WHITE PAPER

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

On February 6, 2020, the Department of Health and Human Services (HHS) published the proposed Notice of Benefit and Payment Parameters for 2021 in the Federal Register.[1] The notice includes important proposed 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 proposed notice, and other related information recently released by HHS. Comments are due by March 2, 2020.

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 proposes to modify automatic enrollment for enrollees in which advance premium tax credit (APTC) covers the entire premium. For those enrollees, HHS is considering requiring these individuals to actively enroll in coverage or lose some if not all of their APTC subsidies.

2. **Risk Adjustment:** HHS has proposed 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.

3. **State EHB Benchmark Plan Deadlines:** HHS proposed 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 proposes to require states to annually identify and report the required benefits mandated by state law, which are in addition to essential health benefits (EHB) and enacted after December 31, 2011. States would be

[1] Department of Health and Human Services, "Proposed Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021", February 6, 2020 https://www.govinfo.gov/content/pkg/FR-2020-02-06/pdf/2020-02021.pdf

required to define the mandates 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 first proposed reporting date is July 1, 2021.

The prosed 2021 NBPP does not propose constraints to Silver-loading

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

6. **Plan Benefits:** HHS provided options on how issuers may implement value-based insurance plan designs (VBID) that would encourage use of high value services at lower costs.

7. **Drug Manufacturer Coupons:** HHS proposes that 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 are permitted, but not required, to be counted toward the member's annual limitation on cost sharing.

8. **Exchange User Fees:** There are two alternative proposals for federal facilitated exchange (FFE) user fee: 1) 3.0% of premiums (same as 2020); and 2) reduced user fee to 2.5% to reflect premium increases and enrollment decreases, savings from cost-savings measures, and to apply downward pressure on premiums.

9. **Silver Loading:** HHS has not proposed any changes or constraints to Silver-loading for 2021 following the passage of the Further Consolidated Appropriations Act in December.

10. **Other:** Transitional plans will continue to be allowable though 2021.[2]

The following provides details on some of the proposed 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. Comments are solicited on modifying the process as follows:

- Any enrollee who would be automatically re-enrolled with APTCs that would cover the enrollee's entire premium would instead be automatically re-enrolled without APTCs.
- A variation of the above approach would reduce APTCs, but not entirely eliminate them.

[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

Eligibility

Special Enrollment Periods (SEPs)

The proposed ruling will allow for enrollees and their dependents who become newly ineligible for CSRs and are enrolled in a silver metal level QHP 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 (i.e., one month later than the proposed ruling).

Limitations for Enrollees who are Dependents

HHS proposes to apply the same limitations to dependents who are currently enrolled in Exchange coverage that applies to current, non-dependent Exchange enrollees. The proposed rule will require that the 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."

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 has established that individuals and dependents who are provided a qualified small employer health reimbursement arrangement (QSEHRA) with a non-calendar year plan year may qualify for this special enrollment period. Although these individuals would be eligible for an SEP, their plan accumulators would reset if they made a plan change.

Termination of Dual Coverage

Currently, only the FFE ends coverage for those with have coverage for individuals enrolled in both Medicare and the exchanges. HHS proposes that exchanges will not redetermine eligibility for individuals with APTCs/CSRs when processing enrollees that are also enrolled in Medicare, Medicaid, CHIP, or a Basic Health Plan and those individuals have provided consent for such actions.

Maximum Out of Pocket Updates

The maximum out of pocket (MOOP) amounts for standard plans[3] and cost sharing variations for 2021 are 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)

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

- 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 proposes several updates to the risk adjustment program in the payment notice.

Sequestration

The transitional reinsurance and risk adjustment programs will both be sequestered at a rate of 5.9 percent for payments made from federal fiscal year 2020 resources, i.e., funds collected during the 2020 federal fiscal year.

Recalibration Using EDGE Data

For 2021 and beyond, HHS proposes 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.

Hierarchical Condition Categories (HCCs) Updates

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

The proposed changes include a net change of 17 HCCs in the adult model, 12 HCCs in the child model, and 8 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. HHS documented its analysis for these model changes in the report "Potential Updates to HHS-HCCs for the HHS-operated Risk Adjustment Program" released on June 17, 2019.[4]

Prescription Drugs

Similar to the 2020 benefit year, HHS proposes 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 proposes 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 proposes 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.

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[4] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Potential-Updates-to-HHS-HCCs-HHS-operated-Risk-Adjustment-Program.pdf

Model Prediction Improvements
HHS seeks comment on various options for modifying the risk adjustment models to improve model prediction for enrollees without HCCs or enrollees with low expenditures including non-linear and count model methods. Analysis to date suggests these methods may improve model predictive power, but HHS did not propose any changes for the 2021 benefit year and still plans to test these approaches with more data. These proposed model changes were also included in the June 17, 2019 CMS report.[5]

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 what was finalized in the 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.[6] 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
Similar to the 2020 benefit year, HHS seeks comment on Alabama's request to reduce risk adjustment transfers in the small group market by 50 percent (maximum allowed) for the 2021 benefit year.

Risk Adjustment Data Validation (RADV)
Beginning in the 2019 benefit year, HHS proposes to not consider as an outlier any issuer's HCC group's failure rate 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 would have their data included in the national metrics and calculations, but their risk score would 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 proposes 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

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[5] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Potential-Updates-to-HHS-HCCs-HHS-operated-Risk-Adjustment-Program.pdf
[6] Individual, catastrophic and merged markets will be treated as one national market while small group is its own separate market.

considered than was originally expected and that the metrics used to validate RXCs are different from coding an HCC.

Risk Adjustment User Fee

HHS proposes a 2021 risk adjustment user fee of $2.28 per billable member per year, or $0.19 per member per month (PMPM) for the 2021 benefit year. 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.

EHB Benchmark plans

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

1) selecting an EHB-benchmark that another state used for 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 would become the state's EHB-benchmark plan.

HHS proposes a May 7, 2021 deadline for states to request changes to their 2023 plan year benchmark.

HHS proposes the following clarifications for states considering changes to their benchmark plan:

- 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. This requirement must be demonstrated through an actuarial equivalence test.
- The "typical employer plan test"[7] and "generosity test"[8] 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 proposed to require each state to report on all state 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 would need to have their costs defrayed. HHS proposes that states would need to submit the information by July 1, 2021. If a state does not submit the necessary information, HHS would identify the benefits that need to be defrayed on behalf of the state. HHS is also considering that either the exchange (and therefore HHS for state exchanges it operates) or itself should instead make the determination rather than the state.

Minimum Loss Ratio (MLR) Changes

HHS proposes to change how certain costs are reported in the MLR for the 2021 reporting year.

[7] 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.

[8] 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.

The change would require 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.

Value-based Insurance Designs (VBID)

HHS presented information an issuer could use to structure cost sharing that varies for high and low value services. A table of services from the University of Michigan, Center for Value-based insurance designs was provided to assist issuers in developing plans by identifying low and high value services. Plans will continue to be subject to actuarial value and non-discrimination provisions such as the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Cost-Sharing and Drug Manufacturers' Coupons

HHS proposes that issuers may choose to not count cost sharing toward the maximum out of pocket (MOOP) if costs are covered by a drug manufacturer coupon 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.

The 2021 Issuer Letter

There are limited changes from the 2020 issuer letter. The annual Stand Alone Dental Plan (SADP) MOOPs will remain unchanged at $350/$700. HHS is aiming to support automatic re-enrollment for SADP plans offered during the 2021 plan year.

Timeline

1) The initial QHP application deadline is June 17, 2020. However, the Rate Template is not due until July 22, 2020 for states with an effective rate review program.
2) For states without an effective rate review program, the deadline to submit proposed rate filing justifications is June 3, 2020.
3) The initial application window will end on August 12, 2020. Corrections after August 19, 2020 will only be allowed at the direction of HHS or the state.

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