

HHS Notice of Benefit and Payment Parameters for 2021 Final Rule Fact Sheet

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

Overall, the final 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 further the Administration's goals of lowering premiums, promoting program integrity, stabilizing markets, enhancing the consumer experience, and reducing regulatory burden.

Lowering Premiums

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

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

Treatment of Drug Manufacturer Support, Including Coupons

We finalized changes to the policy regarding how direct drug manufacturer support, including coupons, may accrue towards the annual limitation on cost sharing in response to stakeholder feedback indicating confusion about the regulatory requirement finalized in the 2020 Payment Notice. This new policy provides that, to the extent consistent with State law, issuers will 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.

Medical Loss Ratio (MLR)

We finalized amendments to current MLR regulations to require issuers to deduct from incurred claims not only prescription drug rebates received by the issuer, but also any price concessions received and retained by the issuer, and any prescription drug rebates and other price concessions received and retained by an entity providing pharmacy benefit management services to the issuer beginning with the 2022 MLR reporting year (MLR reports filed in 2023). We also finalized the requirement that issuers must report prescription drug rebates and other price concessions

received and retained by an entity providing pharmacy benefit management services to the issuer as non-claims costs. This requirement will also be applicable beginning with the 2022 MLR reporting year (MLR reports filed in 2023). We further clarified 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 will 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 amended the MLR regulations to explicitly allow issuers to report certain wellness incentives as quality improvement activities in the individual market for MLR reporting and calculation purposes.

FFE and SBE-FP User Fees

For the 2021 benefit year, we will 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.

Promoting Program Integrity

Defrayal and Annual Reporting of State Mandates

Our rules require that any state-required benefits applicable to the individual and/or small-group market that are enacted after December 31, 2011, other than for purposes of compliance with Federal requirements, are considered to be in addition to the essential health benefits (EHB) required under section 1302 of the Patient Protection and Affordable Care Act (PPACA). HHS continues to be concerned that states are not defraying the costs of their state-required benefits that are in addition to EHB in accordance with Federal requirements. To promote program integrity and help ensure that advance payments of the premium tax credit (APTC) dollars are protected, we finalized the requirement for 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 finalized 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 identify which state-required benefits are in addition to EHB for the applicable plan year.

Automatic Re-enrollment

HHS will not finalize any changes to the current automatic re-enrollment process discussed in the proposed rule. In response to APTC program integrity concerns, we solicited comment on new automatic re-enrollment processes for consumers with \$0 plans after application of APTC, 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. Commenters overwhelmingly opposed such changes to the automatic re-enrollment processes.

Special Enrollment Periods (SEPs)

We will 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 with them.

Employer sponsored Coverage (ESC) Verification

We will not take enforcement action against Exchanges that do not perform random sampling as required by § 155.320(d)(4), when the Exchange does not reasonably expect to obtain sufficient verification data as described in § 155.320(d)(2)(i) through (iii), for plan years 2020 and 2021. HHS will exercise such discretion in anticipation of receiving the results of an 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. This change would not impact Exchanges that currently verify employer sponsored coverage using approved data sources under § 155.320(d)(2)(i) through (iii), or use the random sampling procedures under § 155.320(d)(4), and have determined these methods are the appropriate for their Exchanges to meet the requirement to verify offers of affordable employer-sponsored coverage.

Periodic Data Matching (PDM)

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

Increasing Market Stability

Risk Adjustment

Consistent with the policy announced in the 2020 Payment Notice, we will no longer incorporate MarketScan® data in the recalibration process for the HHS risk adjustment models beginning with the 2021 benefit year. Rather, we finalized that for the 2021 benefit year, HHS will blend the 3 most recent years of available enrollee-level External Data Gathering Environment (EDGE) data. This approach will also apply for the 2022 benefit year and beyond unless changed through notice-with-comment rulemaking. This policy will 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 will maintain 2 years of EDGE data that were used in the previous years' models. We also finalized a number of updates to the HHS risk adjustment models' Hierarchical Condition Categories (HCCs) based on the availability of more recent diagnosis code information and the availability of more recent claims data. These finalized changes further our efforts to recalibrate the risk adjustment models using data from issuers' individual and small group market populations (including merged markets). These changes should also improve the clinical and cost distinctions of certain HCCs in the risk adjustment program, encourage issuer participation, and strengthen the individual and small group (including merged) markets.

Risk Adjustment Data Validation (RADV)

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

Premium Adjustment Percentage Index

We updated the annual premium adjustment percentage using National Health Expenditure Accounts estimates and projections of per enrollee premiums for private health insurance (excluding Medigap and the medical portion of property and casualty insurance) that were available at the time of publication of the proposed rule. 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 premium adjustment percentage is 1.3542376277, which represents an increase in per enrollee premiums for private health insurance (excluding Medigap and the medical portion of property and casualty insurance) premiums of approximately 35.4 percent over the period from 2013 to 2020.

Maximum Annual Limitation on Cost Sharing

The finalized 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 CSR plan variations by the amount prescribed in statute. We finalized a 2021 reduced annual limitation on cost sharing for enrollees with incomes between 100 and 200 percent of the Federal Poverty

Level (FPL) at \$2,850 for self-only coverage and \$5,700 for other than self-only coverage. The final 2021 reduced annual limitation on cost sharing for enrollees with incomes between 200 and 250 percent 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 finalized 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 finalized a requirement that non-Federal governmental plan sponsors that offer excepted benefit HRAs provide a 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 must 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 generally consistent with ERISA requirements. The notice requirement addresses comments received in response to the recent HRA rulemaking supporting an individual's receipt of clear information about their excepted benefit HRA offer.

Quality Rating Information Display Standards for Exchanges

We finalized 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 codified an option for State Exchanges that operate their own eligibility and enrollment platforms to display the quality rating information provided by HHS or to display quality rating information with certain state-specific customizations of the quality rating information provided by HHS.

Terminating Qualified Health Plan Coverage or Enrollment

We finalized a policy allowing 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 will align this provision with other enrollee-initiated termination effective date rules. We also finalized a requirement for issuers to provide termination notices to enrollees in all scenarios where Exchange coverage or enrollment is terminated. This change will help promote continuity of coverage by ensuring that

enrollees are aware that their Exchange coverage or enrollment is ending, the reason for their termination, and their termination effective date, so that they can take appropriate action to enroll in new coverage, if eligible.

Special Enrollment Periods (SEPs)

We finalized revisions to existing rules related to SEPs. Starting in 2022, we will 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. Starting in January 2022, we will also shorten the time between the date a consumer selects a plan through certain special enrollment periods and the effective date of that plan. We further finalized to revert to a 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 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.

Reducing Regulatory Burden

Early Retiree Reinsurance Program (ERRP)

We finalized the deletion of 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.