WHITE PAPER

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Summary of Provisions of HHS' Proposed 2022 Notice of Benefit and Payment Parameters and Other Key Regulations

On November 25, 2020, the Department of Health and Human Services (HHS) released the proposed Notice of Benefit and Payment Parameters for 2022 in the Federal Register.[1] The notice includes important proposed rules and parameters for the operation of the individual and small group health insurance markets in 2022 and beyond. This paper summarizes key provisions of the proposed notice and other related information recently released by HHS. Comments are due within 30 days of filing.

Overview

The following highlights the key changes included in the 2022 proposed Payment Notice. More information on these and other proposed changes follow.

1. **Direct-Enrollment Flexibilities:** HHS proposes allowing states to end state-sponsored online enrollment portals (e.g., opt out of Healthcare.gov) and allow for enrollees to only have the ability to enroll into an on-Exchange plan through direct enrollment entities. HHS also proposes to provide DE entities with more flexibility as to what information they share with potential enrollees.
2. **Risk Adjustment:** HHS has proposed several updates to the risk adjustment model Hierarchical Condition Categories (HCCs), the data used to recalibrate the model, the risk adjustment coefficients, the risk adjustment data validation (RADV) program, and the risk adjustment user fee.
3. **User Fees:** HHS proposes to lower user fees to issuers to 2.25% for issuers in the FFE and 1.75% in SBE-FPs.
4. **PBM Reporting:** HHS proposes to require PBMs (or issuers without a PBM) to report key information about prescription drugs, such as prescription drug rebate information.
5. **MLR Changes:** HHS proposes to change the definition of prescription drug rebates to include all direct and indirect remuneration received by an issuer, including discounts or charge backs. Issuers will need to deduct

[1] Department of Health and Human Services, "Proposed Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022", https://www.HHS.gov/files/document/HHS-9914-p.pdf

these amounts from incurred claims starting in 2022 if the proposal is finalized.

6. **1332 Waiver Regulation:** HHS proposes to incorporate its 2018 guidance on 1332 Waiver into regulation.
7. **Actuarial Value Calculator**: HHS has proposed that there would be no changes to the 2022 Actuarial Value Calculator relative to 2021.

Exchange Establishment Standards (Direct Enrollment)

HHS proposes two major changes to increase the importance of direct enrollment (DE) for the Marketplaces. First, HHS proposes to allow states to elect not to have a state-sponsored online portal (i.e., Healthcare.gov or a state exchange portal) for enrollment and instead only have enrollment via DE. If a state selected this type of Exchange model while a state would still provide supporting functions, individuals could only enroll in Exchange coverage through a DE entity. This would be available for State-Based Exchanges (SBE) in 2022 and for Healthcare.gov states in 2023. These new exchange types will have "-DE" appended to the end of its current acronym (SBE-DE, FFE-DE, and SBE-FP-DE)

The other major proposed change would allow for greater flexibility in how DE entities display information on QHPs. The proposal would allow DE entities not to list as much information on QHPs that it cannot sell. For example, if a web-broker does not have a relationship with a particular issuer, it would not have to display certain information about the plan.

The current regulations require that product choices be separated across three different web pages by product type as follows:

- QHPs On-Exchange
- Off-Exchange QHPs and non-QHPs other than excepted benefits
- All other products, including excepted benefits

HHS proposes to relax this requirement under certain circumstances. In particular, On and off Exchange plans (other than excepted benefits) can be on the same page to accommodate HRA arrangements where an employee would need to compare on and off exchange options since there is an employer subsidy for the off exchange options and a potential federal subsidy for on-exchange options.

User Fees

HHS proposes to reduce user fees for issuers in states that utilize Healthcare.Gov. In particular, HHS proposes to charge issuers in FFE 2.25% (down from 3.0%) and 1.75% in SBE-FP states (down from 2.5%). If a state were to select the Exchange-DE option, HHS would only charge a user fee of 1.5%.

Eligibility

HHS proposes to allow individuals a special enrollment period if they did not receive timely notice of an event that triggers an enrollment period

HHS also proposes to increase SEP verification for State-Based Marketplaces. HHS proposes to require all Exchanges to verify at least 75% of all

enrollees claiming eligibility for a Special Enrollment Period, effective in 2024.

Data Collection for Pharmacy Benefit Managers

HHS proposes requiring PBMs (or QHP Issuers if they do not use a PBM) to report the following required data to HHS:

- Percent of all prescription drugs dispensed through retail vs. mail-order pharmacies,
- Generic dispensing rate
- Aggregate amount and type of rebates, discounts, or price concessions, excluding bona fide service fees (e.g., distribution service fee, inventory management fees, product stocking allowances, and administrative service agreement and patient care program fee)
- Aggregate amount of rebates, discounts, or price concessions that are passed through to the plan sponsor, and the total number of prescriptions dispensed
- Aggregate amount of the difference between the amount health plan pays the PBM and amount the PBM pays retail pharmacies and mail-order pharmacies (spread pricing)
- Civil Monetary Penalties are assessed for non-compliance.

Maximum Out of Pocket Updates

HHS is proposing that the maximum out-of-pocket (MOOP) amounts for standard plans[2] and cost sharing variations for 2022 are increased 6.4% from 2021 amounts of $8,550/$17,100 (single/family).

- Standard Plans: $9,100/$18,200 (single/family)
- 100%-150% FPL: $3,000/$6,000 (single/family)
- 150%-200% FPL: $3,000/$6,000 (single/family)
- 200%-250% FPL: $7,250/$14,500 (single/family)

The catastrophic plan's deductible and MOOP will be set to $9,100/$18,200 (single/family).

Issuer Requirements

HHS proposes to expand audit and compliance authority from APTC and CSR compliance, to also include, for FFE and SBE-FP states, reviews on exchange user fees, coverage effectuation and termination, and premium calculation. HHS may recoup any APTC, CSR, or user fees in the case of audit non-compliance.

HHS also proposes expanding this audit and compliance authority in states whose SBE or SBE-FP are not adequately enforcing the applicable standards. In any such case, the

[2] Standard plans include platinum, gold, silver non-cost sharing variation, bronze metal offerings as well as catastrophic plans.

authority to de-certify a QHP would remain solely with the SBE or SBE-FP.

Beginning with the 2020 OEP, HHS has displayed QHP quality rating information (similar to MA STAR ratings), based on clinical quality measure and enrollee satisfaction survey data, to consumers shopping for coverage on HealthCare.gov platforms (FFE and SBE-FP) and SBEs. HHS is proposing to reduce the number of levels of the display hierarchy for 2022.

HHS also proposes to make the full results of the aforementioned QHP enrollee satisfaction survey available as a Public Use File for each benefit year, beginning with 2021 benefit year results during 2022 OEP (as opposed to the current limited information available).

Payment Disputes

HHS is proposing to extend the window during which issuers may report APTC payment inaccuracies to HHS from the current 90-day window to up to three years after payments are received, as long as they are reported within 15 days of discovery, and a good-faith effort is made to research and identify such inaccuracies.

RADV Appeals

HHS is clarifying that the 30-day window to request an appeal of the second RADV audit begins on the date of release of the report on RADV Adjustments to the Risk Adjustment Transfers for the particular benefit year.

Member Enrollment

HHS proposes requiring QHP issuers to accept premium payments on behalf of an enrollee from a Health Reimbursement Arrangement (HRA) or Qualified Small Employer HRA (QSEHRA) by paper or cashier's check, money order, Electronic Funds Transfer, or Pre-Paid debit card.

Risk Adjustment

HHS proposes several updates to the risk adjustment program in the payment notice.

Risk Adjustment Model Recalibration

HHS will continue to use three consecutive years of EDGE Server data to recalibrate the risk adjustment model annually. However, they are proposing to use the three most recent consecutive years of data available at the time of the annual NBBP to contain draft coefficients – effectively using one-year lagged data from the current regulation. The intention is to have the coefficients in the proposed rule be final to help plans incorporate this information into pricing and promote stability.

Model Updates to Improve Predictive Power

HHS proposes including a two-stage specification in both the adult and child models and to separately add severity and transplant indicators that would interact with HCC count factors. Limiting the HCC count factor to interact with only severity and transplant indicators seeks to limit the potential for gaming and capture the compounding costs of multiple HCCs. The current HCC severity interaction terms would be removed as well.

HHS also proposes removing the current 11 enrollment duration factors (EDFs) and replace them with six EDFs (up to six months)

attributable to only those members with one or more payment HCCs.

The preceding changes seek to improve the predictive power of the model for both low and high cost enrollees.

Similar to previous benefit years, HHS proposes an adjustment to the Hepatitis C prescription drug class (RXC) to mitigate overprescribing incentives and better reflect the average cost of Hepatitis C treatments in the 2021 benefit year adult models. HHS proposes to adjust the plan liability associated with Hepatitis C drugs to reflect future market pricing of Hepatitis C drugs before solving for the adult model coefficients

Finally, HHS is proposing that risk score adjustments for CSR plans will continue for the 2022 benefit year as finalized in the 2019 and 2020 payment notices

Premium Credits

HHS proposes that statewide average premiums would be reduced for any premium credits (as a reduction to the applicable benefit year premiums) and therefore reflect actual premiums billed to members. These lower premiums must also be reported to the EDGE Server.

State Flexibility Requests

Alabama was the only state to request a reduction of risk adjustment transfers in 2022[3]. HHS proposes to allow states to request a reduction in transfers for up to three years beginning in 2023.

Audit and Compliance Review of Reinsurance-eligible Plans

HHS proposes several amendments to clarify and expand its compliance review authority, establishing timeframes for issuers to respond to audit notices, reports, inquiries, and requests for supplemental information, and the process for issuers to request extensions to respond.

Audit and Compliance Review of Risk Adjustment Covered Plans

Consistent with the proposals for reinsurance-eligible plans and in addition to the HHS-RADV process, HHS also proposes amendments for reviewing risk adjustment covered plans.

EDGE Discrepancy Materiality Threshold

HHS is proposing increasing the materiality threshold for EDGE server data issues from $10,000 to $100,000. This means the amount in dispute must equal or exceed $100,000 or one percent of the total estimated transfer amount in the applicable state risk pool for reconsideration requests.

Risk Adjustment User Fee

HHS estimates the 2022 risk adjustment user fee will be $0.25 PMPM, unchanged from 2021.

[3] Alabama requested a 50% reduction in transfers for both Individual and Small Group in 2022. In 2020-2021, Alabama only requested this reduction for the Small Group market.

Risk Adjustment Data Validation (RADV)

RADV Exemptions

HHS proposes to codify RADV exemptions for issuers with only small group market carryover coverage and sole issuers in a state market risk pool.

RADV IVA Demonstrations

HHS proposes IVA entities must demonstrate they are reasonably free of conflicts. Specifically, the IVA entity must 1) not have or previously have had a role in establishing any relevant internal controls of the issuer's risk adjustment or EDGE server data process for the applicable year and 2) not have served in any capacity as an advisor regarding the risk adjustment or EDGE server data submission for the applicable year.

Discrepancy and Appeals

HHS clarified that issuers are not permitted to use the discrepancy or administrative appeal process to contest IVA findings. Plans should review and discuss IVA findings with the IVA entity prior to submitting and attesting those results to HHS.

HHS proposes to shorten the SVA discrepancy reporting window to 15 days, beginning with the 2020 benefit year RADV.

Collections, Disbursements, and MLR Reporting

HHS is proposing to revert to the previous schedule for the collection and disbursements of RADV adjustments. This will result in collections and disbursements to occur in the same calendar year in which HHS-RADV results are released, beginning with the 2019 benefit year RADV.

For example, 2021 RADV results would be released in early summer 2023, and issuers will be instructed to report these amounts in the 2022 MLR reporting year (submitted by July 31st, 2023). Collections and disbursements of RADV charges and allocations for the 2021 RADV results will begin in summer or fall of 2023.

If finalized, RADV results for 2019 and 2020 will be released in 2022, and issuers will report the results for 2021 MLR (reported by July 31st, 2022).

Minimum Loss Ratio (MLR) Changes

HHS proposes to require insurers to deduct prescription drug rebates and other price concessions from incurred claims under the MLR rules starting in the 2022 MLR reporting year. HHS defines prescription drug rebates and other price concessions to mean all direct and indirect remuneration received or receivable by an issuer and entities providing pharmacy benefit management services to the issuer, related to the provision of a prescription drug covered by the issuer. This deduction applies regardless of the entity from whom the issuer receives the remuneration (e.g., pharmaceutical manufacturer, wholesaler, retail pharmacy, or other vendor).

HHS also proposes to adopt the public health emergency (PHE) data reporting and rebate requirements developed in the September 2020 interim final rule. Under this rule, issuers must account for temporary premium credits as a reduction in earned premium for MLR rebate calculations.

HHS proposes to continue this flexibility going forward with the following changes:

- A safe harbor under which an issuer that prepays at least 95% of the total rebate owed to enrollees in the given MLR report will not be subject to penalty. Members enrolled over multiple years would get the current year's rebate plus the remaining balance after prepayment from the prior year. For members no longer enrolled, the remaining balance after prepayment would be issued.
- Allowing premium credits to be applied no later than October following the MLR reporting year.

1332 Regulations

HHS proposes to codify the existing guidance issued in October 2018 regarding 1332 waiver applications into regulation (no modifications from current guidance). In particular, this would codify the current Administration's interpretation of the 1332 guardrails and would require notice and comment for the new Biden Administration to change the 1332 waiver rules.

The 2022 Actuarial Value Calculator (AVC)

In a separate release[4], HHS proposes that there will be no changes in the 2022 AVC as compared to the 2021 AVC.[5] That is, the calculated Actuarial Value of any plan in the 2022 AVC will be the same as it was in the 2021 AVC.[6] HHS intentionally used a 0% trend from 2021 to 2022 due to the uncertainty in future healthcare utilization patterns surrounding the COVID-19 pandemic.

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[4] https://www.cms.gov/cciio/resources/regulations-and-guidance/#plan-management

[5] HHS did update the AVC edit that will allow for the Maximum allowed Out-of-Pocket Costs input to go up to at least $9,100, consistent with the what in this proposed notice.

[6] Wakely has tested numerous plan designs in the Draft 2022 AVC and have found no differences from the Final 2021 AVC thus far.