



CMS Releases Notice of Benefit and Payment Parameters for 2021

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On May 14, 2020, the Centers for Medicare and Medicaid Services (“CMS”) released the [final Notice of Benefit and Payment Parameters rule](#), which describes the regulations for health insurance plans subject to the Affordable Care Act (“ACA”). The stated goal of this rule is to promote “affordability, improve consumer choice, ensure program integrity, and increase market stability.” Major takeaways from the new rule include:

- the finalization of the user fee rates;
- the adoption of new rules regarding special enrollment;
- an increased focus on value-based plan designs;
- clarification regarding the use of drug manufacturer coupons;
- the application of category limitations for dependents;
- the treatment of wellness incentives in MLR calculations; and
- the implementation of MLR reporting requirements for outsourced activities.

User Fee Rates

The Department of Health and Human Services (“HHS”) has finalized the user fee rates for issuers offering plans through Exchanges utilizing the federal platform. The user fee is an assessment on each issuer’s total monthly premium and is used to cover the cost of sustaining the Exchange’s operations.

This year, HHS has decided to maintain the Federally-facilitated Exchanges (“FFE”) user fee rate at 3% of premiums and the State-based Exchange on the Federal platform (“SBE-FP”) at 2.55% of premiums. Exchange user fees are typically passed directly to consumers in the form of high premiums. By allowing the fees to stay the same, HHS and CMS have helped prevent the potential rise of premiums for consumers.

Special Enrollment

The new rule has provided several modifications to the existing special enrollment periods. One change, being referred to as the special enrollment period prospective coverage effective date, will provide some consumers an earlier effective date for coverage purchased during special enrollment, starting in January of 2022. All consumers selecting plans during the special enrollment period in 2022 and thereafter will now have an effective date that is the first of the month following enrollment. This is a change from the current rules which determine the effective date based on whether the applicant enrolled on or before the 15th of the month, giving those that did an effective date on the first day of the next month and those that enrolled on or after the 16th of the month an effective date on the first day of the second month following enrollment. Starting in 2022, applicants will get an effective date on the first of the next month, regardless of which day they enrolled during the prior month.

Another change to special enrollment involves retroactive coverage. When special enrollment eligibility verification is delayed beyond the appropriate effective date, the new rule gives consumers the option to either pay premium for retroactive coverage back to that effective date or have coverage begin on a prospective basis. This change gives consumers in these situations more flexibility to purchase and pay for coverage to fit their individual circumstances. But insurers should recognize this rule change will also mean that insurers may collect less premium from special enrollees who choose the prospective option in the future than they do today.

Finally, the rule adopts changes to the special enrollment period related to enrollees in silver plans who lose eligibility for cost-sharing reduction subsidies. The new rules allow these enrollees to now switch to another Qualified Health Plan ("QHP") that is one metal tier higher (gold) or lower (bronze), which is in addition to their ability to switch to another silver plan under the current rules. Individuals losing cost-sharing reduction subsidies may be unable to afford the remaining silver-level plan options, so this change will allow them to switch to a less expensive plan. Therefore, starting in 2021, anyone enrolled in a silver QHP who loses cost-sharing reduction subsidies will have a special enrollment period in which to

switch to another bronze, silver, or gold QHP.

Value-Based Plan Design

Another major goal of the new rule is to provide flexibility for plan design that allows insurers to put more emphasis in plan design on high-value services (over low-value services). The new rule allows insurers to decrease cost-sharing for high-value services and increase cost-sharing for low-value services, in an effort to improve the quality and cost of their care. CMS defines high-value services as those services that most people will benefit from and have strong clinical evidence demonstrating an appropriate level of care. By lowering cost-sharing for these types of services, consumers can utilize their health insurance in a more efficient manner. Some examples that CMS provided of high-value services are blood pressure monitoring or cardiac rehabilitation with zero cost-sharing.

While these new value-based plans will not receive special treatment in the Exchanges, CMS and HHS are now seeking comments on the best way to identify “value-based” plans to consumers and ways to assist consumers in selecting these plans.

Use of Drug Manufacturer Coupons

The new rule provides clarity regarding the use of drug manufacturer coupons. A drug manufacturer coupon is a coupon issued directly by the drug manufacturer and can be used by consumers to help reduce out-of-pocket costs. In the proposed rule released in January, CMS indicated that insurers and plans do not have to count the value of coupons towards the annual cost-sharing limit in all circumstances not specifically included in the rule. “Cost-sharing” was then clarified to include expenditures covered by pharmaceutical manufacturer coupons.

In the final rule, CMS has stated it is not finalizing any changes to the definition of cost-sharing and that it is now “subject to interpretation.” Under the new rule, plans may, but are not required to, count financial support offered by drug manufacturers to enrollees toward the annual limit on cost-sharing. This flexibility will allow issuers to make this determination, even when a generic

equivalent is available, without fear of repercussions from CMS.

Plan Category Limitations to Dependents

Currently, enrollees who add a new dependent through the special enrollment period may add the dependent to their current QHP, or if the enrollee's current QHP does not allow for the enrollee to add dependents, the Exchange must then allow the enrollee and the dependent to change to another plan within the same level of coverage (or one metal level higher or lower if no such plan is available).

While the current rules address the common situation described above, the new rule will now address the situation where a dependent is an enrollee, but the individual is not. Many unique situations involving varying types of coverages between an individual and their dependents are not addressed in the current rules. The example given by CMS of such a unique situation is a mother who has job-based coverage of her while her two children are enrolled in their own QHP through the Exchange. If the mother loses her employer-based coverage, she will now be allowed to be added to her dependent children's QHP. If her dependent children's QHP does not allow for this, the mother and the dependents may switch to another QHP on the Exchange that does. The new rule will now provide for these unique situations to be treated in a similar manner to the current special enrollment rules and will allow for individuals to enroll in the same plan as their dependents.

Wellness Incentives

The new rule will amend existing regulations to include the cost of certain wellness incentives as qualified improvement activity ("QIA") expenses for purposes of calculating the insurer's medical loss ratio ("MLR"). Currently, insurers in the individual market are permitted to offer only participatory wellness programs. These programs do not offer rewards to enrollees who meet certain designated health outcomes. Presently in the group market, wellness QIA expenses are included in the MLR rules. By allowing these incentives to be included in the MLR reporting for individual plan insurers, CMS

believes this will create more consistency across the individual and group markets. These calculation rules will be used for the 2021 MLR reporting year, the deadline for which is July 31, 2022.

Reporting of Services Outsourced

The new rule has clarified the treatment of expenses for outsourced functions or services by other entities in calculating and reporting an insurer's MLR. Starting for policy year 2021, these expenses must be reported in the same manner as expenses for functions performed directly by the insurer. Therefore, administrative services provided by third-party vendors must be calculated as non-claims administrative expenses, while reimbursements to a third-party vendor under a capitation agreement can be counted as a health care claim in an insurer's MLR.

In summary, the new rule will have a significant impact for issuers on the federal Exchanges and will help provide consumers with more innovative and affordable health plans. If you have questions about these final rules or any other regulatory requirements, Frost Brown Todd's [Insurance Regulation & Risk Management](#) team can help. Please contact [Matt Wagner](#) or [Bill Williams](#) for more information.

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