Summary of Provisions of HHS' Final 2021 Notice of Benefit and Payment Parameters and Other Key Regulations

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On May 7, 2020, the Department of Health and Human Services (HHS) published the final Notice of Benefit and Payment Parameters for 2021 in the Federal Register.[1] The notice includes important final rules and parameters for the operation of the individual and small group health insurance markets in 2021 and potentially 2022. This paper summarizes key provisions of the finalized notice, and other related information recently released by HHS.

Overview

The key provisions in the notice and other related guidance are as follows:

1. **Auto-Enrollment:** The automatic re-enrollment process will generally continue for plan year 2021. However, HHS did not finalize its proposal to modify automatic enrollment for enrollees in which advance premium tax credit (APTC) covers the entire premium.

2. **Risk Adjustment:** HHS has finalized several updates to the risk adjustment model Hierarchical Condition Categories (HCCs), the data used to recalibrate the model, the risk adjustment coefficients, the risk adjustment data validation (RADV) program, and the risk adjustment user fee. There were some slight modifications to the risk adjustment model from 2019 detailed below.

3. **State EHB Benchmark Plan Deadlines:** HHS finalized May 7, 2021 as the deadline for submission of a state's EHB benchmark plan for the 2023 plan year.

4. **State Mandate Reporting:** HHS required states to annually identify and report benefits mandated by state law, which are in addition to essential health benefits (EHB) and enacted after Dec. 31, 2011. States are required to define the mandates that are in addition to EHB and subject to defrayal of costs. This emphasizes the need for states to identify these benefits and ensure that costs are being defrayed as required. The state must provide CMS with information on its state mandated benefits by July 1, 2021.

5. **MLR Changes:** HHS finalized changes to how certain costs are reported in the MLR for the 2021 reporting year. The change requires issuers to deduct rebates and price concessions received by the issuer from incurred claims. Expenditures related to wellness programs may qualify as quality

[1] Department of Health and Human Services, "Final Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021", May 7, 2020 https://www.federalregister.gov/documents/2020/05/14/2020-10045/patient-protection-and-affordable-care-act-benefit-and-payment-parameters-for-202-notice-requirement

improvement expenses.

6. **Drug Manufacturer Coupons:** HHS will allow amounts paid toward reducing the cost sharing incurred by an enrollee using any form of direct support offered by drug manufacturers to enrollees for specific prescription drugs to be counted toward the member's annual limitation on cost sharing.

7. **Exchange User Fees:** HHS set the FFE user fee at 3.0% and the SBE-FP (state Exchanges that use the Federal platform) at 2.5%.

8. **Silver Loading:** HHS did not make any changes or add any constraints to silver-loading for 2021 following the passage of the Further Consolidated Appropriations Act in December.

9. **Other:** Transitional plans will continue to be allowable though 2021.[2] CMS also gave insurers that use Healthcare.gov an extra week to change their 2021 QHP applications.

The following provides details on some of the changes.

Automatic Re-enrollment

Automatic re-enrollments will continue for 2021, but HHS remains concerned that this process leads to incorrect advanced premium tax credit (APTC) expenditures for highly subsidized members. CMS did not finalize its proposal that would reduce or end subsidies for enrollees with APTCs that are automatically re-enrolled. CMS did not finalize the proposal due to "overwhelming opposition" in the comments received.

Eligibility

Special Enrollment Periods (SEPs)

The final rule will allow for enrollees and their dependents who become newly ineligible for CSRs to change to a bronze or gold metal level QHP. Currently, these individuals are not permitted to enroll in a different metal level on the Exchange as part of SEP.

Additionally, for special enrollment periods currently following regular effective date rules, individuals will obtain coverage effective on the first of the month following plan selection, regardless of the date of selection during the month. Currently, if the plan selection occurred after the 15th of the month, the coverage date would become effective the first day of the second following month.

Limitations for Enrollees who are Dependents

HHS finalized its regulation to apply the same align current SEP rules for dependents. The rule will require that an Exchange allow a qualified individual who is not an enrollee, who qualifies for an SEP and has dependents who are enrollees, to add him or herself to a dependent's current QHP, enroll with his or her dependents in another QHP, or enroll in a separate QHP alone. CMS provided the following example, "where the rules do not currently address what limitations apply when a mother loses her self-only employer-sponsored coverage, thereby gaining eligibility for a SEP, and seeks to be added as an enrollee to the Exchange coverage in which her two young children are currently enrolled."

[2] "2021 Proposed NBPP\Limited-Non-Enforcement-Policy-Extension-Through-CY2021.pdf"; https://www.cms.gov/files/document/extension-limited-non-enforcement-policy-through-calendar-year-2021.pdf

Enrollees Covered by a Non-Calendar Year Plan Year QSEHRA

Those who are enrolled in a health reimbursement arrangement (HRA) with a non-calendar year plan year (i.e., the HRA's plan year begins on a day other than January 1) will be eligible for the special enrollment period annually. HHS established that individuals and dependents who are provided a qualified small employer health reimbursement arrangement (QSEHRA) with a non-calendar year plan year will qualify for this special enrollment period. Although these individuals would be eligible for an SEP, their plan accumulators will reset if they make a plan change.

Termination of Dual Coverage

Currently, FFE only ends coverage for those individuals enrolled in both Medicare and the Exchanges. HHS extended this process to other forms of minimum essential coverage (i.e., Medicaid/CHIP/Basic Health Plans) for those that opted into the termination process rather than re-determine eligibility for individuals with APTCs/CSRs when processing enrollees. In other words, the FFE will end coverage, under certain circumstances, for individuals with both Exchange coverage and Medicare coverage. The FFE will also, under certain circumstances, now end coverage for individuals who simultaneously have both Exchange coverage and another major medical coverage (i.e., Medicaid).

Maximum Out-of-Pocket Updates

The maximum out of pocket (MOOP) amounts for standard plans[3] and cost sharing variations for 2021 increased by 4.9% from 2020.

- Standard Plans: $8,550/$17,100 (single/family)
- 100%-150% FPL: $2,850/$5,700 (single/family)
- 150%-200% FPL: $2,850/$5,700 (single/family)
- 200%-250% FPL: $6,800/$13,600 (single/family)

The catastrophic plan's deductible and MOOP will be set to $8,550/$17,100 (single/family)

Risk Adjustment

HHS finalized several proposed updates to the risk adjustment program in the payment notice.

Sequestration

The risk adjustment programs will both be sequestered at a rate of 5.9 percent for payments made from federal fiscal year 2020 resources and 5.7 percent for payments made from the federal fiscal year 2021 resources.

Recalibration Using EDGE Data

For 2021 and beyond, HHS finalized its proposal to recalibrate the risk adjustment model coefficients using equally blended coefficients from the three most recent years of available EDGE data. For benefit year 2021, coefficients will be blended from separately solved models using 2016, 2017, and 2018 enrollee-level EDGE data. Draft coefficients blended from 2016 and 2017 EDGE data were released for illustration purposes. Final 2021 coefficients are expected to be published in June 2020.

[3] Standard plans include platinum, gold, silver non-cost sharing variation, bronze and catastrophic metal offerings.

Hierarchical Condition Categories (HCCs) Updates

For the 2021 benefit year, HHS proposed significant changes to the risk adjustment model HCCs based on the availability of more recent diagnosis code and claims data. HHS' main goal in reclassifying the HCCs is to better reflect the coding changes due to the transition to ICD-10 as well as the recently available EDGE data.

HHS finalized the proposed changes to the risk adjustment model with slight modifications to certain conditions.

The finalized changes include a net change of 16 HCCs in the adult model, 11 HCCs in the child model, and 7 HCCs in the infant model. HHS also released a table of illustrative risk coefficients calculated from 2016 and 2017 data that incorporate these HCC updates as well as a crosswalk of ICD-10 codes to the revised set of HCCs and their hierarchies for the 2021 benefit year.

Prescription Drugs

Similar to the 2020 benefit year, HHS proposed an adjustment to the Hepatitis C prescription drug class (RXC) to mitigate overprescribing incentives and better reflect the average cost of Hepatitis C treatments in the 2021 benefit year adult models. HHS proposed to adjust the plan liability associated with Hepatitis C drugs to reflect future market pricing of Hepatitis C drugs before solving for the adult model coefficients.

In response to the U.S. Preventative Service Task Force's recommendation to expand the use of pre-exposure prophylaxis (PrEP) as a preventive service that health plans must cover for members with high risk HIV, HHS proposed to incorporate PrEP as a preventive service for the adult and child risk adjustment model recalibrations for the 2021 benefit year. PrEP was not incorporated into RXC 1 (Anti-HIV), since it does not indicate an HIV/AIDs diagnosis, and RXCs are designed to impute missing diagnosis or indicate severity of a diagnosis.

Both the Hepatitis C and PrEP proposals are finalized.

High Cost Risk Pooling Adjustment

HHS is maintaining the $1 million threshold and 60 percent coinsurance rate for the high-cost risk pooling adjustment for the 2021 benefit year risk adjustment program.

Cost-Sharing Reductions Adjustment

Risk score adjustments for CSR plans will continue for the 2021 benefit year as finalized in the 2019 and 2020 payment notices.

Risk Adjustment Payment Transfer Formula

There is no change to the 2021 risk adjustment payment transfer formula from the final 2020 payment notice. High-cost risk pooling charges and payments will continue to apply to the formula. The charges will be determined as a percentage of premiums for each of the national markets.[4] HHS also upheld that statewide average premiums used in the 2021 risk adjustment formula will continue to be reduced by 14 percent to account for the proportion of administrative costs that do not vary with claims.

State Flexibility Requests

HHS granted Alabama's request to reduce risk adjustment transfers in the small group market

[4] Individual, catastrophic and merged markets will be treated as one national market while small group is its own separate market.

by 50 percent (maximum allowed) for the 2021 benefit year.

Risk Adjustment Data Validation (RADV)

Beginning with the 2019 benefit year RADV, HHS will not consider any issuer's HCC group's failure rate as an outlier if the issuer has less than 30 HCCs recorded in that group in their EDGE data. Issuers with less than 30 HCCs in a particular HCC group will have their data included in the national metrics and calculations, but their risk score will not be adjusted for that HCC group even if they were an outlier. However, the same issuer could still be considered an outlier and have their risk score adjusted for another HCC group if they have at least 30 HCCs recorded for that HCC group on the EDGE server. HHS believes this change will improve the precision and reliability of RADV results and will help remove some burden from smaller issuers.

HHS also finalized that the 2019 benefit year RADV will function as a second pilot year for the purposes of prescription drug validation, similar to the 2018 benefit year RADV. This extension aims to give HHS and issuers more experience with RXC validation before using the results to adjust risk scores and transfers. HHS recognizes that there may be more differences between validating HCCs and RXCs that need to be considered than was originally expected and that the metrics used to validate RXCs are different from coding an HCC.

Risk Adjustment User Fee

HHS set the 2021 risk adjustment user fee at $0.25 per member per month (PMPM) for the 2021 benefit year as opposed to $0.19 PMPM as initially proposed. This is an increase from $2.16 per billable member per year, or $0.18 PMPM in the 2020 benefit year, due to a projected decline in billable member months in both the individual and small group markets in 2021 as well as an increase in projected costs to operate the risk adjustment program.

EHB Benchmark plans

States may modify their essential health benefit (EHB) benchmark plan by:

1. Selecting an EHB-benchmark that another state used for the 2017 plan year; or
2. Replacing one or more EHB categories of benefits with another state's EHB-benchmark plan; or
3. Selecting a set of benefits that will become the state's EHB-benchmark plan.

HHS set May 7, 2021 as the deadline for states to request changes to their 2023 plan year benchmark.

HHS included the following clarifications for states considering changes to their benchmark plan in the final rule:

- When selecting an updated EHB-benchmark plan, the new EHB plan may not exceed the generosity of the most generous among the set of comparison plans. Any increase, defined as anything above 0.0 percentage points, would result in CMS not approving a state's application.
- The "typical employer plan test"[5] and

[5] The "typical employer plan" relies on one of four benchmark plan options: (1) the largest plan by enrollment in the state's small group market; (2) any of the largest three state employee health benefit plans options by enrollment; (3) any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment; or (4) the HMO plan with the largest enrollment in the state.

"generosity test"[6] are separate and states must comply with both. HHS suggests that states should consider using the same plan as the comparison plan for both tests to help minimize burden and to mitigate any potential conflict caused by applying each test with a different comparison plan.

State Mandate Benefit Reporting

HHS also required each state to report on all state mandated benefits that apply to the ACA individual and small group markets. Furthermore, the state would have to note and justify if each mandate exceeds EHB. State mandates that are not justified will need to have their costs defrayed. States will need to submit the state mandate information by July 1, 2021. If CMS has concerns about a state's submission or compliance, CMS could rescind up to 1% of payments due to a state. If a state does not submit the necessary information, HHS will identify, on behalf of the state the benefits that need to be defrayed.

Minimum Loss Ratio (MLR) Changes

HHS changed how certain costs are reported in the MLR for the 2021 reporting year. The change requires issuers to deduct rebates and price concessions received by the issuer from incurred claims. Price concessions may include costs associated with administering the issuer's prescription drug benefits. The change will include a conforming language change to require issuers to report rebates and price concessions as non-claim costs. These changes are designed to align the commercial MLR rules with those for Medicare Advantage and Medicaid programs.

Additionally, issuers in the individual market may include wellness incentives, as is permitted in the group market, as a quality improvement activity. Finally, CMS clarified how issuers report expenses related to third-party vendors (depending on the types of activity it could be incurred claims, non-claims administrative expenses, or quality improvement).

Value-based Insurance Designs (VBID)

CMS will not include a VBID indicator for the Healthcare.gov platform for 2021 although indicated it may do so in future rule making.

Cost-Sharing and Drug Manufacturers' Coupons

HHS finalized its proposal that issuers may choose to count cost sharing toward the maximum out of pocket (MOOP) if a drug manufacturer coupon covers costs and there is a generic equivalent available and medically appropriate. States can pre-empt this regulation and require that such amounts count toward the annual limit on cost sharing.

Rate Review Timeline

CMS issued new guidance that keeps the proposed final rate deadline (July 22) but moves the final rate submission deadline back one week (now August 26) for insurers in Healthcare.gov states. Issuers in states that do not use Healthcare.gov must submit rates no later than October 15. CMS announced it plans to post final rate information by November 2.

[6] The generosity test specifies that a state's EHB-benchmark plan must not exceed the generosity of the most generous among a set of comparison plans, including the EHB benchmark plan used by the state in 2017.

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