on Non-Standardized Plan Options**
  - In PY2024, issuers could offer up to four non-standardized plan options in a given service area that share the same product network type, metal level, and inclusion of dental and/or vision benefit coverage.
  - The limit decreased from four in PY2024 to **two** in PY2025.
- These plan requirements apply only to QHPs, and continue to **not** apply to SBM issuers, SHOP issuers, or stand-alone dental plans.

Simplifying Choice and Improving the Plan Selection Process (continued)

- **New in PY2025:** Plans focused on treating a chronic and high-cost condition can be excepted from the PY2025 limit on non-standardized plans.
  - Issuers must justify each additional plan by describing how the plan reduces cost sharing for enrollees' treatment of the condition
  - **Reduced cost sharing for these benefits will reduce barriers to accessing services important to consumers with chronic and high-cost conditions.**
  - If available in their service area, an enrollee may select one of these plans *whether or not* they have the targeted condition.
  - These plans may be identifiable by the plan name or in marketing material.

150% SEP Extension

150% SEP Extension

- The rule **extends the special enrollment period (SEP)** for consumers with household incomes at or below 150% of the federal poverty level (for the 2025 plan year, $38,730 for a family of three) to enroll in coverage in any month rather than only during Open Enrollment.
- Additionally, the rule aims to prevent coverage gaps for those transitioning between different Marketplaces or from other insurance coverage by allowing those selecting coverage during certain SEPs to **receive coverage beginning the first day of the month after the QHP is selected**, as opposed to coverage beginning at a later date if the consumer enrolls between the 15th and the end of the month.

Essential Health Benefits

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Essential Health Benefits

- This rule codifies that **prescription drugs covered in excess of the minimum number of drugs required to be covered are considered essential health benefits (EHB).**
  - This coverage of additional prescription drugs is subject to EHB protections, including the annual limitation on cost sharing and the restriction on annual and lifetime dollar limits.
  - However, if the coverage of the drug is mandated by state action, the drug would not be considered EHB.
  - This policy applies to issuers of non-grandfathered individual and small group market plans subject to the requirement to provide EHB.
  - The Payment Notice does not address the application of this policy to the large group market health plans and self-insured plans group market health plans.
  - The Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments) issued a FAQ* to address the applicability of this provision in the final 2025 Notice of Benefit and Payment Parameters to self-insured group health plans and large group market plans for purposes of the prohibition on lifetime and annual limits under PHS Act section 2711 and the annual limitation on cost sharing under PHS Act section 2707(b). The Departments intend to address the applicability of this policy to those plans in future notice-and-comment rulemaking.

*This FAQ can be found here: https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-66

Essential Health Benefits (continued)

- **States may now add routine adult dental services as an EHB** by updating their EHB-benchmark plans.
  - This policy aims to remove regulatory and coverage barriers to expanding access to adult dental benefits.
  - It is up to each state to determine whether to add routine adult dental services as an EHB.
  - Interested states may add routine adult dental services via the EHB-benchmark application process beginning in 2025, which would first be effective for benefit years beginning on or after January 1, 2027.
  - States must continue to meet all requirements for updating their EHB-benchmark plans.

Failure to File and Reconcile Process

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Failure to File and Reconcile Process

- This policy regulates that **all Marketplaces must send informative notices to consumers or tax filers who are found to have failed to reconcile for one year to inform them of the risk of being determined ineligible for APTC**
- This adds on to the policy finalized in the 2024 Payment Notice, requiring all Marketplaces to only redetermine a consumer ineligible for APTC due to failing to reconcile if that consumer has failed to reconcile for two consecutive years.
- This requirement is to ensure that **tax filers enrolled in all Marketplaces, included a State Marketplace have more adequate notice** to correct potential failed APTC reconciliation.
- Nothing in this policy relieves the consumer of their requirement to file and reconcile taxes after the receipt of APTC.

Resources

CMS.gov Resources

Press Release	https://www.cms.gov/newsroom/press-releases/hhs-finalizes-policies-make-marketplace-coverage-more-accessible-and-expand-essential-health
2025 Notice of Benefit and Payment Parameters Final Rule	https://www.cms.gov/files/document/cms-9895-f-patient-protection-final.pdf
Fact Sheet	https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2025-final-rule
FAQ about Affordable Care Act Implementation Part 66	https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-66

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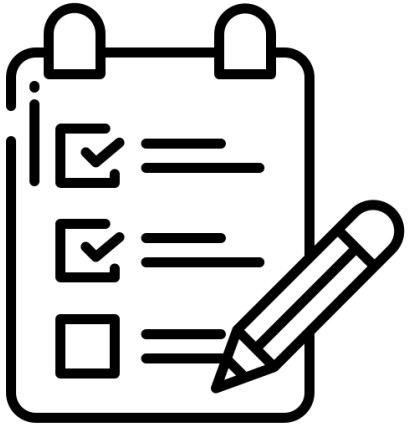
Webinar Session Survey

CMS welcomes your feedback regarding this webinar and values any suggestions that will allow us to enhance this experience for you.



Shortly after this call, we will send a link to you for a convenient way to submit any ideas or suggestions you wish to provide that you believe would be valuable during these sessions.
Please take time to complete the survey and provide CMS with any feedback.

Agents and brokers are valued partners to all of us at CMS for the vital role you play in enrolling consumers in qualified health coverage.

We thank you for the trusted advice, support, and assistance you provide throughout the year and wish you continued success throughout the year!