CHAMBER HILL

INSIGHTS

Summary of Contract Year 2026 Medicare Advantage & Part D Technical Changes Proposed Rule

Summary of Contract Year 2026 Medicare Advantage & Part D Technical Changes Proposed Rule

On November 26, 2024, the Centers for Medicare and Medicaid (CMS) released their proposed rule with technical changes to Medicare Advantage (MA) and Medicare Part D Prescription Drug plans for Contract Year 2026. This rule creates policy changes based on last year's final MA payment rule and the Inflation Reduction Act.1 The CMS press release can be found here. The CMS fact sheet can be found here. Comments are due by January 27, 2025. As the rule will be finalized after the administration transition, it is unclear if the entirety of this proposed rule will be implemented. However, many of these provisions are mandated by the Inflation Recovery Act, so some will be implemented.

MEDICARE ADVANTAGE PROVISIONS

Prior Authorization

CMS is concerned about reports of high rates of prior authorization requirements from MA plans to providers. Key proposals include defining the meaning of "internal coverage criteria" to clarify when MA plans can apply utilization management, ensuring plan internal coverage policies are transparent and readily available to the public (i.e. posted on websites), ensuring plans are making enrollees aware of appeals rights, and addressing after-the-fact overturns that can impact payment, including for rural hospitals.

For internal coverage criteria, CMS is tightening up the regulatory language to close any loopholes being used to create prior authorizations that CMS did not intend. For example, they are changing "general provisions" to "the plain language of applicable Medicare coverage and benefit criteria." They also explicitly state, "internal coverage criteria cannot be used to add new, unrelated (that is, without supplementary or interpretive value) coverage criteria for an item or service that already has existing, but not fully established, coverage policies." CMS is also removing the requirement that MA plans must demonstrate that the additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms. After reviewing many prior authorization claims, CMS found the clinical benefits are highly likely to outweigh any clinical harms. A full explanation of all internal coverage criteria changes can be found starting on page 358 of the proposed rule.

1 We expect the payment update rule to be dropped at the beginning of 2025, usually at the end of January.

Promoting Informed Choice

CMS is proposing several initiatives with the goal of ensuring beneficiaries have robust information to make plan choices. First, CMS is proposing to require plans to submit their MA provider directory data to CMS, so CMS can use it to populate the Medicare Plan Finder. There will also be a plan attestation requirement that all data will be accurate and consistent.

Second, CMS is expanding requirements on plan benefits and options for MA agents and brokers. This includes discussing: the availability of low-income supports, including the Part D Low-Income Subsidy and Medicare Savings Programs; general information on Medigap Federal guaranteed issue (GI) rights, and the practical implications of switching from MAto traditional Medicare. In addition, the rule would require that agents pause to address remaining questions the beneficiary may have related to enrollment in a plan prior to moving forward with enrollment.

Third, CMS is proposing to expand its oversight of MA and Part D marketing and communication materials by broadening the definition of marketing in order to strengthen beneficiary protections.

Dual Eligibles Provisions

CMS has a goal of creating less fragmented care for dual eligible beneficiaries. To meet that goal, they are proposing requiring Dual Eligible Special Needs Plans (D-SNPs) to do the following:

- Have integrated member identification (ID) cards that serve as the ID cards for both the Medicare and Medicaid plans in which an enrollee is enrolled.
- Conduct an integrated health risk assessment (HRA) for Medicare and Medicaid rather than separate HRAs for each program.
- Codify timeframes for all SNPs to conduct HRAs and individualized care plans (ICPs) and prioritize the involvement of the enrollee or the enrollee's representative, as applicable, in the development of the ICPs.

Enhancing Behavioral Health Benefits

As part of an effort to improve beneficiaries' access to behavioral health care, CMS is proposing that in-network cost-sharing may be no greater for MA plans than the cost-sharing that traditional Medicare requires for these services. CMS proposes to limit copayments to 20% or an actuarially equivalent copayment limit, for mental health specialty services, psychiatric services, partial hospitalization/ intensive outpatient services, and outpatient substance use disorder services. Also, the rule proposes zero cost-sharing for opioid treatment program services. CMS is also asking for comments on whether a

transition period would be needed for these changes to avoid potentially disruptive changes in MA cost-sharing standards.

Clarifying Debit Card Use for Supplemental Benefits

Many MA plans receive significant rebates and transfer some of those funds to beneficiaries to use for supplemental benefits. Often, those funds are given to beneficiaries in the form of debit cards. To clarify what those cards may be used for, CMS proposes the following:

- Additional disclosure requirements to beneficiaries to increase transparency, including additional disclosure rules around supplemental benefits and plan debit cards.
- A requirement that MA organizations allow an enrollee to receive covered benefits through an alternative process if there is an issue with a plan debit card.
- A requirement for debit cards to be electronically linked to plan-covered items and services through a real-time identification mechanism.
- Clarification on what types of over-the-counter products are acceptable as primarily health-related supplemental benefits.
- A prohibition on MA organizations from marketing the dollar value of a supplemental benefit or the method by which a supplemental benefit is administered.

MEDICARE PART D PROVISIONS

Coverage of Anti-Obesity Medication

CMS has changed regulations to permit the coverage of anti-obesity medications (i.e., Ozempic) for the treatment of obesity when the drugs are indicated for weight loss or weight maintenance even without the existence of another medically accepted indication (i.e., type 2 diabetes). This provision also recognizes obesity as a chronic disease. This will only be for those persons labeled obese, not for those who are overweight. This will also be applied to Medicaid plans as well. CMS estimates that this will cost the federal government $24.8 billion for Part D costs and $14.8 billion for Medicaid costs over a ten-year period.

Vaccine Cost-Sharing

This provision would implement section 11401 of the IRA requiring that the Part D deductible will not apply to, nor is there any cost-sharing for, adult vaccines recommended by the Advisory Committee on

apply to, nor is there any cost-sharing for, adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). This includes common vaccines like flu, HPV, COVID-19, Shingles, and other vaccines for more rare occurrences like anthrax and Dengue Fever.

Insulin Cost-Sharing Changes

This proposal would implement section 11406 of the IRA requiring that the Medicare Part D deductible will not apply to covered insulin products and that the Part D cost-sharing amount for a one-month supply of each covered insulin product must not exceed the statutorily defined "applicable copayment amount" for all enrollees. The applicable copayment amount for 2023, 2024, and 2025 is $35. From 2026 on, a decision tree will be used for the copayment based on drug prices for that year.

Medicare Prescription Payment Plan

The rule continues the existing provisions of the Medicare Prescription Payment Plan through 2026 – but adds two new features. First, CMS proposes an automatic renewal process for the beneficiary for the next calendar year unless the enrollee opts out. Second, CMS is asking for comments on a potential requirement for Part D sponsors to effectuate election requests received via phone or web in real time for 2026 or future years.

Pharmacy Network Transparency for Pharmacies and Beneficiaries

CMS is proposing two new initiatives to strengthen pharmacy networks. First, they propose requiring Part D plans to provide contracted pharmacies with information about which Part D plans they are in-network for before open enrollment and afterward on request. Secondly, CMS proposes allowing pharmacies to terminate their network contracts without cause after the same notice period that the sponsor is allowed to terminate pharmacy network contracts without cause.

Biosimilar and Generic Drugs

While already in statute, CMS clarifies that drug plans must provide beneficiaries with broad access to generics, biosimilars, and other lower-cost drugs. CMS is making this statement as a result of reports from external entities that pharmacy benefit managers (PBMs) and Part D plans have y been favoring more expensive brand drugs and reference biological products over generics, biosimilars, and other lower-cost drugs in terms of formulary placement or non-placement.

2. https://www.cdc.gov/acip-recs/hcp/vaccine-specific/

MA AND PART D PLAN PROVISIONS

Medical Loss Ratio (MLR)

To increase oversight and CMS is proposing to better align MA and Part D MLR requirements with commercial MLR and Medicaid MLR requirements, CMS is proposing the following changes:

- Require that provider incentive and bonus arrangements be tied to clinical or quality improvement standards in order to be included in the MA MLR numerator.
- Require administrative costs be excluded from quality-improving activities in the MA and Part D MLR numerators.
- Codify the current practice by which MA and Part D MLR reports include a description of how expenses are allocated across lines of business.
- Establish compliance standards for MA and Part D MLR audits by proposing to regulate CMS actions taken as a result of audit findings. CMS is putting forward standards for selecting contracts for audit examinations, clarifying compliance actions that will be taken as a result of audit findings, and outlining an appeals process (a detailed explanation of these audit provisions can be found starting on page 335 of the proposed rule).
- Exclude Medicare Prescription Payment Plan unsettled balances from the MLR

CMS is also requesting information on MLR and vertical integration in MA and Part D. CMS estimates these provisions could result in an increase of around $101 Million in annual remittances paid by MA organizations to the government and an increase of annual remittances from the audit process of $32 million.

We trust you found this summary useful. Please reach out to us with any questions.