# Policy Overview for 2021

## April 21, 2020

**Qualified Health Plan (QHP) Issuer Conference**



The information provided in this presentation is not intended to take the place of the statutes, regulations, and formal policy guidance that it is based upon. This presentation summarizes current policy and operations as of the date it was shared. Links to certain source documents may have been provided for your reference. We encourage persons attending the presentation to refer to the applicable statutes, regulations, and other guidance for complete and current information.

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# Agenda

- 2021 Proposed Payment Notice
- 2021 Final Rate Review Timeline
- 2021 Draft Letter to Issuers
- Final Program Integrity Rule

Documents available at:
https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html

# 2021 Proposed Payment Notice

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# 2021 Proposed Payment Notice

The proposed rule *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans* was posted for display on January 31, 2020 and published in the Federal Register on February 6, 2020 (85 FR 7088).

- Also released on the CMS website:
  - Press Release
    - https://www.cms.gov/newsroom/press-releases/cms-releases-proposed-notice-benefit-and-payment-parameters-rule-2021
  - Fact Sheet
    - https://www.cms.gov/files/document/proposed-2021-hhs-notice-benefit-and-payment-parameters-fact-sheet.pdf

# User Fees

- We proposed 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.
- Alternatively, we sought 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 premium.

# Value-based Insurance Designs (VBID)

- We proposed 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.

# Prescription Drug Provisions

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

# Medical Loss Ratio (MLR)

- We proposed 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 proposed 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.

# Medical Loss Ratio (MLR) (continued)

- 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 proposed to clarify that expenditures related to certain wellness incentives in the individual market qualify as quality improvement activity expenses in the MLR calculation.

# 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.
- The Department of Health and Human Services (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.

# Defrayal and Annual Reporting of State Mandates (continued)

- We proposed 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 proposed 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 sought 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 sought 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.

# 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.
- We proposed 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 2021 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.

# Maximum Annual Limitation on Cost Sharing (continued)

- 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.

# Terminating QHP Coverage or Enrollment

- We also proposed 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.

# 2021 Final Rate Review Timeline

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# 2021 Final Rate Review Timeline

- Submission of proposed rate filings*:
  - For single risk pool coverage (rate increases, no rate changes, rate decreases and rates for new coverage):
    - June 3 – in a state without an Effective Rate Review Program; or
    - July 22 – in a state with an Effective Rate Review Program. (Note: This is also the date the Rates Table Template is due to Plan Management for QHPs.)
- Posting of proposed rate filings:
  - July 31 – CMS intends to post proposed rate filings for all single risk pool coverage on https://ratereview.healthcare.gov (including both QHPs and non-QHPs), regardless of whether the product includes a plan with a rate increase that is subject to review under 45 CFR §154.210.

**Note: Submissions are due in the HIOS system by 3:00 p.m. EDT on the dates indicated.*

# 2021 Final Rate Review Timeline (continued)

- CMS deadline for finalization of rates:
  - August 19 – all rate filing justifications for single risk pool coverage *that include a QHP* to be in a final status in the URR system.
  - October 15 – all rate filing justifications for single risk pool coverage *that include only non-QHPs* to be in a final status in the URR system.

- Posting of final rate filings:
  - November 2 – CMS intends to post final rate information for single risk pool coverage on https://ratereview.healthcare.gov (including both QHPs and non-QHPs), regardless of whether the product includes a plan with a rate increase that is subject to review under 45 CFR §154.210.

* *Note: Submissions are due in the HIOS system by 3:00 p.m. EDT on the dates indicated.*

# 2021 Draft Letter to Issuers

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# 2021 Draft Letter to Issuers

- The *2021 Draft Letter to Issuers* (Letter) was posted for display on January 31, 2020.
- The Letter is streamlined, as it was in prior years, and contains updates for the 2021 certification cycle.
- The Letter builds on previously issued rules and policy documents to provide operational and technical guidance.

# Certification Process for QHPs

- The proposed “Early Bird” QHP Application submission window is an optional submission window for issuers wishing to submit application data prior to the first formal submission deadline.
  - Early Bird Deadline: April 23, 2020
  - Formal Deadline: June 17, 2020
- CMS will review and return results on this data as available prior to the first submission deadline, and if the identified corrections are corrected, CMS will not flag it as a correction in the full review round and the issuer will not receive a correction notice.

# Submission Deadlines for Transparency and Machine Readable

- CMS will require issuers to submit Transparency in Coverage data as part of the QHP certification application.

# Telehealth Services

- CMS will continue to support State efforts to encourage use of telehealth services, and encourage issuers to consider increasing the use of telehealth.

# Medical Cost Scenarios

- CMS previously developed several decision support tools and publishes certain plan data to empower patients to understand their insurance options and select a plan through an FFE or SBE-FP, including through an FF-Small Business Health Options Program (SHOP).
- Consumer testing of the summary of benefits and coverage (SBC) shows that hypothetical medical scenarios illustrating the consumer portion of medical costs help consumers understand and compare health plan coverage options.
- In order to provide consumers greater cost transparency for plan year 2021, CMS is considering whether to provide additional medical cost scenarios to QHP customers on HealthCare.gov.

# Program Integrity Rule

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# Program Integrity Rule

The final *HHS Exchange Program Integrity Rule* was posted for display on December 20, 2019 and published in the Federal Register on December 27, 2019 (84 FR 71674).

- Also released on the CMS website:
  - Press Release
    - https://www.cms.gov/newsroom/press-releases/cms-announces-enhanced-program-integrity-efforts-exchange
  - Fact Sheet
    - https://www.cms.gov/newsroom/fact-sheets/2019-health-and-human-services-exchange-program-integrity-final-rule-fact-sheet

# Segregation of Abortion Funds

- As finalized at §156.280(e)(2), individual market on-Exchange QHP issuers are required to begin separately billing policy holders for certain abortion services for which federal funding is prohibited ("non-Hyde abortion services") beginning with their first billing cycle following June 27, 2020.
  - For monthly billing cycles that begin on the 1st of each month, QHP issuers would be required to begin complying with the separate billing policy on July 1, 2020.

# Segregation of Abortion Funds: Applicability

- Generally, QHP issuers are only permitted to use federal funds for abortion services in the limited cases of:
  - Rape, incest, or if a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed (Hyde abortion services).
- If a QHP offers coverage for abortion services beyond these specific limited exceptions (non-Hyde abortion services), the QHP is considered to offer coverage for non-Hyde abortion services and is subject to the separate billing policy finalized in the Program Integrity Rule as required by section 1303 of the PPACA.
- This rule applies to all QHPs offered through Exchanges that cover non-Hyde abortion services, regardless of Exchange type.

# Segregation of Abortion Funds: Enforcement Discretion on Separate Billing

HHS will consider extending enforcement discretion to an Exchange or QHP issuer that fails to timely comply with the separate billing policy as required under the final rule, if HHS finds that the Exchange or QHP issuer attempted in good faith to timely meet the requirements.

# Segregation of Abortion Funds:
## Enforcement Discretion on Separate Billing (continued)

- Evidence of such good faith efforts might include:
  - Records showing that planning for compliance with the requirements began within a reasonable time following the publication of the final rule, but that events outside the Exchange's or QHP issuer's control caused implementation delays.
- HHS will consider exercising this enforcement discretion based on the circumstances of the particular Exchange or QHP issuer.
  - We do not anticipate that HHS would exercise such discretion for an Exchange or QHP issuer that fails to meet the separate billing requirements after more than 1 year following publication of this final rule.

# Segregation of Abortion Funds: Billing

- If sending paper bills, QHP issuers may send the separate bill in the same mailing/envelope as the bill for the other portion of the policy holder's premium, or in a separate mailing/envelope.
  - If in the same mailing/envelope, the separate paper bill must remain distinct and separate, on separate pieces of paper, with separate explanations of the charges to ensure the policy holder understands the distinction between the two (2) paper bills and understand that they are expected to pay the separate bill for non-Hyde abortion coverage in a separate transaction.
- If sending bills electronically, QHP issuers must send the separate bill in a separate email or electronic communications from the bill for the other portion of the policy holder's premium.

# Segregation of Abortion Funds: Payment

- QHP issuers are required to instruct the policy holder to pay the separate bill in a separate transaction.
  - If the policy holder fails to pay the separate bill in a separate transaction, the issuer may not terminate their coverage on this basis, provided the amount due is otherwise paid.
- QHP issuers that receive combined enrollee premiums in a single payment must treat the portion of the premium attributable to coverage of non-Hyde abortion services as a separate payment and must disaggregate the amounts into the separate allocation accounts, consistent with §156.280(e)(2)(iii).

# Segregation of Abortion Funds: Best Practices

- In the email or electronic communication containing the premium bill *not* attributable to coverage of non-Hyde abortion services, QHP issuers should include language notifying policy holders that they:
  - Will receive a second, separate email or electronic communication containing a separate bill for the portion of their premium attributable to coverage of non-Hyde abortion services.
  - Should pay this separate bill in a separate transaction.
- This language should help to mitigate enrollee confusion and satisfy the requirement to instruct policy holders to pay the separate bill in a separate transaction.

# Segregation of Abortion Funds: Best Practices (continued)

- We also suggest that issuers state clearly for policy holders on both bills that:
  - The policy holder is receiving two (2) bills to cover the total amount of premium due for the coverage period;
  - The policy holder's total premium due is inclusive of the amount attributable to coverage of non-Hyde abortion services; and
  - Instructs the policy holder to make separate payments for each bill.

# Segregation of Abortion Funds: Best Practices (continued)

- QHP issuers should also explain to the policy holder in layperson terms on the separate bill for coverage of non-Hyde abortion services, or otherwise communicate to enrollees through enrollee outreach and education, that:
  - Non-payment of any premium due (including non-payment of the portion of the policy holder's premium attributable to coverage of non-Hyde abortion services) would continue to be subject to state and federal rules regarding grace periods (unless the QHP issuer elects to take advantage of the available enforcement discretion).

# Segregation of Abortion Funds: Enforcement Discretion on Nonpayment

Option 1

- HHS will not take enforcement action against a QHP issuer that adopts and implements a policy, applied uniformly to all its QHP enrollees, under which an issuer does not place an enrollee into a grace period and does not terminate QHP coverage based solely on the policy holder's failure to pay the separate payment for coverage of non-Hyde abortion services.

# Segregation of Abortion Funds: Enforcement Discretion on Nonpayment (continued)

Option 1 cont.

- Under this enforcement discretion:
  - We would expect issuers to apply such a policy uniformly to all of their enrollees for the duration of the applicable plan year.
  - The QHP issuer would still be prohibited from using any federal funds for coverage of non-Hyde abortion services.
  - The QHP issuer would still be required to collect the premium for the non-Hyde abortion coverage, which means that the QHP issuer cannot relieve the policy holder of the duty to pay the amount of the premium attributable to coverage for non-Hyde abortion services.

# Segregation of Abortion Funds:
## Enforcement Discretion on Nonpayment (continued)

Option 1 cont.

- This enforcement posture will take effect on June 27, 2020, the effective date of the separate billing requirements under 45 CFR 156.280, which is six (6) months after publication of the Final Rule in the Federal Register.

# Segregation of Abortion Funds:
## Enforcement Discretion on Nonpayment (continued)

Option 2

- HHS will not take enforcement action against a QHP issuer that modifies the benefits of a plan either at the time of enrollment or during a plan year to effectively allow enrollees to opt out of coverage of non-Hyde abortion services by not paying the separate bill for such services.
  - This would result in the enrollees having a modified plan that does not cover non-Hyde abortion services, meaning that they would no longer have an obligation to pay the required premium for such services.

# Segregation of Abortion Funds: Enforcement Discretion on Nonpayment (continued)

Option 2 cont.

- Where a QHP issuer allows an enrollee to opt out of coverage of non-Hyde abortion services by not paying the separate bill for such services:
  - The user fee a QHP issuer in an FFE or SBE-FP would pay would continue to be based on the original premium, which includes the portion of the premium attributable to non-Hyde abortion coverage.
  - A policy holder's opt-out would have to be applied to all persons in the enrollment group under the policy.
  - A policy holder's opt-out would be effective for the remainder of the benefit year.
    - The policy holder would not be allowed to retract the opt-out decision and reinstate coverage of non-Hyde abortion services for that benefit year, by paying premiums that could cover a portion of premium attributable to coverage of non-Hyde abortion services.
  - Issuers would not use Enrollment Data Alignment to adjust premium under the coverage opt-out option.

# Segregation of Abortion Funds: Enforcement Discretion on Nonpayment (continued)

Option 2 cont.

- We expect QHP issuers taking this approach to take appropriate measures to distinguish between a policy holder's inadvertent non-payment of the separate bill for coverage of non-Hyde abortion services and intentional nonpayment of the separate bill for the purposes of opting out of non-Hyde coverage.
  - The QHP issuer could include on the separate bill or separate electronic communication an option (such as a check box or option button) where the policy holder can affirmatively indicate their intent to opt-out of such coverage by not paying the separate bill.
  - We also recommend including an explanation for the policy holder that by affirmatively opting out, the policy holder would no longer have coverage for non-Hyde abortion services and would no longer have an obligation to pay the required premium for such services.

# Segregation of Abortion Funds:
## Enforcement Discretion on Nonpayment (continued)

Option 2 cont.

- This enforcement posture will become effective on the effective date of this Final Rule, which will be 60 days after its publication in the Federal Register (February 25, 2020).

# Segregation of Abortion Funds:
## Enforcement Discretion on Nonpayment (continued)

Options 1 & 2

- We encourage states to take an enforcement approach that is consistent with these two (2) options.

# Segregation of Abortion Funds: Compliance Reviews

- The compliance reviews governing QHP issuers participating in the FFE include reviews of compliance with section 1303 of the PPACA and §156.280.
- The compliance reviews for future benefit years will include the new requirements finalized in this rule for separate billing of the portion of the policy holder's premium attributable to coverage of non-Hyde abortion services, as finalized at §156.280(e)(2).
- FFE issuers subject to compliance reviews under §156.715 must retain all documents and records of compliance with section 1303 of the PPACA and these requirements in accordance with §156.705, and should anticipate making available to HHS the types of records specified at §156.715(b) that would be necessary to establish their compliance with these requirements.

# Segregation of Abortion Funds: Additional Requirements

*Segregation Plan & Attestation Requirement*

- We remind issuers that pursuant to §156.280(e)(5)(ii), any issuer offering coverage of non-Hyde abortion services on the Exchange must submit a plan to the relevant state insurance regulator that details the issuer's process and methodology for meeting the requirements of section 1303(b)(2)(C), (D), and (E) of the PPACA.
- We also remind issuers offering medical QHPs in the FFEs that they already must attest to adhering to all applicable requirements of 45 CFR part 156 as part of the QHP certification application, including those requirements related to the segregation of funds for abortion services implemented in §156.280.
  - As part of the QHP certification process, issuers in states with FFEs where the states perform plan management functions must also complete similar program attestations attesting to adherence with §156.280.
  - Issuers in states with State Exchanges that offer QHPs that cover non-Hyde abortion services should contact their state regarding the QHP certification process.

# Questions



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