Wynne Health Group

Memorandum

January 14, 2021

CMS RELEASES 2022 NOTICE OF BENEFIT AND PAYMENT PARAMETERS FINAL RULE

Today, the Centers for Medicare and Medicaid Services (CMS) released the 2022 Notice of Benefit and Payment Parameters final rule (press release; fact sheet), finalizing a subset of originally proposed policies affecting Exchanges and plans in the individual and small group markets.

- **What it is.** The highly anticipated final rule represents the Trump administration's last attempt to substantially shape the Exchanges and qualified health plans (QHPs) ahead of the Biden-Harris inauguration on January 20, 2021. CMS finalizes policies addressing Exchange Direct Enrollment and 1332 waiver guidance. Proposed policies on risk adjustment, medical loss ratio, and pharmacy benefit manager transparency are not included in the final rule, with CMS deferring finalization to subsequent rulemaking.

  Unlike previous years, the final letter to issuers in the federal exchange; key dates for QHP certification, rate review, and risk adjustment; and other materials were not released in conjunction with the final rule.

- **Why it is important for you.** CMS finalizes its proposal to allow states the option of relying primarily on direct enrollment (DE) through plans, web brokers, and agents and brokers in the individual market instead of (or in addition to) offering a centralized Exchange website. CMS also finalizes provisions aligning its regulations with aspects of the Trump administration's 1332 waiver guidance, which loosened the agency's interpretation of the statutory guardrails for such waivers. The agency also lowers the user fee paid by issuers on the federally-facilitated Exchange (FFE) and State-based Exchange on the Federal Platform (SBE-FP) to 2.25 and 1.75 percent of total monthly premiums, respectively.

  The provisions drew significant opposition from stakeholders, including House and Senate Democratic health care leaders who sent a letter to HHS Secretary Alex Azar, CMS Administrator Seema Verma, and Treasury Secretary Steven Mnuchin, urging the Trump administration to not finalize its proposed changes. In particular, they criticized the provision allowing states to use the Direct Enrollment option operated by private sector entities in lieu of the Exchange. They also raised concerns about the codifying the Trump administration's Section 1332 guidance.

- **Potential next steps**. The incoming Biden-Harris administration is likely to delay the rule's effective date of March 15, 2021. Now that the rule is finalized, the new administration will have to restart the notice and comment process to formally withdraw or otherwise modify the rule. As a midnight final rule, it is also subject to disapproval under the Congressional Review Act.

Highlights of the final rule follow:

Exchange Direct Enrollment Option (p. 22)

- **FFE, SBE-FP, and State Exchange Direct Enrollment Options** – CMS finalized its proposal to establish a process for the state – through its State Exchange, State-based Exchange on the Federal Platform (SBE-FP), or federally-facilitated Exchange (FFE) – to approve one or more private sector entities to operate the "Exchange direct enrollment (DE) option" (i.e., non-Exchange enrollment website(s)). Through these private sector entities, consumers will be able to (1) apply and enroll for coverage; (2) receive an eligibility determination from the Exchange for enrollment in a qualified health plan (QHP), advance premium tax credits and (APTCs) and cost-sharing reductions (CSRs); and (3) receive an assessment from the Exchange for Medicaid and CHIP eligibility. A state will be allowed to operate the DE option in addition to or in lieu of its existing Exchange.

    - Additional Requirements for State Exchanges – A State Exchange is required to meet the following requirements in order to operate the DE option, pending CMS approval:

        - Demonstrate operational readiness to enroll qualified individuals, including making eligibility determinations and assessments;
        - Provide a detailed implementation plan and timeline, including its communication and outreach strategy; and
        - Ensure that at least one private sector entity approved by the state to operate the DE option meets the minimum federal requirements to participate in the FFE direct enrollment program. Specifically, a state must have at least one DE partner that displays detailed information for all available QHPs and meets all accessibility requirements. If not, the state is required to provide a consumer-facing website that displays such information and meets other requirements.

      Pending agency approval, SBE-DE option may be implemented in states with a State Exchange in plan year 2022, and FFE-DE and SBE-FP-DE option may be implemented in states with FFE or SB-FP starting in plan year 2021.

State Innovation Waivers (p. 64)

- **1332 Guardrails** – CMS proposes to incorporate the 2018 Guidance the agency released regarding section 1332 waiver application procedures, monitoring and compliance, and periodic evaluation requirements into existing regulations governing 1332 waivers. In response to comments, CMS says that it is not including direct reference to the 2018 guidance itself in the regulatory text but is instead making direct changes to the text that align with much of what was included in the guidance. Of note, CMS is also finalizing a change that will require the agency to periodically evaluate approved 1332 waivers to ensure ongoing programs are consistent with the principles expressed in the 2018 guidance.

CMS says it is doing so to provide greater certainty to states regarding how CMS will apply 1332 guardrails when determining whether a state's waiver propose can receive and maintain approval. CMS also believes this action will increase state innovation and lead to more affordable health coverage for consumers in states implementing a section 1332 waiver program.

As a reminder, the 2018 guidance reinterpreted how the agency previously defined the waiver "guardrails," allowing states to more liberally interpret the Affordable Care Act requirements around coverage and access requirements in the context of 1332 waiver authority (WHG summary of this guidance is available here).

Health Insurance Issuer Standards (p. 47)

- **User Fee Rates for the 2022 Benefit Year (§ 156.50) (p. 47)** – CMS finalizes its proposal to reduce the user fee for Federally-facilitated Exchanges (FFEs) to 2.25 percent of total monthly premiums for benefit year 2022 – lower than the user fee rate of 3.0 percent established for benefit years 2020 and 2021. For State-based Exchanges on the Federal platform (SBE-FP), CMS finalizes to lower the user fee rate to 1.75 percent of total monthly premiums (reduced from the user fee rate of 2.5 percent for benefit year 2021).

  CMS asserts that these finalizes rates reflect its estimates of costs for operating the Exchanges, premiums, enrollment, as well as state Exchange transitions for the 2022 benefit year, and the costs associated with performing such services. CMS adds that it is finalizing these reductions after accounting for the cost-saving measures it has implemented over the last several years and hopes that these changes will create downward pressure on premiums.

- **Network Adequacy Standards (§ 156.230) (p. 56) –** CMS finalizes a revision to the QHP network adequacy standards regulation to clarify that a plan that does not vary benefits based on whether the issuer has a network participation agreement with a provider that furnishes covered services is not required to comply with the network adequacy standards to qualify for certification as a QHP. CMS says the finalized policy should not substantially impact the QHP certification process for these plans.

- **Enrollment Process for Qualified Individuals (§ 156.1240) (p. 59)** – CMS finalizes that QHP issuers must accept payments made on behalf of an enrollee directly from an individual coverage health reimbursement arrangement (HRA) or qualified small employer health imbursement arrangement (QSEHRA) and the final rule adds the modification that QHP issuers must also accept payment made directly by an enrollee using funds from an individual coverage HRA or QSEHRA, so long as such payments are made using currently acceptable payment methods.

Regulatory Impact Analysis (p. 93)

- **User Fee Reductions** – CMS estimates that issuers will pay $270 million less in user fees in 2022 and $60 million less in 2023 stemming from reductions in user fees and state transitions to different Exchange models. See p. 96.

- **Exchange DE Option** – CMS says it does not anticipate SBEs will implement the Exchange DE option in plan year 2022 as SBEs currently do not leverage DE interfaces. The agency notes that states pursuing the option may incur additional costs for monitoring and overseeing DE entities, offset by reduced call center and consumer support expenditures now handled by the entities. The agency also alludes to the possibility that DE entities will enroll individuals who may not otherwise enroll, who may improve the individual market risk pool. See p. 97-98.

- **1332 Waiver Guidance** – While commenters sought further analysis of the impacts of incorporating the 2018 guidance into the regulatory text, CMS responds that its finalized policy is not determinative of what waivers ultimately will be proposed. The agency says that consequently, it cannot provide the distributive analysis (i.e., impacts by age, income, race, and other dimensions) sought by commenters. CMS anticipates that more states may apply for 1332 waivers if the standards are "reasonable" and less likely to be modified.