Biden Administration Lowers Costs of the Marketplace Health Plans

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3-Minute Read

The Biden Administration is using its rulemaking authority to lower health care costs for consumers and improve access to health care in connection with health plans sold on the Affordable Care Act's (ACA) exchanges. Lower cost marketplace plans could serve as a disincentive for employees to enroll in employer sponsored health plans. The first 2022 payment notice final rule setting forth the Biden Administration's agenda was released in January 2021, as outlined in a fact sheet available on the CMS website. The second 2022 payment notice final rule (Final 2022 Rules) were released on April 30, 2021. The press release states that:

> "The Centers for Medicare & Medicaid Services (CMS) today adopted new provisions to lower maximum out-of-pocket costs to consumers by $400, while increasing competition and improving the consumer experience for millions of Americans who will rely on the Federal Health Insurance Marketplaces in plan year 2022. These actions demonstrate a strong commitment by the Biden-Harris Administration to protect and build on the Affordable Care Act (ACA), reduce health care costs, and make our health care system easier to navigate and more equitable."

The guidance, in part, reflects changes related to out-of-pocket costs, special enrollment periods (SEPs), web broker display requirements, pharmacy benefit management (PBM) transparency and audit and oversight of exchanges.

The highlights are summarized below.

Out-of-Pocket Costs

The maximum out-of-pocket costs has been lowered by $400. The Final 2022 Rules reduced the annual limitation on cost sharing for eligible enrollees with incomes between 100% and 200% of the federal poverty level (FPL) to $2,900 for self-only coverage and $5,800 for other-than-self-only coverage. The Final 2022 Rules also reduced the annual limitation on cost sharing for eligible enrollees with incomes above 200% and through 250% FPL to $6,950 for self-only coverage and $13,900 for other-than-self-only coverage.

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SEPs

The Department of Health and Human Services (HHS) is finalizing a policy to permit exchange enrollees who qualify for a SEP because they lose advance payment of premium tax credit (APTC) eligibility to change to a new plan at any metal level, and a policy to allow an individual who did not receive timely notice of an SEP triggering event, and was otherwise reasonably unaware that a triggering event occurred, to select a new qualified health plan (QHP) within 60 days of the date that he or she knew, or reasonably should have known, of the occurrence of the triggering event. HHS is also finalizing a policy to codify that individuals with COBRA coverage may qualify for a SEP to enroll in individual health insurance coverage on- or off-exchange based on the cessation of employer contributions or government subsidies (such as those provided for under the American Rescue Plan Act of 2021) to COBRA continuation coverage.

Web Broker Display Requirements

HHS is not finalizing the proposal to create an exception to existing requirements related to the QHP comparative information that web broker non-exchange websites are required to display. HHS agreed with commenters that the display of more QHP comparative information on web broker non-exchange websites is in the best interest of consumers to aid them in comparing QHP options without having to potentially navigate to multiple websites. Beginning with the start of the plan year 2022 open enrollment period, web broker non-exchange websites will be required to display QHP comparative information consistent with existing rules (which will align the QHP information displayed on web broker websites with the QHP information displayed on HealthCare.gov). HHS intends to clarify the display requirements in future rulemaking.

PBM Transparency

HHS is finalizing a rule to provide for collecting prescription drug data directly from PBMs. The data will be used to enhance HHS's understanding of the true cost of prescription drugs provided in exchange plans, and shed light on the role that PBMs play in their cost. The data collected is required to be kept confidential and may only be disclosed for limited purposes.

Program Integrity

The Final 2022 Rules grant HHS the authority to conduct compliance review to ensure compliance with federal APTC, cost sharing reductions and user fee requirements. The rules also finalized procedural changes for administrative appeals of civil monetary penalties by health insurance issuers and non-federal governmental plans to align with Departmental Appeals Board practices.

The overall impact of these rules is to strengthen the ACA exchanges to make access to healthcare more affordable and to increase HHS's oversight authority.

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