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

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On April 30, 2021, the Department of Health and Human Services (HHS) released the remainder of the final Notice of Benefit and Payment Parameters for 2022.[1] The notice includes important final 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 final notice and other related information on forthcoming regulations by HHS.

Overview

The following highlights the key changes and information included in the 2022 final Payment Notice

1. **Maximum Out-of-Pocket:** HHS finalized a different formula for the maximum out-of-pocket (and related) cost-sharing limits. Consequently, the new maximum out-of-pocket in 2022 will be $8,700 for self-only coverage or $400 less than in the proposed Payment Notice.
2. **Risk Adjustment:** HHS did not finalize their proposed policies to add severity and transplant indicators, the two-stage specification adjustment, and their proposed changes to enrollment duration factors. The 2022 risk adjustment model will include the same factors as the 2021 risk adjustment model. HHS finalized other proposed policies, including the data period used to recalibrate the model, the 2022 risk adjustment coefficients, key timelines for the risk adjustment data validation (RADV) program, and the risk adjustment user fee.
3. **User Fees:** HHS announced that it would release a regulation to increase user fees to 2.75% for issuers in the Federally-facilitated Exchange (FFE) and 2.25% in State-based Exchanges that use the Federal platform (SBE-FPs) for 2022.
4. **PBM Reporting:** HHS finalized the requirement that Prescription Drug Benefit Managers (PBMs) or issuers without a PBM report key information about prescription drugs, such as prescription drug rebate information.
5. **MLR Changes:** HHS finalized 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 these amounts from incurred claims starting for the 2022 Medical Loss

[1] Department of Health and Human Services, "Final Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022", https://public-inspection.federalregister.gov/2021-09102.pdf

Ratio (MLR) reporting year. Additionally, HHS eliminated the option to automatically include the 0.8% for quality improvement from MLR reporting and rebate calculations.

6. **Forthcoming regulation:** HHS intends to propose future regulations on user fees, 1332 waivers, standard plan designs, and other items in either a new regulation released sometime this spring or the 2023 Payment Notice.

The following provides details on the specific changes in the final 2022 Notice of Benefit and Payment Parameters, as well as potential future rule-making from HHS.

Exchange Establishment Standards (Direct Enrollment)

HHS did not finalize the proposed changes to allow greater flexibility in how Direct Enrollment (DE) entities display information on QHPs. The proposal would have allowed DE entities not to list as much information on QHPs that they cannot sell (such as an issuer with which a broker does not have an agreement).

User Fees

Previously, HHS announced it intended to change the 2022 user fee rates. The Trump Administration set user fee rates for issuers in states that utilize Healthcare.Gov in a previous regulation. In particular, the prior Administration set user fee rates at 2.25% for FFE (down from 3.0%) and 1.75% for SBE-FP states (down from 2.5%). However, the Biden Administration announced it intends to set user fee rates for issuers in FFE states at 2.75% and at 2.25% for SBE-FP states for the calendar year 2022 in a forthcoming regulation.

Eligibility

HHS finalized the requirement to allow individuals a special enrollment period if they did not receive timely notice of an event that triggers an enrollment period (i.e., if someone was not reasonably made aware of their eligibility for a SEP, they would maintain access to SEP).

HHS did not finalize the proposal to increase SEP verification for State-Based Exchanges or require all Exchanges to verify at least 75% of all enrollees claiming eligibility for a Special Enrollment Period, which would have been effective in 2024.

Data Collection for Pharmacy Benefit Managers

HHS finalized the requirement that PBMs (or QHP Issuers if they do not use a PBM) must 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 the health plan pays the PBM and the amount the PBM pays retail and mail-order pharmacies (spread pricing)

Civil Monetary Penalties will be assessed for non-compliance.

Issuer Requirements

Maximum Out of Pocket Updates

HHS finalized that the maximum out-of-pocket (MOOP) amounts for standard plans[2] and cost sharing variations for 2022.

- Standard Plans: $8,700/$17,400 (single/family)
- 100%-150% FPL: $2,900/$5,800 (single/family)
- 150%-200% FPL: $2,900/$5,800 (single/family)
- 200%-250% FPL: $6,950/$13,900 (single/family)

The new single MOOP is $400 less than the proposed rule ($9,100) because of a change in HHS's indexing methodology (the premium adjustment percentage index).

The catastrophic plan's deductible and MOOP will also be set to $8,700/$17,40 (single/family). Going forward, HHS announced it would release MOOP and related cost sharing amounts in January via guidance rather than in the Payment Notice unless there is a change in the indexing methodology.

Audit and Compliance

HHS finalized to expand audit and compliance authority for APTC and CSR compliance for FFE and SBE-FP states, which includes reviews of Exchange user fees, coverage effectuation and

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

termination, and premium calculations. HHS may recoup any APTC, CSR, or user fees in the case of audit non-compliance.

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

HHS did not finalize the proposal to change the quality rating system and instead asked for further comments if the quality rating system methodology should be changed. HHS did announce the full QHP enrollee satisfaction survey would be made public, beginning with the 2021 results during 2022 OEP (as opposed to the current limited information available).

Payment Disputes

HHS finalized its proposal 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.

Risk Adjustment

HHS finalized several updates to the risk adjustment program in the payment notice but did not finalize any proposals specific to structural changes of the HCC model.

Risk Adjustment Model Recalibration

HHS finalized to use the three most recent and available consecutive years of EDGE Server data at the time of the proposed Payment Notice to recalibrate the risk adjustment model annually. In addition, HHS will not update the coefficients for additional years of data between the proposed and final rule if an additional year of enrollee-level EDGE data becomes available.

Risk Adjustment Model Updates

HHS did not finalize their proposal to include a two-stage specification in both the adult and child models. HHS also did not finalize to separately add severity and transplant indicators that would interact with HCC count factors. HHS did not finalize removing current severity illness indicators as well. This means that the 2022 risk adjustment model's HCCs remain the same as 2021.

HHS also did not finalize removing the current 11 enrollment duration factors (EDFs) and replacing them with six EDFs (up to six months) attributable to only those members with one or more payment HCCs. This means that the categories for the 2022 enrollment duration factors remain the same as 2021.

HHS finalized the proposal 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 finalized that risk score adjustments for CSR plans will continue for the 2022 benefit year as finalized in the previous payment notices.

Premium Credits

HHS finalized the requirement 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

HHS finalized Alabama's request for a reduction of risk adjustment transfers in 2022[3].

HHS did not finalize the proposed policy to allow states to pursue multi-year state flexibility reduction requests.

Audit and Compliance Review of Transitional (Federal) 2014 through 2016 Transitional Reinsurance-eligible Plans

HHS finalized 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. However, HHS made some slight modifications to certain audit timelines in response to comments received.

Audit and Compliance Review of Risk Adjustment Covered Plans

Consistent with the finalized policies for reinsurance-eligible plans and in addition to the HHS-RADV process, HHS also finalized amendments for reviewing risk adjustment covered plans, with slight modifications to certain audit timelines.

HHS is not finalizing its proposal to disburse high-cost risk pooling payments or charges recovered by HHS during an audit on a pro-rata basis. HHS is continuing to consider options.

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

EDGE Discrepancy Materiality Threshold

HHS finalized their proposal to increase 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 finalized the 2022 risk adjustment user fee to be $0.25 PMPM, unchanged from 2021.

Risk Adjustment Data Validation (RADV)

RADV Exemptions

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

RADV Initial Validation Audit (IVA) Demonstrations

HHS finalized the policy that 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.

RADV Appeals

HHS clarified 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.

Collections, Disbursements, and MLR Reporting

HHS is finalizing the proposal to revert to the previous schedule for the collection and disbursement of RADV adjustments. This will result in collections and disbursements occurring in

the same calendar year in which HHS-RADV results are released, beginning with the 2019 benefit year RADV.

For example, 2021 RADV results will 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.

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

Table 1: Risk Adjustment and HHS-RADV Benefit Years to Include in MLR Reports for MLR Reporting Years 2020-2025

MLR Reporting Year	RA Benefit Year to Include	RADV Benefit Year(s) to Include
2020 (Filed in 2021)	2020	NA
2021 (Filed in 2022)	2021	2017 2019 & 2020 *
2022 (Filed in 2023)	2022	2018 2021*
2023 (Filed in 2024)	2023	2022
2024 (Filed in 2025)	2024	2023
2025 (Filed in 2026)	2025	2024

* Including multiple years of HHS-RADV due to transition to the policy finalized in this rule to revert to the prior schedule for collection and disbursement of HHS-RADV results beginning with the 2019 benefit year.

Medical Loss Ratio Changes

HHS will 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 remuneration received 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 excludes any remuneration, coupons, or price concessions that are passed on to the enrollees or bona fide service fees. This deduction applies regardless of the entity from which the issuer receives the remuneration (e.g., pharmaceutical manufacturer, wholesaler, retail pharmacy, or other vendor).

HHS also adopted 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 during a declared PHE as a reduction in earned premium for MLR rebate calculations.

HHS finalized the proposal to continue the flexibility of accounting for temporary premium credits through a reduction in earned premiums 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 a 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.
- Allow premium credits to be applied no later than October following the MLR reporting year.
- As discussed below, issuers will no longer be allowed to report 0.8% of earned premium as quality improvement expenses and must report itemized expenditures beginning with the 2020 MLR reporting year.

Rules Vacated by Columbus v Cochran

The Payment Notice also included a discussion about the implications of the recent ruling in the Columbus v. Cochran cases. On March 4, 2021, the United States District Court for the District of Maryland decided City of Columbus et al. v. Cochran.[4] The plaintiffs challenged nine rules from the 2019 Notice of Benefit and Payment Parameters. The court upheld five of the rules but also ordered that the following four rules be vacated:

- The elimination of federal network adequacy reviews for certain FFEs, where the state performed a sufficient review. Starting in Plan Year 2023, there will be a federal review of network adequacy for all FFM states.
- The elimination of designating some plans as "standardized options" on FFEs. Starting in Plan Year 2023, standardized option designations will resume on FFEs.
- Requirement of additional documentation for those. Going forward, additional documentation will no longer be required under these circumstances.

[4] Some also refer to this as the "Take Care" case.

- The option to use 0.8% of revenue as Quality Improvement Expenses to satisfy the minimum loss ratio requirements. Going forward, starting with the MLR filing for 2020 (due on July 31, 2021), issuers will have to itemize the Quality Improvement expenses in order to count them in the numerator of the MLR calculation.

Actuarial Value Calculator

HHS also released the final 2022 actuarial value calculator (AVC). [5] Similar to the 2015 AVC, HHS did not include any trend factor for medical or drug spending for 2021 to 2022 in the AVC.

Future Regulation

HHS announced that it intends to revisit a number of topics that were finalized in the 2022 Payment Notice under the Trump Administration, notably 1332 State Innovation waivers and Exchange Direct Enrollment (DE) options for states in future rule-making.

If you have any questions or to follow up on any of the concepts presented here, please contact any of the following authors:

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