Proposed HHS Notice of Benefit and Payment Parameters for 2021 Fact Sheet

In the HHS Notice of Benefit and Payment Parameters for 2021 proposed rule released today, the Centers for Medicare & Medicaid Services (CMS) proposed standards for issuers, Exchanges, and excepted benefit health reimbursement arrangements sponsored by non-Federal governmental plan sponsors.

Overall, the proposed rule minimizes the number of significant regulatory changes to provide states and issuers with a more stable and predictable regulatory framework that facilitates a more efficient and competitive market. These changes would further the Administration's goals of lowering premiums, promoting program integrity, stabilizing markets, enhancing the consumer experience, and reducing regulatory burden.

Lowering Premiums

FFE and SBE-FP User Fees

For the 2021 benefit year, we propose to maintain the Federally-facilitated Exchange (FFE) user fee rate of 3.0 percent of premium, and the State-based Exchange on the Federal platform (SBE-FP) user fee rate of 2.5 percent of premium based on the portion of FFE user fee-eligible costs allocated to SBE-FP activities. Alternatively, we are considering and seek comment on reducing the FFE and SBE- FP user fee rate below the 2020 plan year level to reflect our estimates of premium increases and enrollment decreases for the 2021 plan year, as well as potential savings resulting from cost-saving measures implemented over the last several years in hopes of reducing the user fee burden on consumers and creating downward pressure on premiums.

Promoting the Adoption of Value-based Insurance Designs (VBID)

We propose detailed options to qualified health plan (QHP) issuers on ways they can implement value-based insurance plan designs that would empower consumers to receive high value services at lower costs. Offering a value-based QHP would be voluntary for issuers, and value-based plans would not be preferentially displayed on HealthCare.gov. Issuers would have flexibility in adopting some, all or none of the recommended cost-sharing designs.

Treatment of Drug Manufacturer Coupons

We propose changes to the policy regarding how drug manufacturer coupons accrue towards the annual limitation on cost sharing in response to stakeholder feedback indicating confusion about the current regulatory requirement. We propose to revise the regulation finalized in the 2020 Payment Notice to provide that issuers would be permitted, but not required, to count toward the annual limitation on cost sharing amounts paid toward reducing out-of-pocket costs using any form of direct support offered by drug manufacturers to enrollees for specific prescription drugs.

We propose to interpret the definition of cost sharing to exclude expenditures covered by drug manufacturer coupons.

Medical Loss Ratio (MLR)

We propose to amend current MLR regulations to require issuers to deduct from incurred claims the prescription drug rebates and other price concessions attributable to the issuer's enrollees and received and retained by an entity providing pharmacy benefit management services to the issuer. We further propose to clarify more generally that issuers must report expenses for services outsourced to or provided by other entities in the same manner as issuers' expenses for non-outsourced services. These changes would help lower premiums by helping ensure that consumers' premiums reflect the full benefit of prescription drug rebates and are not artificially inflated by outsourcing expenses. We also propose to clarify that expenditures related to certain wellness incentives in the individual market qualify as quality improvement activity expenses in the MLR calculation.

Promoting Program Integrity

Defrayal and Annual Reporting of State Mandates

Our rules currently require that any state-required benefits enacted after December 31, 2011, other than for purposes of compliance with Federal requirements, are considered "in addition to" the essential health benefits (EHB) required under section 1302 of the Patient Protection and Affordable Care Act (PPACA), even if embedded in the state's selected benchmark plan. HHS is aware of stakeholder concerns that there may be states not defraying the costs of their state-required benefits in addition to EHB in accordance with federal requirements. HHS shares these concerns. We propose to require states, beginning in plan year 2021, to annually notify HHS in a form and manner specified by HHS, and by a date determined by HHS, of any state-required benefits applicable to QHPs in the individual and/or small group market that are in addition to EHB. We also propose that if a state does not notify HHS of benefits the state requires in addition to EHB by the annual reporting submission deadline, or does not do so in the form and manner specified by HHS, HHS will determine which benefits are in addition to EHB for the state for the applicable plan year.

Automatic Re-enrollment

We are seeking comment on new automatic re-enrollment processes for consumers with $0 plans after advance payments of the premium tax credit (APTC) are applied. For example, we seek comment on a process under which a consumer's APTC would be discontinued or reduced for a new plan year unless the consumer returns to the Exchange during the annual open enrollment period to update their application and receive a new determination of their eligibility for APTC. This change could reduce the risk of incorrect expenditures of APTC, some of which cannot be recovered through the reconciliation process due to statutory caps.

Special Enrollment Periods (SEPs)

We propose revisions to existing rules related to SEPs. We propose to allow Exchange enrollees and their dependents who are enrolled in silver plans and become newly ineligible for cost-sharing reductions to change to a QHP one metal level higher or lower, if they choose. We propose to require Exchanges to apply plan category limitations to dependents who are currently enrolled in Exchange coverage and whose non-dependent household member qualifies for a special enrollment period to newly enroll in coverage and seeks to enroll in a plan with the dependent. We also propose to shorten the time between the date a consumer enrolls in a plan through certain special enrollment periods and the effective date of that plan. We further propose to revert to the single retroactive effective date and binder payment rule that provides consumers who have an SEP with a retroactive effective date the option to pay one month's premium and only receive prospective coverage. Lastly, we propose to allow individuals and their dependents who are provided a qualified small employer health reimbursement arrangement with a non-calendar year plan year to qualify for the existing special enrollment period for individuals enrolled in any non-calendar year group health plan or individual health insurance coverage, based on the last day of their plan year.

Employer-sponsored Coverage (ESC) Verification

We propose to not take enforcement action against Exchanges that do not perform random sampling as required by § 155.320(d)(4) for plan years 2020 and 2021. HHS will exercise such discretion in anticipation of receiving the results of the employer verification study to 1) determine the unique characteristics of the population with offers of employer-sponsored coverage that meets minimum value and affordability standards, 2) compare premium and out-of-pocket costs for consumers enrolled in affordable employer-sponsored coverage to Exchange coverage, and 3) identify the incentives, if any, that drive consumers to enroll in Exchange coverage rather than coverage offered through their current employer.

Periodic Data Matching (PDM)

Currently, applicants can provide written consent to permit Exchanges to end their Exchange coverage if an applicant is later found through periodic data matching (PDM) to be dually enrolled in other minimum essential coverage (MEC) such as Medicare, Medicaid/CHIP, and the Basic Health Program (BHP). We are proposing changes to clarify that when Exchanges process a voluntary termination for a dual enrollee, Exchanges will not re-determine eligibility for APTC/CSRs, as would occur under current rules. We also propose that when an Exchange enrollee is identified as deceased through Death PDM, Exchanges will not re-determine eligibility for APTC/CSRs and will terminate Exchange coverage back to the date of death. These changes would reduce the risk of incorrect APTC/CSR payments.

Increasing Market Stability

Risk Adjustment

Consistent with the policy announced in the 2020 Payment Notice, we propose to no longer incorporate MarketScan® data in the recalibration process for the HHS risk adjustment models beginning with the 2021 benefit year. Rather, we propose for the 2021 benefit year and beyond, to blend the 3 most recent years of available enrollee-level EDGE data. This approach would incorporate the most recent years' claims experience that is available without resulting in drastic year-to-year changes to risk scores, as the recalibration of the models for the applicable benefit year would maintain 2 years of EDGE data that were used in the previous years' models. We also propose a number of updates to the HHS risk adjustment models' Hierarchical Condition Categories (HCCs) based on availability of more recent diagnosis code information and the availability of more recent claims data. These proposed changes incorporate our efforts to recalibrate the risk adjustment models using data from issuers' individual and small group market populations (including merged markets). These changes would improve the accuracy and reliability of the risk adjustment program, encourage issuer participation and strengthen the individual and small group markets.

Risk Adjustment Data Validation (HHS-RADV)

We proposed modifications to the application of HHS-RADV adjustments in cases where an issuer's HCC count is low. Beginning with 2019 benefit year HHS-RADV, we will not consider as an outlier in an HCC failure rate group any issuer with fewer than 30 HCCs (diagnostic conditions) within that HCC failure rate group. This proposed change would help to ensure that issuers are identified as outliers based on HCC sample counts that are sufficient to reliably determine outlier status. For 2019 benefit year of HHS-RADV, we also propose to pilot the validation of prescription drug categories (RXCs) in HHS-RADV for a second year. The proposed additional pilot year for incorporating RXCs into HHS-RADV, which is consistent with the two pilot years provided for the 2015 and 2016 benefit years of HHS-RADV, is intended to give issuers more time and experience with the prescription drug data validation process.

Premium Adjustment Percentage Index

We propose to update the annual premium adjustment percentage using the most recent estimates and projections of per enrollee premiums for private health insurance (excluding Medigap and property and casualty insurance) from the National Health Expenditure Accounts (NHEA), which are calculated by the CMS Office of the Actuary. For the 2021 benefit year, the premium adjustment percentage will represent the percentage by which this measure for 2020 exceeds that for 2013. For the 2021 benefit year, the proposed premium adjustment percentage for the 2021 benefit year is 1.3542376277, which represents an increase in private health insurance (excluding Medigap and property and casualty insurance) premiums of approximately 35.4 percent over the period from 2013 to 2020.

Maximum Annual Limitation on Cost Sharing

The proposed 2021 maximum annual limitation on cost sharing is $8,550 for self-only coverage and $17,100 for other than self-only coverage. This represents an approximately 4.9 percent

increase above the 2020 parameters of $8,150 for self-only coverage and $16,300 for other than self-only coverage.

Reduced Maximum Annual Limitation on Cost Sharing

The reduced maximum annual limitation on cost sharing is a PPACA-required annual calculation to reduce maximum out-of-pocket costs for individuals enrolled in the various cost sharing reduction (CSR) plan variations by the amount prescribed in statute. We propose a 2021 reduced annual limitation on cost sharing for enrollees with incomes between 100 and 200 percent of the Federal Poverty Level (FPL) of $2,850 for self-only coverage and $5,700 for other than self-only coverage. The 2020 reduced annual limitation on cost sharing for enrollees with incomes between 200% and 250% FPL is $6,800 for self-only coverage and $13,600 for other than self-only coverage.

Required Contribution Percentage

The required contribution percentage is used to determine whether individuals age 30 and older qualify for a hardship exemption that would enable them to enroll in catastrophic coverage. For plan years after 2014, the required contribution percentage is the percentage determined by HHS that reflects the excess of the rate of premium growth between the preceding calendar year and 2013, over the rate of income growth for that period. We propose a required contribution percentage for 2021 of 8.27392, which represents an increase of approximately 0.04 percentage points from the 2020 parameter of 8.23702.

Enhancing the Consumer Experience

Excepted Benefit Health Reimbursement Arrangements (HRAs)

We propose to require excepted benefit HRAs offered by non-Federal governmental plan sponsors to provide notice that is generally consistent with the content of summary plan descriptions required under the Employee Retirement Income Security Act of 1974 (ERISA). The notice would state conditions of eligibility to receive benefits under the HRA, describe annual or lifetime caps or other limits on benefits under the HRA, and provide a summary of the benefits consistent with ERISA requirements. The notice requirement would address comments on recent HRA rulemaking that individuals should receive clear information about their excepted benefit HRA offer.

Quality Rating Information Display Standards for Exchanges

We propose changes to the quality rating information display standards for State Exchanges that operate their own eligibility and enrollment platforms. To continue providing flexibility for State Exchanges, we propose to codify in regulation the option for State Exchanges that operate their own eligibility and enrollment platforms to display the quality rating information as provided by HHS or to display quality rating information with certain permissible state-specific customizations of the quality rating information provided by HHS.

Terminating Qualified Health Plan Coverage or Enrollment

We propose to allow enrollees whose requests for termination of their coverage were not implemented due to an Exchange technical error to terminate their coverage retroactive to the date the enrollee had previously requested to end his or her coverage, or retroactive to another appropriate date identified in Exchange regulations. This change would align this provision with other enrollee-initiated termination effective date rules. We also propose to require issuers to provide termination notices to enrollees in all scenarios where Exchange coverage or enrollment is terminated. This change would help promote continuity of coverage by ensuring that enrollees are aware that their Exchange coverage or enrollment is ending, as well as the reason for their termination, and their termination effective date, so that they can take appropriate action to enroll in new coverage, if eligible.

Reducing Regulatory Burden

Early Retiree Reinsurance Program (ERRP)

We propose to delete regulations relating to the ERRP. The ERRP expired January 1, 2014. All ERRP payments have been made and there are no outstanding claims or disputes. A portion of the original appropriation remains, and will be returned to the Treasury when the appropriation is closed out in due course.