75 Varick St, 5th Floor
New York, NY 10013

January 8, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS–9895–P
P.O. Box 8016
Baltimore, MD 21244–8016

Submitted electronically via www.regulations.gov

RE: File Code CMS-9895-P: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters ("NBPP") for 2025

Dear Administrator Brooks-LaSure:

Creating a personally tailored, best-in-class healthcare experience for our members is built into the ethos of Oscar Health ("Oscar"), the first health insurance company built around an end-to-end technology platform and a relentless focus on the consumer. Oscar believes the individual market is the market for everyone – and we use our technology platform, culturally competent care programs, and uniquely curated plan designs to make care more equitable, accessible, affordable, and member-centric. In these respects, our policy goals are aligned with CMS. Therefore, we urge CMS to re-examine the proposal to further limit non-standardized plans in the NBPP for 2025.

In general, we echo the comments proffered by our trade group, AHIP, on this proposed rule. However, because Oscar is a unique player in the Affordable Care Act ("ACA") marketplace, we write to emphasize our particular concerns with CMS' proposed limitation on non-standardized plan offerings.

The letter below seeks to demonstrate that the proposal to reduce non-standardized plans to two, especially so quickly after reducing these plans to four, will cause significant disruption for the 1.78 million[1] additional consumers who will be displaced from their 2024 plan selection. The proposal will also reduce issuers' ability to tailor benefits to meet the unique needs of some members.

We urge CMS to delay implementation of further non-standardized plan limits for plan year 2025. We further urge CMS to finalize its proposed exceptions process to allow for additional plans designed to address chronic and high-cost conditions, and to add a third category for benefit designs that address health disparities in underserved communities. We suggest technical modifications to the proposed exceptions process to ensure it can be successfully implemented for plan year 2025 and beyond. Finally, we request that CMS perform a comprehensive study on the effects of non-standardized plan reduction in plan year 2024 on consumers.

1. **Oscar is serving vulnerable populations uniquely well through plan designs.**

[1] CMS estimate in NBPP for Plan Year 2025, 88 Fed. Reg. 82607 (November 24, 2023).

Oscar's key differentiator is our member experience: we have an industry-leading Net Promoter Score (NPS) of 60[2] and strong membership retention. Oscar creates a best-in-class member experience by pairing high-touch, seamless member engagement with data-driven plan design to improve health outcomes. We leverage claims data, membership data, and market prevalence to identify clinical and cultural cohorts that could benefit from plans tailored for chronic conditions – then pilot these plans in select markets. It is our belief and experience that innovative plan design, when coupled with best-in-class technology and member experience, can help advance health equity and improve health outcomes. As discussed in detail in section 3 below, data regarding our Diabetes Plan supports this hypothesis.

2. **Delaying the transition from four to two non-standardized plans will protect 1.78 million[3] additional consumers from displacement from their 2024 plan selection.**

CMS indicates in the proposed rule that it phased in the two plan limit over two plan years (instead of adopting the limit of two in plan year 2024) "primarily to decrease the risk of disruption for both issuers and enrollees, and to provide increased flexibility to issuers."[4] Despite the phased approach noted, CMS projected in the final NBPP for plan year 2024 that of the approximately 10.21 million enrollees in the FFEs and SBE–FPs in plan year 2022, approximately **2.72 million (26.6 percent) of these enrollees would have their current plan offerings affected**, and issuers would therefore be required to select another qualified health plan to crosswalk these enrollees into for plan year 2024.[5] CMS anticipates further disruption under the proposed transition of a limit to two non-standardized plans for plan year 2025, estimating that approximately **1.78 million of the 14.94 million enrollees on the FFE and SBE–FPs (11.9 percent) will be affected by these discontinuations in plan year 2025**.[6]

We fear that CMS is underestimating the severity of impact to these consumers as part of this disruption for the second consecutive plan year. Crosswalking is, at best, disruptive to members. It moves a member to a plan they did not select and creates an administrative need for a member to review new plan materials with modified benefits, out-of-pocket costs, and potentially modified networks. In many cases, there truly is no "apples to apples" alternative for members, particularly as insurers are required to reduce the total number of non-standardized plan options. Therefore, crosswalking may result in members being mapped to plans that do not adequately suit their needs. For example, as of 1/5/24, 54% of members crosswalked during open enrollment 2024 affirmatively selected a different plan with Oscar or left Oscar. This is significantly higher than the 26% of members who selected different plans with Oscar or left when auto-renewed on the plan they were already on during the same period. Even more concerning, crosswalking can lead to higher costs for members for desired services. As discussed further below, Oscar diabetes plan members who were crosswalked after their diabetes plan was discontinued to comply with plan year 2024 non-standardized plan limits incurred higher out of pocket costs as a result: these members will pay $80 more for diabetic specialist visits, $10 more for diabetic related labs and tests, and $20 more for primary care and behavioral health visits. There will be even fewer alternatives available to crosswalked members if there are only two non-standardized plans permitted in plan year 2025.

3. **Limiting non-standardized plans impedes the ability to tailor benefits to meet specific needs.**

Non-standardized plan limits hinder innovation and commoditize a critical market for underserved populations. Healthcare is not one size fits all: individuals have different needs based on factors including,

[2] Net Promoter Score (NPS) received as of Q3 2023. An NPS is a common metric used in customer experience programs that represents how likely a customer is to recommend a business to a friend or colleague.
[3] CMS estimate at NBPP for Plan Year 2025, 88 Fed. Reg. 82607 (November 24, 2023).
[4] NBPP for Plan Year 2025, 88 Fed. Reg. 82607 (November 24, 2023).
[5] CMS estimate at NBPP for Plan Year 2024, 88 Fed. Reg. 25856 (April 27, 2023).
[6] CMS estimate at NBPP for Plan Year 2025, 88 Fed. Reg. 82607 (November 24, 2023).

but not limited to age, gender identity, health history, and whether they live with a chronic illness. Oscar's mission requires us to be thoughtful and inclusive in product development, using benefit design to address the unique needs of all members – including and especially underserved populations. A non-standardized plan provides more flexibility in benefit designs and can allow for lower cost-sharing in the specific areas that matter most to a given member. Because of these unique needs and preferences, consumers tend to choose non-standardized plans when given the choice. For example, approximately 88% of Oscar's members nationally enrolled in non-standardized plans in plan year 2023. As of 1/5/24, 83% of members nationally enrolled in non-standard plans during Open Enrollment 2024, notwithstanding that CMS imposed a four-plan limit.

While we appreciate CMS' stated policy goal of reducing the number of non-standardized plans to reduce the risk of "plan choice overload," the current and proposed limitations on non-standardized plans exceed this objective. Plan limits do eliminate choices that are not "meaningfully different" from each other (an objective that Oscar supports), but they also force payers to eliminate plans that *are* meaningfully different and provide unique value to consumers. As noted in the RAND study[7] CMS cited in the final NBPP for plan year 2024 as a basis for non-standardized plan limits, "…limiting the choice set can detract from consumer well-being if desirable options are excluded from the choice set (citing Dafny, Ho, and Varela, 2013)." Eliminated plans include options tailored to meet the needs of underserved populations that lower costs, improve quality, and improve health outcomes.

By necessity, plan design options in the four (or two) permitted non-standardized plan slots must competitively appeal to the majority of consumers – significantly diluting the business case for designs tailored to improve health outcomes in smaller, underserved communities. Moreover, payers are limited by the actuarial value (AV) calculator when deciding which high value, specialized benefits to incorporate into products designed for the average consumer. As demonstrated in Attachment A, incorporating the rich benefits of condition specific plans into more popular plans designed for the average consumer puts the popular plan out of AV range, necessitating cost-sharing increases on that plan (i.e., a higher deductible or maximum out-of-pocket cost) to comply. This is one of many reasons Oscar decided to pursue condition specific plan designs: to ensure vulnerable members with chronic conditions would have plan choices with rich, condition specific benefits for the services they need, without necessitating adjustments to other valuable benefits on plans designed to appeal to the majority of consumers.

For example, Oscar's Diabetes Plan has been available in select markets since 2022 and includes benefits designed to lower out-of-pocket costs for services members need to manage their diabetes.[8] Benefits include $0 for tier 1a drugs, a $100 out-of-pocket maximum on insulin, primary care visits, diabetic foot and retinal eye exams, labs, wellness programs and health coaching. Members enrolled in this plan have seen notable results: **9% better adherence to diabetes medications, 17% higher rates of eye exam screenings, and 12% higher rates of kidney disease screenings.[9]** As a result of CMS' limitation on non-standardized plans, Oscar ultimately discontinued **10 diabetes plans in six markets** in 2024.

---

[7] See "Consumer Decisionmaking in the Health Care Marketplace", pg 27. https://www.rand.org/content/dam/rand/pubs/research_reports/RR1500/RR1567/RAND_RR1567.pdf. Accessed December 18, 2023. See also NBPP for Plan Year 2024, 88 Fed. Reg. 25852 (April 27, 2023).

[8] See: "Meet the plan designed to support diabetes care", Oscar Health. https://www.hioscar.com/diabetes. Accessed December 18, 2023.

[9] As of plan year 2022. Comparison of diabetic members in Oscar's Diabetes Care plan to diabetic members not enrolled in Oscar's Diabetes Care plan.

The negative member impact of this discontinuation can be quantified by a case study performed on 2023 membership. There were 6,254 members on our Diabetes plan in one particular state during plan year 2023. Early data showed that members with more severe cases enrolled in this plan, and members were adhering to insulin at better rates. For plan year 2024, we had to discontinue this plan in favor of four silver plans, each of which had more than 25,000 members. These diabetic members were crosswalked to a very similar plan, but without diabetic-specific benefits. **As noted above, as a result, these members will pay $80 more for diabetic specialist visits, $10 more for diabetic related labs and tests, and $20 more for primary care and behavioral health visits.**

Oscar also launched a "Breathe Easy" Plan for 2024 for individuals with chronic obstructive pulmonary disease (COPD) and asthma, two leading respiratory diseases in America. Plan benefits include the following at $0: pulmonologist and Primary Care visits, pulmonary rehabilitation, oxygen services, Tier 1 preferred generics, nicotine replacement, and behavioral health services. Members can also access financial incentives for health checkups. As a result of non-standardized plan limits, **Oscar limited the roll out of this plan to three markets instead of the goal of six to eight markets in plan year 2024.**

Notably, the conditions addressed by both of these products disproportionately impact underserved communities. For example, Hispanic adults are 70 percent more likely than non-Hispanic White adults to be diagnosed with diabetes.[10] African Americans are 30 percent more likely to have asthma than Whites, and are almost three times more likely to die from asthma related causes.[11] Chronic condition plan designs, when coupled with culturally competent care management and the best-in-class member experience offered by Oscar, can improve disparate health outcomes and serve as an important tool for combatting health inequities.

4. **<u>The proposed exceptions process should be broadened to include benefit designs that address health disparities in underserved communities.</u>**

    a. **Substantive Recommendations**

We applaud CMS for proposing an exceptions process that will enable issuers to bring innovative products addressing chronic and high-cost conditions to market. **However, we strongly recommend the exceptions process categories be expanded to allow for plan design options with benefits tailored to address documented health disparities in underserved communities**. Such plans might include benefits designed to improve access, enhance quality of care, and/or lower out of pocket costs for critical services, as well as provide access to wellness programs and native-language inclusivity to increase engagement and health literacy. Medicare Advantage plans are already piloting plans targeted to cultural and ethnic communities,[12] and we believe such products should also be available to consumers in the individual marketplace.

[10] See: "Diabetes and Hispanic Americans", U.S. Department of Health and Human Services Office of Minority Health. https://minorityhealth.hhs.gov/diabetes-and-hispanic-americans. Accessed December 18, 2023.
[11] See: "Asthma and African Americans", U.S. Department of Health and Human Services Office of Minority Health. https://minorityhealth.hhs.gov/asthma-and-african-americans. Accessed December 18, 2023.
[12] See: "New Medicare Advantage plans tailor offerings to Latinos, Asian Americans and LGBTQ+ people" https://www.latimes.com/business/story/2023-09-25/medicare-advantage-plans-asian-americans-latinos-lgbtq-people. Accessed December 20, 2023.

The additional exception would be consistent with and complimentary to CMS' ongoing efforts to improve health equity. In the CMS Framework for Health Equity 2022-2023 ("the Framework"),[13] CMS discusses strategies to address well-known health disparities[14] and affirms its commitment to partner with all stakeholders on innovation to advance health equity.[15] The Framework lists multiple documented health disparities with respect to certain conditions or certain underserved populations that are not captured in the exceptions process as proposed, including: maternal health, behavioral health, LGBTQ+ communities and rural communities. **Benefit designs that address health disparities in underserved communities, as defined by CMS,[16] should be permitted through the exceptions process, subject to the 25% cost-share differential test.** We suggest amendment language in Attachment B.

Payers could meet the parameters of this exception the same way they would for a chronic or high-cost condition exception: by demonstrating that cost-sharing for the benefits targeting the specific disparity reduces annual enrollee cost-sharing by 25% or more relative to the cost-sharing for the same corresponding benefits in the issuer's other non-standardized plan offerings.

As an example, maternal health is a well-documented disparity among underserved populations that is not captured by the exceptions process as proposed. CMS' new Transforming Maternal Health (TMaH) Model[17] is a 10-year program where states receive up to $17 million to increase Medicaid and CHIP beneficiaries' access to midwives, birth centers, and doulas to improve care and reduce maternal mortality. We note that 46% of ACA consumers and ~37% of Oscar members are just above Medicaid eligibility limits (100-150% Federal Poverty Level) on average across FFM states (a number anticipated to grow as a result of Medicaid Unwinding) and therefore are also particularly vulnerable to these disparities.[18] The TMaH policy concept translates seamlessly into a non-standardized plan with customized benefits for maternal health such as midwives, doulas, perinatal support, and other benefits and care programs that focus on whole-person care. Such a product would not be attractive to everyone and may not be viable in an issuer's portfolio if the payer is limited to four (or two) non-standardized plans. However, a health disparity exception would create a path for issuers to engage in this important innovation.

---

[13] See: "CMS Framework for Health Equity 2022–2032", Center for Medicare and Medicaid Services (CMS). https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf. Accessed December 18, 2023.

[14]CMS defines health disparities as "Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health, health quality, or health outcomes that are experienced by underserved populations." See CMS definition, adapted from CDC: https://www.cms.gov/priorities/innovation/key-concepts/health-equity. Accessed December 18, 2023.

[15] CMS defines health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes." See CMS definition, adapted from CDC: https://www.cms.gov/priorities/innovation/key-concepts/health-equity Accessed December 18, 2023.

[16] CMS defines "underserved community" as **"**Individuals who share a particular characteristic – demographic, geographic (urban or rural), or other factor – that results in them being systematically denied full opportunity to participate in aspects of economic, social, and civic life." See CMS definition, adapted from Executive Order 13985: https://www.cms.gov/priorities/innovation/key-concepts/health-equity. Accessed December 18, 2023.

[17] See: "Transforming Maternal Health (TMaH) Model", Center for Medicare and Medicaid Services (CMS). https://www.cms.gov/priorities/innovation/innovation-models/transforming-maternal-health-tmah-model. Accessed December 18, 2023.

[18] See: "2023 Marketplace Open Enrollment Period Public Use Files, Center for Medicare and Medicaid Services (CMS).https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products/2023-marketplace-open-enrollment-period-public-use-files. Accessed December 19, 2023.

Adding an additional exception for plan designs targeting documented health disparities would not compromise CMS's desired narrow approach to additional non-standardized plans. CMS's exception form approval process enables it to consider the clinical and statistical validity of the documented disparities and related cost-sharing for members and to make the ultimate decision on any plan petitioning for an exception.

As CMS notes in the Framework, to ultimately achieve health equity, personalized interventions are needed to address health disparities in underserved communities. Oscar's experience demonstrates that plan design is a critical tool to deliver personalized care to underserved communities. To this end, we believe it is crucial to broaden the category for exceptions to allow issuers to innovate and pilot new evidence-based plan designs in this space to further our shared goals of eliminating health disparities in all underserved and disadvantaged communities and advancing health equity.

b. Technical Recommendations

We appreciate that creating this new exceptions process introduces new administrative requirements for both issuers and CMS with a short runway for implementation. As proposed, plans would demonstrate compliance with the exceptions process through a justification form to be provided by CMS as part of the final rule, and payers would submit the application by the QHP certification Early Bird deadline (May 15, 2024). This justification form would ask the issuer to:

1. Identify the specific condition(s) for which cost-sharing is reduced;
2. Explain which benefits would have reduced annual enrollee cost-sharing (as opposed to reduced cost-sharing for a limited number of visits) for the treatment of the specified condition(s) by 25% or more relative to the cost-sharing for the same corresponding benefits in an issuer's other non-standardized plan offerings in the same product network type, metal level, and service area; and
3. Explain how the reduced cost-sharing for these services pertains to clinically indicated guidelines for treatment of the specified chronic and high-cost condition(s).[19]

We suggest the following technical modifications and clarifications for the 25% cost-share differential test to ensure it can be successfully implemented for plan year 2025 and beyond (see Attachment C for supporting actuarial exhibits):

Recommendation 1: **CMS should confirm that the 25% cost-share differential test applies only to plans without preferential cost-sharing. At a minimum, Cost-Sharing Reduction (CSR) variants and American Indian (AI) /Alaska Native (AN) non-standardized plans should be excluded from the test.** *Rationale*: Certain variants among metal levels include preferential cost-sharing for certain populations such as CSR variants or AI /AN non-standardized plans. There are little to no cost-shares allowable in those respective variants, making it impossible to build a chronic or high-cost condition product, even at a $0 benefit level, that contains a 25% cost-share differential. See Attachment C, Exhibits 1 and 2. Therefore, we recommend that CMS clarify that the test applies only to base plans within each metal level, excluding preferential variants.

Recommendation 2: **We suggest implementing a "safe harbor" test under which chronic or high-cost condition plans are deemed compliant with the 25% cost-share differential test if benefits pertaining to treating the condition in the chronic or high-cost condition plan are $0. See Attachment C, Exhibit 3.**

[19] NBPP for Plan Year 2025, 88 Fed. Reg. 82607 (November 24, 2023).

Rationale: If the benefits in question are covered with no cost-sharing in the high-cost or chronic condition plan (i.e., $0 pre-deductible), then by definition, the plan provides the maximum value for the benefit to the consumer. Requiring a 25% differential in such cases is unnecessary, and could have the unintended consequence of incenting issuers to make these benefits less rich (i.e., increase cost-sharing) in high value non-standardized plans for the purpose of complying with the test. Further, if the cost-share structure for non-standardized plans are inherently different from the chronic or high-cost condition plan (i.e., comparing pre-deductible copay benefits to deductible/coinsurance/HSA benefits), then the benefit differential will require a complex Actuarial Value (AV) analysis at the benefit level, creating significant administrative effort for both the issuer and the CMS reviewer and potential inconsistent methodologies applied among issuers. This effort seems unnecessary since the high-cost or chronic condition plan is already providing the richest benefit possible. A safe harbor will simplify the exception justification as it would limit the need to perform redundant actuarial analyses.

Recommendation 3: **We urge CMS to approve exceptions "in concept" based solely upon the justification form in advance of Qualified Health Plan ("QHP") binder filings in SERFF, subject to subsequent verification of compliance with the 25% cost-share differential test when an issuer submits its full QHP portfolio in SERFF.**
Rationale: It is our understanding that under the current proposal, issuers on the FFM with State Plan Management would be required to submit a complete QHP Binder application via SERFF by the early application deadline to participate in the CMS exceptions process so that CMS can verify an exception's compliance with the 25% cost-share differential test. This is problematic for two reasons.

First, it will be impossible for an issuer to finalize its non-standard plan portfolio absent certainty on whether an exception will be approved in concept. Second, there are numerous technical challenges and inefficiencies with approving exceptions using QHP binder filings in SERFF. Should a proposed exception plan be disallowed by CMS, an issuer would have to go through the formal withdrawal process to remove the disallowed plans from their QHP binder. In some States, this process includes writing a formal email to the State Reviewer requesting the removal and then formally submitting the withdrawal via the Plan Management (PM) Community. This could prove to be administratively burdensome for state reviewers as they would have to transfer data that they have not reviewed against their regulations to CMS ahead of their allotted timeframes and for CMS reviewers that could create a noted uptick in formal withdrawal requests via the PM Community. In States such as Michigan where plans are not allowed to be removed from the initially submitted Plan Benefit Templates regardless of a withdrawal request, issuers would also face administrative and quality assurance challenges as they would need to consistently update "dead" plans across all CMS templates to ensure they pass validation and meet CMS submission deadlines.

As an alternative, we suggest that the exceptions application form be submitted as a narrative with supporting actuarial issuer data to CMS, and that any approvals be contingent upon an issuer's demonstrated compliance with the cost-share differential test in its binder filing when ultimately submitted in SERFF. This shifts the risk to the issuer to ensure the test is met in its filing, but also eliminates the technical and administrative challenges outlined above. It would also provide issuers with needed certainty to finalize business decisions on their product portfolios in advance of filing deadlines.

Finally, to streamline this process, we urge CMS to finalize the exceptions application form as soon as possible, and to accept applications immediately following publication of the final rule.

5. **Further study is needed to determine the effect of plan limits on consumers before additional limits are imposed.**

It is too soon to conclude that the plan year 2024 non-standardized plan limits did in fact improve the consumer shopping experience. Before further reducing plan limits to two, the consumer experience during open enrollment for plan year 2024 should be retroactively evaluated to determine whether or not the shopping experience improved as a result of non-standardized plan limits. As part of this study, CMS should also evaluate the role of brokers and navigators in improving the consumer shopping experience, particularly due to the fact that as of plan year 2020, brokers place nearly 50% of ACA customers on the FFM.[20] Oscar's data suggests this may be trending up. In 2023, 84% of Oscar's national business was broker-placed and as of 1/5/24, nearly 89% of Oscar's national business was broker-placed for open enrollment 2024. Navigators also play a significant role in supporting members, and are well funded and well positioned to assist consumers with the consumer shopping experience. CMS invested $98.6 million in grant funding to 57 returning Navigator organizations for the 2024 Open Enrollment Period to provide increased and enhanced enrollment assistance to help consumers find the right health coverage option, complete their Marketplace application, and enroll in coverage.[21] When adequately trained and appropriately deployed, these professionals can help members successfully navigate among the plan choices available to them.

CMS should also continue to study ways to improve plan choice architecture. Improving the filtering and sorting options on healthcare.gov to allow filtering for a specific low cost benefit, such as $0 insulin for example, could greatly enhance the consumer shopping experience and empower shoppers to find the best plans to meet their needs – without deploying strict plan limits.

Finally, CMS should study whether non-standardized plan limits, if imposed, should vary based upon market size. For example, CMS should study whether the adverse impacts to members resulting from non-standardized plan limits, such as higher out-of-pocket costs on desired benefits, were more prevalent in larger markets. In larger markets, a more diversified portfolio may be needed to meet the breadth of member needs and therefore a higher number of non-standard plans may benefit consumers.

For the reasons outlined above, CMS should delay the proposed transition to two non-standardized plan options in the marketplace per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area for plan year 2025. Additionally, CMS should adopt the proposed exceptions process for chronic and high-cost conditions, and add a third exception for plans designed to address health disparities for underserved communities. Finally, CMS should continue to study ways to reduce choice overload without imposing strict plan limits to empower and assist consumers struggling to navigate the shopping experience.

We welcome the opportunity to discuss these issues further with CMS and appreciate the opportunity to formally comment on these proposed rules.

Sincerely,

Alessa Quane
Executive Vice President, Chief Insurance Officer
Oscar Health

---

[20] See: Agents and Brokers in the Marketplace, https://www.cms.gov/sites/default/files/2020-10/Agents-and-Brokers-in-the-Marketplace.pdf. Accessed December 19, 2023.

[21] See: "Biden-Harris Administration Makes Largest Investment Ever in Navigators Ahead of HealthCare.gov Open Enrollment Period". U.S. Department of Health and Human Services. https://www.hhs.gov/about/news/2022/08/26/biden-harris-administration-makes-largest-investment-ever-in-navigators-ahead-of-healthcare-gov-open-enrollment-period.html. Accessed December 18, 2023.

About Oscar Health

Oscar Health, Inc. (“Oscar”) is the first health insurance company built around a full stack technology platform and a relentless focus on serving its members. At Oscar, our mission is to make a healthier life accessible and affordable for all. Headquartered in New York City, Oscar has been challenging the health care system's status quo since our founding in 2012. The company’s member-first philosophy and innovative approach to care has earned us the trust of nearly one million members, as of September 30, 2023. We offer Individual & Family and Small Group plans, and +Oscar, our full stack technology platform, to others within the provider and payor space. Our vision is to refactor health care to make good care cost less. Refactor is a term used in software engineering that means to improve the design, structure, and implementation of the software, while preserving its functionality. At Oscar, we take this definition a step further. We improve our members’ experience by building trust through deep engagement, personalized guidance, and rapid iteration.

ATTACHMENT A-*Demonstrating that the merger of Oscar's Diabetes Plan benefits into a popular Silver Plan exceeds allowed Actuarial Value of Silver Plan, necessitating increased cost-sharing on other benefits for members in Silver Plan to attain AV compliance*

2024 Federal AV Calculation

Why can't Oscar modify non-standard plans to include chronic condition features?

This illustration demonstrates how one of Oscar's most popular plan designs, the "Silver Simple PCP Saver," would not be compliant with the Federal AV de minimis ranges, should we modify cost shares to mirror the differentiated benefits of the Diabetes chronic specific condition plan.

Plan	Silver Simple PCP Saver (Base)	Silver Simple PCP Saver (Base) MODIFIED FOR DIABETES
HIOS ID	40572FL0070025-00	**n/a - illustrative plan design**
Metal	Silver	Silver
AV Screenshot	See Page 11	See Page 12
PCP Visit	$20 copay	$0 copay
Mental Health Visit	$20 copay	$0 copay
Specialist Visit	$80 copay	$40 copay
Generic Tier 1	$3 copay	$0 copay
Preferred Brand drugs	$100 copay	$75 copay
Federal AV	70.23%	72.32%
Status	Calculation Successful	Error: Result is outside of [-2, +2] percent de minimis variation.

Disclaimer: Other preferred cost shares were not included for purposes of illustrating Federal AV Status, as the cost shares described below represent a subset of the standard AV benefit inputs:

- *$0 copay for HbA1c, urinalysis, metabolic, lipid panel Labs*
- *$0 copay for diabetic foot care, diabetic retinal exam ophthalmologist specialist office visit*

Nonetheless, these non-standardized inputs would only further exacerbate the degree to which the diabetes plan would be out of AV range compliance.

To bring the modified Silver Simple PCP Saver plan back to compliance, Oscar would have to greatly increase deductibles and maximum out-of-pocket costs on this plan. This would disproportionately impact a broader set of members, relative to those with diabetes selecting a chronic condition plan.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	✓
Apply Inpatient Copay per Day?	
Apply Skilled Nursing Facility Copay per Day?	
Use Separate MOOP for Medical and Drug Spending?	
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	
Annual Contribution Amount:	

Tiered Network Option	
Tiered Network Plan?	✓
1st Tier Utilization:	20%
2nd Tier Utilization:	80%

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
		$5,500.00
		60.00%
		$8,900.00

Tier 2 Plan Benefit Design		
Medical	Drug	Combined
		$5,500.00
		60.00%
		$8,900.00

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	✓ All	✓ All			✓ All	✓ All			All	All
Emergency Room Services	✓	✓			✓	✓				
All Inpatient Hospital Services (inc. MH/SUD)	✓	✓			✓	✓				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				$20.00				$20.00		
Specialist Visit				$80.00				$80.00		
Mental/Behavioral Health and Substance Use Disorder Outpatient Services				$20.00				$20.00		
Imaging (CT/PET Scans, MRIs)	✓	✓			✓	✓				
Speech Therapy	✓	✓			✓	✓				
Occupational and Physical Therapy	✓	✓			✓	✓				
Preventive Care/Screening/Immunization			100%	$0.00			100%	$0.00		
Laboratory Outpatient and Professional Services				$10.00	✓	✓				
X-rays and Diagnostic Imaging	✓	✓			✓	✓				
Skilled Nursing Facility	✓	✓			✓	✓				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓			✓	✓				
Outpatient Surgery Physician/Surgical Services	✓	✓			✓	✓				
Drugs	✓ All	✓ All			✓ All	✓ All			All	All
Generics				$3.00				$25.00		
Preferred Brand Drugs				$100.00				$100.00		
Non-Preferred Brand Drugs	✓	✓			✓	✓				
Specialty Drugs (i.e. high-cost)	✓	✓			✓	✓				

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Plan Description:

Name: Silver Simple PCP Saver
Plan HIOS ID: 40572FL0070025-03
Issuer HIOS ID: 40572
AVC Version: 2024_1e

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.23%
Metal Tier:	Silver
Additional Notes:	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Calculation Time:	0.0859 seconds

Final 2024 AV Calculator

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Tiered Network Option	
Tiered Network Plan?	☑
1st Tier Utilization:	20%
2nd Tier Utilization:	80%

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,500.00
Coinsurance (%, Insurer's Cost Share)			60.00%
MOOP ($)			$8,900.00
MOOP if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,500.00
Coinsurance (%, Insurer's Cost Share)			60.00%
MOOP ($)			$8,900.00
MOOP if Separate ($)			

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Copay applies only after deductible?**	
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☐	☐		$0.00	☐	☐
Specialist Visit	☐	☐		$40.00	☐	☐		$40.00	☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$0.00	☐	☐		$0.00	☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☑	☑			☑	☑			☐	☐
Occupational and Physical Therapy	☑	☑			☑	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$10.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$0.00	☐	☐		$25.00	☐	☐
Preferred Brand Drugs	☐	☐		$75.00	☐	☐		$75.00	☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: Silver Simple PCP Saver
Plan HIOS ID: 40572FL0070025-03
Issuer HIOS ID: 40572
AVC Version: 2024_1e

Output

Status/Error Messages: Error: Result is outside of [-2, +2] percent de minimis variation.
Actuarial Value: 72.32%
Metal Tier:

NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.

Additional Notes:

Calculation Time: 0.0547 seconds
Final 2024 AV Calculator

ATTACHMENT B-Suggested Amendment Language

§ 156.202 Non-standardized plan option limits.

Add New Definitions

Health Disparity[22]: Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health, health quality, or health outcomes that are experienced by underserved populations.

Underserved Community[23]: Individuals who share a particular characteristic – demographic, geographic (urban or rural), or other factor – that results in them being systematically denied full opportunity to participate in aspects of economic, social, and civic life.

A QHP issuer in a Federally-facilitated Exchange or a State-based Exchange on the Federal platform:

(a) For plan years 2024 and 2025, is limited to offering four non-standardized plan options per product network type, as the term is described in the definition of "product" at § 144.103 of this subchapter, metal level (excluding catastrophic plans), and inclusion of dental and/or vision benefit coverage (as defined in paragraph (c) of this section), in any service area.

~~(b) For plan year 2025 and subsequent plan years, is limited to offering two non-standardized plan options per product network type, as the term is described in the definition of "product" at § 144.103 of this subchapter, metal level (excluding catastrophic plans), and inclusion of dental and/or vision benefit coverage (as defined in paragraph (c) of this section), in any service area.~~

~~(c)~~ (b) For purposes of paragraphs (a) and (b) of this section, the inclusion of dental and/or vision benefit coverage is defined as coverage of any or all of the following:

(1) Adult dental benefit coverage as defined by the following in the "Benefits" column in the Plans and Benefits Template:

(i) Routine Dental Services (Adult);
(ii) Basic Dental Care—Adult; or
(iii) Major Dental Care—Adult.

(2) Pediatric dental benefit coverage as defined by the following in the "Benefits" column in the Plans and Benefits Template:

(i) Dental Check–Up for Children;
(ii) Basic Dental Care—Child; or
(iii) Major Dental Care—Child.

(3) Adult vision benefit coverage as defined by the following in the "Benefits" column in the Plans and Benefits Template: Routine Eye Exam (Adult).

~~(d)~~ (c) For plan year 2025 and subsequent years, an issuer may offer additional nonstandardized plan options per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area if it demonstrates that these additional plans' cost-sharing for benefits pertaining to the

[22] In the Framework, CMS defines health disparities as, "Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health, health quality, or health outcomes that are experienced by underserved populations." See CMS definition, adapted from CDC, https://www.cms.gov/priorities/innovation/key-concepts/health-equity. Accessed December 18, 2023.

[23] In the Framework, CMS defines "underserved community" as, **"**Individuals who share a particular characteristic – demographic, geographic (urban or rural), or other factor – that results in them being systematically denied full opportunity to participate in aspects of economic, social, and civic life." See CMS definition, adapted from Executive Order 13985: https://www.cms.gov/priorities/innovation/key-concepts/health-equity. Accessed December 18, 2023.

treatment of chronic and high-cost conditions (including benefits in the form of prescription drugs, if pertaining to the treatment of the condition(s)) or benefits pertaining to a health disparity in an underserved community is at least 25 percent lower, as applied without restriction in scope throughout the plan year, than the cost-sharing for the same corresponding benefits in an issuer's other non-standardized plan option offerings in the same product network type, metal level, and service area. The reduction must not be limited to a part of the year, or an otherwise limited scope of benefits, and the reduced cost-sharing for these benefits cannot be conditioned on a consumer having a particular diagnosis. Chronic and high-cost conditions and health disparities in underserved communities that may qualify an issuer for this exception will be determined by HHS.

~~(c)~~ (d) An issuer that seeks to utilize this exceptions process is required to submit a written justification in a form and manner and at a time prescribed by HHS that:

(1) Identifies the specific condition(s) for which cost-sharing is reduced;
(2) Explains which benefit(s) would have reduced annual enrollee cost-sharing (as opposed to reduced cost-sharing for a limited number of visits) for the treatment of the specified condition(s) relative to the same corresponding benefits in an issuer's other non-standardized plan offerings in the same product network type, metal level, and service area; and
(3) Explains how the reduced cost-sharing for these benefits pertain to clinically indicated guidelines for treatment of the specified chronic and high-cost condition(s), or addresses a health disparity in an underserved community.

ATTACHMENT C-Recommended Technical Changes to Cost-Share Differential Test

Exhibits 1 and 2

Recommendation 1: **CMS should confirm that the 25% cost-share differential test applies only to plans without preferential cost-sharing. At a minimum, Cost-Sharing Reduction (CSR) variants and American Indian (AI) /Alaska Native (AN) non-standardized plans should be excluded from the test.** *Rationale*: Certain variants among metal levels include preferential cost-sharing for certain populations such as CSR variants or AI /AN non-standardized plans. There are little to no cost-shares allowable in those respective variants, making it impossible to build a chronic or high-cost condition product, even at a $0 benefit level, that contains a 25% cost-share differential. Therefore we recommend that CMS clarify that the test applies only to base plans within each metal level, excluding preferential variants.

Illustration of Diabetes Condition Plan in Georgia (QUANTITATIVE TESTING ONLY)

Exhibit 1 - For Silver Metal Level Test, testing only relative to a Silver base plan

Category	Condition Plan	All other Non-standard plans
Plan	Silver Simple Diabetes	Non-standard plan
HIOS ID - 14 Digit	58081GA0010045	n/a - Most generous cost-share across non-standard plans within Metal
Service Area	GAS001	GAS001
Metal	Silver	Silver
Variant	Base	Base
Cost-sharing for benefits pertaining to the treatment of chronic and high-cost conditions		
PCP Visit	$0 copay before ded	$20 copay before ded
Mental Health Visit	$0 copay before ded	$20 copay before ded
Specialist Visit	$40 copay before ded	$80 copay before ded
Diabetic foot care, diabetic retinal exam opthamologist specialist office visit	$0 copay before ded	$80 copay before ded
Generic Tier 1	$0 copay before ded	$3 copay before ded
HbA1c, urinalysis, metabolic, lipid panel Labs	$0 copay before ded	$10 copay before ded

Cost-share test for benefits pertaining to treating the chronic condition - Average member cost share

Plan	Condition Plan	All other Non standard plans - Richest design Feature	Test	Pass/Fail
PCP Visit	$0	$20	-100.00%	PASS
Mental Health Visit	$0	$20	-100.00%	PASS
Specialist Visit	$40	$80	-50.00%	PASS
Diabetic foot care, diabetic retinal exam opthamologist specialist office visit	$0	$80	-100.00%	PASS
Generic Tier 1	$0	$3	-100.00%	PASS
HbA1c, urinalysis, metabolic, lipid panel Labs	$0	$10	-100.00%	PASS

Illustration of Diabetes Condition Plan in Georgia (QUANTITATIVE TESTING ONLY)
Exhibit 2 - For Silver Metal Level Test, testing relative to all Silver plans and CSR variants

Category	Condition Plan	All other Non-standard plans
Plan	Silver Simple Diabetes	Non-standard plan
HIOS ID - 14 Digit	58081GA0010045	n/a - Most generous cost-share across non-standard plans within Metal
Service Area	GAS001	GAS001
Metal	Silver	Silver
Variant	Base	Base + Variants (CSR 150 is richest)

Cost-sharing for benefits pertaining to the treatment of chronic and high-cost conditions

PCP Visit	$0 copay before ded	$0 copay before ded
Mental Health Visit	$0 copay before ded	$0 copay before ded
Specialist Visit	$40 copay before ded	$10 copay before ded
Diabetic foot care, diabetic retinal exam opthamologist specialist office visit	$0 copay before ded	$10 copay before ded
Generic Tier 1	$0 copay before ded	$0 copay before ded
HbA1c, urinalysis, metabolic, lipid panel Labs	$0 copay before ded	$0 copay before ded

Cost-share test for benefits pertaining to treating the chronic condition - Average member cost share

Plan	Condition Plan	All other Non standard plans - Richest design Feature	Test	Pass/Fail
PCP Visit	$0	$0	0.00%	FAIL
Mental Health Visit	$0	$0	0.00%	FAIL
Specialist Visit	$40	$10	300.00%	FAIL
Diabetic foot care, diabetic retinal exam opthamologist specialist office visit	$0	$10	-100.00%	PASS
Generic Tier 1	$0	$0	0.00%	FAIL
HbA1c, urinalysis, metabolic, lipid panel Labs	$0	$0	0.00%	FAIL

Exhibit 3

Recommendation 2: **We suggest implementing a "safe harbor" test under which chronic or high-cost condition plans are deemed compliant with the 25% cost-share differential test if benefits pertaining to treating the condition in the chronic or high-cost condition plan are $0.**
Rationale: If the benefits in question are covered with no cost-sharing in the high-cost or chronic condition plan (i.e., $0 pre-deductible), then by definition, the plan provides the maximum value for the benefit to the consumer. Requiring a 25% differential in such cases is unnecessary, and could have the unintended consequence of incenting issuers to make these benefits less rich (i.e., increase cost-sharing) in high value non-standardized plans for the purpose of complying with the test. Further, if the cost-share structure for non-standardized plans are inherently different from the chronic or high-cost condition plan (i.e., comparing pre-deductible copay benefits to deductible/coinsurance/HSA benefits), then the benefit differential will require a complex Actuarial Value (AV) analysis at the benefit level, creating significant administrative effort for both the issuer and the CMS reviewer and potential inconsistent methodologies applied among issuers. This effort seems unnecessary since the high-cost or chronic condition plan is already providing the richest benefit possible. A safe harbor will simplify the exception justification as it would limit the need to perform redundant actuarial analyses.

Exhibit 3

Examples of Different Types of Cost-Shares	Average Member Cost-Share	Benefit Level AV Required
$0	No cost to member	No (cost-share = $0)
Copay before deductible	Fixed cost per visit	No (cost-share = fixed copay)
Copay after deductible	Cost of visit up to deductible, or combination of Deductible + Copay	Yes
Coinsurance after deductible	Cost of visit up to deductible, or combination of Deductible + Coinsurance	Yes

*Note - As demonstrated in Exhibit 1, any $0 cost-share will always be 100% cheaper relative to any benefit with a non-zero cost-share, in another plan. While the 25% cheaper cost share may already imply this, Oscar suggests clarifying, that if any associated cost-shares for relevant benefits are $0 then a safe harbor would avoid the need to quantitatively demonstrate the average cost-share for the non-standard plans -- as long as those comparable services in the non-standard plans are subject to cost-share.