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Special Bulletin

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CMS Issues Second Final Notice of Benefit and Payment Parameters for 2022

The Centers for Medicare & Medicaid Services last week released a second final notice of benefit and payment parameters to implement standards governing health insurance issuers and marketplaces for 2022 that were not finalized in the Jan. 19 final rule. In the rule, CMS chose not to finalize the proposed premium adjustment percentage and instead finalized a lower percentage, resulting in lower maximum out-of-pocket costs for consumers than originally proposed. CMS also did not finalize a proposed verification process for special enrollment periods (SEPs) but did finalize additional SEPs, including one for individuals that lose employer contributions or government subsidies for COBRA. Notably, the rule does not address the policies related to direct enrollment entities, Section 1332 waiver regulations, or user fees as it finalized those policies in the Jan. 19 final rule. However, CMS noted that it expects to issue rulemaking this spring to propose new 2022 user fee rates and revisit the direct enrollment state option and Section 1332 waiver regulations.

Key Takeaways

- CMS finalized a lower premium adjustment percentage than proposed, resulting in smaller increases to the annual maximum out-of-pocket limitations. The 2022 limits will be $8,700 for an individual and $17,400 for a family.
- CMS expects to issue additional rulemaking this spring addressing the 2022 user fee rates, direct enrollment state option, and Section 1332 waiver regulations.

Highlights of provisions important to hospitals and health systems follow.

Major Provisions

Premium Adjustment Percentage. CMS finalized a premium adjustment percentage of 1.38 for the 2022 benefit year, rather than the proposed percentage of 1.44. The premium adjustment percentage drives several calculations, including the annual maximum out-of-pocket limit, affordability exemption determinations and the employer shared responsibility payment. For benefit year 2023 and beyond, CMS will release the premium adjustment percentage and related calculations in guidance by January of the year before the applicable benefit year, in order to give issuers more time to incorporate this information into plan design.

Out-of-Pocket Cost Limitations. Based on the updated premium adjustment percentage, the annual maximum out-of-pocket limit will increase for the 2022 plan year to $8,700 for an individual and $17,400 for a family, up from $8,550 (individual) and $17,100 (family) in 2021. For cost-sharing reduction plans, the annual maximum limit on cost sharing will be $2,900 (individual) and $5,800 (family) for those with household incomes between 100% and 200% of the federal poverty level and $6,950 (individual) and $13,900 (family) for those households with incomes between 200% and 250% of the federal poverty level. For benefit year 2023 and beyond, CMS established standard reduction rates at two-thirds for households with incomes between 100% and 200% of the federal poverty level and one-fifth for households with incomes between 200% and 250% of the federal poverty level, unless changed through notice- and-comment rulemaking.

Special Enrollment Periods (SEPs). CMS did not finalize its proposal to require all exchanges to conduct SEP verification for at least 75% of new enrollees that gain coverage through a SEP, agreeing with commenters such as the AHA that this could impose excessive administrative burden on consumers. CMS did finalize additional SEPs, including for enrollees who lose tax credit eligibility to switch to a lower metal level plan and for individuals who lose employer contributions or government subsidies for their COBRA coverage. CMS also finalized its proposal to allow individuals who qualify for a SEP but do not receive timely notice, to base their SEP timing on when the individual knew, or reasonable should have known, about the triggering event and subsequent SEP.

Medical Loss Ratio (MLR). In the 2021 payment notice, CMS finalized a proposal to require issuers to deduct prescription drug rebates and other drug-related price concessions but did not adopt the proposed definition of price concession, based on comments the agency received at the time. In this rule, CMS finalized with modification a new definition for prescription drug rebates and other price concessions for this regulation, to help issuers more accurately and consistently report these costs. CMS defined *prescription drug rebates and other price concessions* as all direct and indirect remunerations, such as discounts, rebates, or goods in kind, received by an issuer or contracted pharmacy benefit manager (PBM) related to the provision of prescription drugs, regardless of the remuneration source (e.g., pharmaceutical manufacturer, wholesale, retail pharmacy), unless the full value is passed on to the enrollee. This policy goes into effect for the 2022 MLR reporting year.

CMS also finalized as proposed, with some clarifications, a number of policies related to prepayment of MLR rebates, including allowing issuers to offer prepayments in multiple forms (e.g., lump-sum checks, premium credits) and granting a safe harbor for issuers that prepay at least 95% of total rebates to defer payments of the remaining rebates until the following MLR reporting year. In addition, CMS codified its recent MLR policies related to the COVID-19 public health emergency, amending the MLR data reporting and rebate requirements for issuers offering temporary premium credits during a public health emergency.

Employer-sponsored Coverage Verification. CMS extended non-enforcement of the regulation requiring exchanges to perform random sampling of enrollees for the purpose of verifying whether enrollees have access to employer-sponsored coverage for plan year 2022. CMS is still evaluating the best process to conduct this verification based on the results of the 2019 employer verification study and plans to exercise enforcement discretion until that evaluation is complete.

State Reporting. In the 2021 payment notice, CMS finalized a requirement that states annually report any state-required qualified health plan (QHP) benefits in the individual and/or small group market that are in addition to the essential health benefits, beginning in the 2021 plan year. In this final rule, CMS announced that it will not enforce this policy in 2021. CMS finalized a deadline of July 1, 2022 for states to submit their report for the 2022 plan year.

Risk Adjustment. CMS did not finalize its proposed updates to the adult and child risk adjustment models, and instead intends to release a technical paper in the future with additional analysis on the impact of this proposed model. CMS also did not finalize an expansion of the current framework for state flexibility requests, to allow states to request a reduction in their risk adjustment state transfers for up to three years. CMS will maintain the current framework instead, requiring states to submit flexibility requests annually.

CMS finalized updates to the risk adjustment reporting requirements for issuers that provide temporary premium credits during a declared public health emergency. The agency also finalized a modified schedule for collecting data validation changes and issuing payments so that they occur in the same year that the risk adjustment data validation results are released. CMS approved the 2022 benefit year request by the state of Alabama to reduce risk adjustment state transfers by 50% for both the individual and small-group markets.

Essential Health Benefits. In the 2019 payment notice, CMS finalized a policy giving states additional flexibility in defining the essential health benefits (EHB) for plans sold in and after 2019. In this rule, CMS finalized May 6, 2022 as the deadline for states to report the required documents for their EHB-benchmark plan selection for the 2024 plan year. That date also will be the deadline for states to notify the Department of Health and Human Services (HHS) if they want to permit between-category substitutions for the 2024 plan year.[1]

PBM Transparency. CMS codified the statutory requirement that PBMs under contract with QHP issuers report certain prescription drug data. To maintain confidentiality, this data only will be disclosed for limited purposes. The agency expects to use this data to better understand the cost of prescription drugs provided in exchange plans.

[1] The proposed rule mistakenly listed this deadline for the 2023, rather than 2024, plan year. The final rule clarifies that May 6, 2022 is the deadline for the **2024** plan year.

Audit, Compliance Review, and Civil Monetary Penalty (CMP) Authority. CMS finalized a number of amendments to clarify HHS' authority to audit premium tax credit payments, cost-sharing reductions, and user fee programs and impose civil monetary penalties when enforcing applicable federal requirements in any of the exchanges. CMS also codified similar audit and compliance review processes for the federal transitional reinsurance program and risk adjustment program.

QHP Enrollee Experience Survey Results. CMS finalized its plans to release annually a new public use file with the results of the QHP Enrollee Experience Survey.

Next Steps

For more information, contact Ariel Levin, AHA senior associate director for state issues, at alevin@aha.org.