

# Notice of Benefit and Payment Parameters for 2022 Proposed Rule Fact Sheet

In the Notice of Benefit and Payment Parameters for 2022 proposed rule released today, the Centers for Medicare & Medicaid Services (CMS) proposed standards for states, issuers, Exchanges, pharmacy benefit managers, direct enrollment entities, and the administrative appeals processes with respect to health insurance issuers and non-Federal governmental plan sponsors.

The rule would implement a limited number of regulatory changes to provide states and issuers with a more stable and predictable regulatory framework that facilitates a more efficient and competitive market. These changes would further the Administration's goals of lowering premiums, promoting program integrity, stabilizing markets, enhancing the consumer experience, and reducing regulatory burden.

## *Lowering Premiums*

### **FFE and SBE-FP User Fees**

For the 2022 benefit year, we propose a reduction in the Federally-facilitated Exchange (FFE) user fee rate to 2.25% of premium charged and a reduction in the State-based Exchange on the Federal Platform (SBE-FP) user fee rate to 1.75% of premium charged to reflect cost-saving measures implemented over the last several years in hopes of reducing the user fee burden on consumers and creating downward pressure on premiums.

## *Promoting Program Integrity*

### **Defrayal and Annual Reporting of State Mandates**

In the 2021 Payment Notice, we finalized a requirement for states to annually notify HHS of any state-required benefits applicable to QHPs in the individual and/or small group market that are considered to be "in addition to EHB" and set a July 1, 2021 deadline for states to submit to HHS their first complete reporting package. In the 2022 proposed rule, we are proposing July 1, 2022 as the deadline for states to submit to HHS the complete reporting package for the second year of reporting.

### **Essential Health Benefits**

The 2019 Payment Notice stated that we would propose EHB benchmark plan submission deadlines in the HHS annual Notice of Benefit and Payment Parameters. Accordingly, we are proposing May 6, 2022, as the deadline for states to submit the required documents for the state's EHB-benchmark plan selection for the 2023 plan year. We are also proposing May 6, 2022 as the

deadline for states to notify HHS that they wish to permit between-category substitution for the 2023 plan year.

### **Special Enrollment Periods**

In order to protect the risk pool from adverse selection and ensure program integrity in the utilization of special enrollment periods (SEPs), we propose to require all Exchanges to conduct SEP verification for at least 75% of new enrollments for consumers not already enrolled in coverage through the relevant Exchange. Because some SBEs are very small and will have very low volumes on certain SEP types, we proposed to provide flexibility for SBEs to conduct verification through alternative means, with HHS's permission.

### **Pharmacy Benefit Manager Transparency**

HHS proposes to codify in regulation the statutory requirement that Pharmacy Benefit Managers (PBMs) under contract with QHP issuers report certain prescription drug data. The data will be used to enhance our understanding of the true cost of prescription drugs provided in Exchange plans. The data collected is required to be kept confidential and may only be disclosed for limited purposes outlined in statute.

### **Audits, Compliance Reviews, and Civil Money Penalties (CMPs) Authority**

HHS proposes to codify audit and compliance review processes to further protect the integrity of federal funds. Specifically, HHS proposes several amendments to provide more clarity on its audit authority over the advance payments of the premium tax credit (APTC), cost-sharing reductions (CSR), and user fee programs. We also propose to extend these authorities to QHP issuers in State Exchanges on the Federal platform to align with our existing authority over issuers in FFE and State Exchange states. In addition, HHS proposes to make amendments to clarify that HHS has the ability to impose civil monetary penalties (CMPs) when it is enforcing the applicable federal requirements in any Exchange, regardless of whether the Exchange is established and operated by HHS or a state (including a regional Exchange or subsidiary Exchange). Additionally, HHS proposes minor procedural changes to the requirements for administrative appeals of CMPs by health insurance issuers and non-federal governmental plans to align with current practices for the Departmental Appeals Board. HHS also proposes to codify similar audit and compliance review processes for the transitional reinsurance program operated by HHS, as well as the HHS-operated risk adjustment program.

### **Medical Loss Ratio (MLR)**

We propose to amend the MLR regulation to establish the definition of prescription drug rebates and other price concessions that issuers must deduct from incurred claims for medical loss ratio (MLR) reporting and rebate calculation purposes beginning with the 2022 MLR reporting year (MLR reports filed in 2023). We additionally propose to explicitly allow issuers the option to prepay a portion or all of the estimated MLR rebate for a given MLR reporting year in advance of the deadlines set forth in §§ 158.240(e) and 158.241(a)(2) and the filing of the MLR Annual

Reporting Form. We also propose to establish a safe harbor allowing such issuers, under certain conditions, to defer the payment of any remaining rebates owed after prepayment until the following MLR reporting year beginning with the 2020 MLR reporting year (MLR reports filed in 2021). In addition, we propose to allow issuers to provide MLR rebates in the form of a premium credit prior to the date that the rules currently provide and beginning with the 2020 MLR reporting year (MLR reports filed in 2021). Lastly, we propose to clarify MLR reporting and rebate requirements for issuers that choose to offer temporary premium credits during a public health emergency declared by the Secretary of HHS for future benefit years, beginning with the 2021 MLR reporting year (MLR reports filed in 2022).

### *Increasing Market Stability*

#### **Risk Adjustment (RA) Model Specifications**

Beginning with the 2022 plan year, we propose updating the RA model specifications to better predict issuer liability for the healthiest and sickest enrollees. Specifically, we propose changes to the risk adjustment models to include a two-stage specification in the adult and child models, add severity and transplant indicators interacted with hierarchical condition category (HCC) counts factors to the adult and child models, and modify the enrollment duration factors in the adult models. These changes would refine the HHS risk adjustment models, encourage issuer participation, and strengthen the individual and small group markets. We also propose risk adjustment reporting requirements for issuers of risk adjustment covered plans who choose to provide temporary premium credits, if permitted by HHS during a future public health emergency. If finalized as proposed, these issuers would be required to report to their EDGE servers the lower, adjusted plan premiums that reflect actual premiums billed to enrollees.

#### **Risk Adjustment Data Validation**

For risk adjustment data validation (RADV), we propose to modify the schedule for the collection of HHS-RADV charges and disbursement of payments so they would occur within the same calendar year in which RADV results are released.

#### **Premium Adjustment Percentage Index**

We updated the annual premium adjustment percentage using National Health Expenditure Accounts estimates and projections of per enrollee premiums for private health insurance (excluding Medigap and the medical portion of property and casualty insurance) that were available at the time of publication of the proposed rule. For the 2022 benefit year, the premium adjustment percentage will represent the percentage by which this measure for 2021 exceeds that for 2013. For the 2022 benefit year, the proposed premium adjustment percentage is 1.4409174688, which represents an increase in per enrollee premiums for private health insurance (excluding Medigap and the medical portion of property and casualty insurance) premiums of approximately 44.1 percent over the period from 2013 to 2021. In addition, for the 2023 benefit year and beyond, we propose to release the premium adjustment percentage in guidance by January of the year preceding the applicable benefit year which will provide issuers

with this information earlier than in previous years and allow them more time to incorporate this information in plan design for the upcoming year.

### **Maximum Annual Limitation on Cost Sharing**

The proposed 2022 maximum annual limitation on cost sharing is \$9,100 for self-only coverage and \$18,200 for other than self-only coverage. This represents an approximately 6.4 percent increase above the 2021 parameters of \$8,550 for self-only coverage and \$17,100 for other than self-only coverage. Similar to the proposal for the premium adjustment percentage index, for the 2023 benefit year and beyond, we propose to release the maximum annual limitation on cost sharing in guidance by January of the year preceding the applicable benefit year.

### **Reduced Maximum Annual Limitation on Cost Sharing**

The reduced maximum annual limitation on cost sharing is a PPACA-required annual calculation to reduce maximum out-of-pocket costs for individuals enrolled in the various CSR plan variations by the amount prescribed in statute. We propose a 2022 reduced annual limitation on cost sharing for enrollees with incomes between 100 and 200 percent of the Federal Poverty Level (FPL) at \$3,000 for self-only coverage and \$6,000 for other than self-only coverage. The proposed 2022 reduced annual limitation on cost sharing for enrollees with incomes between 200 and 250 percent FPL is \$7,250 for self-only coverage and \$14,500 for other than self-only coverage. Similar to the proposal for the premium adjustment percentage index, for the 2023 benefit year and beyond, we propose to release the reduced maximum limitation on cost sharing in guidance by January of the year preceding the applicable benefit year. We also propose to establish reductions rates at 2/3<sup>rd</sup>s reduction for households with incomes between 100 and 200 FPL and 1/5<sup>th</sup> reduction for households with incomes between 200 and 250 FPL for the 2023 benefit year and beyond, unless changed through notice-and-comment rulemaking.

### **Required Contribution Percentage**

The required contribution percentage is used to determine whether individuals age 30 and older qualify for an affordability exemption that would enable them to enroll in catastrophic coverage. For plan years after 2014, the required contribution percentage is the percentage determined by HHS that reflects the excess of the rate of premium growth between the preceding calendar year and 2013, over the rate of income growth for that period. We proposed a required contribution percentage for 2022 of 8.47228, which represents an increase of approximately 0.20 percentage points from the 2021 parameter of 8.27392. Similar to the proposal for the premium adjustment percentage index, for the 2023 benefit year and beyond, we propose to release the required contribution percentage in guidance by January of the year preceding the applicable benefit year.

### ***Enhancing the Consumer Experience***

#### **Employer-Sponsored Coverage Verification**

For Exchanges that do not obtain sufficient verification data to verify whether an applicant has an offer of affordable coverage that meets minimum value standards through their employer, we

propose extending non-enforcement discretion for the requirement to conduct random sampling from plan year 2021 to plan year 2022. We also discuss our intentions for future rulemaking to determine the best verification process for employer-sponsored coverage verification that is contingent on HHS completing its evaluation of the 2019 study results. This study was conducted to help HHS determine the populations greatest at risk to inappropriately enroll in Exchange coverage with APTC in lieu of coverage offered through their employer.

### **Special Enrollment Periods**

In order to promote continuity of coverage for consumers, we propose to permit Exchange enrollees who lose APTC eligibility to change to a plan of a lower metal level, and to allow qualified individuals who do not receive timely notice of an SEP qualifying event and otherwise are reasonably unaware that a triggering event occurred to select a plan based on the date that they knew, or reasonably should have known, of their triggering event. We also propose to clarify the availability of an SEP for individuals when an employer completely ceases contributions to COBRA continuation coverage.

### **QHP Enrollee Experience Survey Results**

To further support transparency of QHP quality data and provide consumers, states, issuers, and researchers with valuable enrollee experience data, we propose to make full QHP Enrollee Experience Survey (QHP Enrollee Survey) results across Exchanges publicly available in an annual public use file (PUF).

### **Web-broker and DE Entity QHP and Plan Display Requirements**

In order to provide web-brokers greater flexibility and to improve the shopping experience for consumers using web-brokers, we propose to create flexibility for web-broker non-Exchange websites to display a subset of QHP details rather than all QHP information in certain circumstances and subject to certain requirements. We further propose web-brokers must include premium and cost-sharing information in the details they display, as well as disclaimer language informing consumers of where they can find additional QHP information. We also propose to allow DE entities to display and market QHPs offered through the Exchange and other individual health insurance coverage offered outside the Exchange on the same website pages in certain circumstances.

### **Establish Exchange Direct Enrollment Options**

HHS proposes to establish in regulation a new option by which an SBE, SBE-FP or FFE state may satisfy requirements under 45 CFR 155.400 related to the enrollment of qualified individuals into individual market QHPs by electing to use direct enrollment, through private sector entities, as the enrollment pathway for the consumers in their state. Under these new Exchange Direct Enrollment (DE) options, in lieu of using a centralized, Exchange-run website, an SBE, SBE-FP or FFE state that is approved by HHS to implement this option would direct consumers to approved private sector-operated websites through which consumers could apply for coverage and enroll in a QHP, as well as receive a determination of APTC and CSR

eligibility from the Exchange. Under this option, the Exchange would remain responsible for making all eligibility determinations, performing required verifications of consumer application information, and meeting all of the statutory and regulatory requirements for the operation of an Exchange. SBE-FP and FFE states electing the Exchange DE option would enter into an agreement defining the responsibilities of HHS and the state and outlining the terms and conditions for the arrangement. We propose to permit State Exchanges to elect this option beginning with the 2022 plan year and to permit FFE and SBE-FP states to elect this option beginning with the 2023 plan year. For an FFE or SBE-FP state that exercises this option, HHS would continue to collect user fees from FFE and SBE-FP issuers. For the 2023 benefit year, we propose a FFE-DE and SBE-FP-DE user fee rate of 1.5% of premiums charged.

### ***Reducing Regulatory Burden***

#### **Section 1332 Application, Monitoring and Compliance, and Periodic Evaluations**

HHS and the Department of the Treasury (collectively, the Departments) propose that Departments reference and incorporate section 1332 guidance published in the Federal Register in 2018 (83 FR 53575) in existing regulations governing section 1332 waiver application procedures, monitoring and compliance, and periodic evaluation requirements. The Departments believe this proposal would give states greater certainty regarding how they will apply section 1332's statutory guardrails when determining whether a state's waiver proposal can receive and maintain approval. It will also mitigate risk that substantial state taxpayer funds and other state resources will be wasted on preparing and submitting incomplete waiver applications or proposals that are not approvable.

#### **Risk Adjustment State Flexibility Requests**

HHS proposes to expand the current framework for state flexibility requests to permit states to request a reduction in risk adjustment state transfers calculated under the HHS methodology for up to three benefit years. HHS would retain the right to request additional information, terminate, or modify these requests after approval if the circumstances within the applicable state market risk pool materially change during the three-year period. This proposal may reduce burden in information submission for states and promote stability in risk adjustment state transfers and rate setting, since issuers in states with approved multi-year requests could depend on the state flexibility request applying for up to three benefit years. Additionally, the rule details the 2022 benefit year request submitted by the state of Alabama to reduce risk adjustment state transfers by 50 percent for both the individual market (including both the catastrophic and non-catastrophic risk pools) and the small group market.