Notice of Benefit and Payment Parameters for 2021 – Summary of Proposed Changes

Comments are due March 2, 2020. Read the proposed rule and submission instructions.

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Insurer Plan Management	
State reporting on state-mandated benefits	• **Annual report:** Requires states to submit annual reports of state-required benefits outside of essential health benefit (EHB) requirements. Format and date of report submission will be determined by the Department of Health and Human Services (HHS). In addition to identifying state-mandates outside of EHB, the report will include information on state-required benefits that are not in addition to EHB. Other details in the report will include: ○ Date of state action imposing the requirement; ○ Effective date of the applicable state action; ○ The market it applies to (that is, individual, small group, or both); ○ The precise benefit or set of benefits that qualified health plans (QHPs) in the individual and/or small group market are required to cover; ○ Any exclusions; ○ Citation to the relevant state action; and ○ Indication of whether benefit requirements previously reported to HHS under this paragraph (f) have been amended, repealed, or otherwise affected by state regulatory or legislative action. States would be required to submit annual reports even if no changes have been made during the year. States may submit the same report from the prior year with affirmative indication that no changes have been made.

	State reports must be signed by a state official with authority to make the submission on behalf of the state. • **Deference to HHS:** In the case a state does not submit a report, HHS will issue a determination of state-mandated benefits outside of EHB. Where states defer to HHS the task of identifying state-required benefits that require defrayal, states may modify their existing timeline for defrayal as necessary to work in tandem with HHS determinations as to which of the state required benefits are in addition to EHB. Encourages states to contact HHS concerning issues related to defrayal of state-mandated benefits in advance of passing and implementing benefit mandates. • **Deadline:** Sets deadline of July 1, 2021, for the first state EHB report. Requires that information in the report cover state activity taken through May 2, 2021 (60 days prior to report submission deadline). The reporting cut-off date would not impact a state's ability to defray the cost of benefits in addition to EHB that result from state action taken after the cut-off date. Future report deadlines will be set in subsequent payment notices. • **Transparency:** State submissions will be posted on the US Centers for Medicare & Medicaid Services (CMS) website prior to the end of the plan year during which they were submitted. • **Cost Analysis:** Clarifies that QHP issuers may rely on outside entities, such as the state, to produce cost-analysis of state-mandated benefits. Clarifies that actual cost of benefits refers to an actuarial estimate of what part of the premium is attributable to the state-required benefit that is in addition to EHB, and that analysis should be performed prospectively to the extent possible. **Rationale:** ○ To address concerns that states may not be defraying the costs of their state-required benefits in addition to EHB; ○ To improve transparency with regard to the types of benefit requirements states are enacting; ○ To provide the necessary information to HHS for increased oversight over whether states are appropriately determining which state-required benefits require defrayal and whether states are correctly implementing the definition of EHB; and ○ To determine whether QHP issuers are properly allocating the portion of premiums attributable to EHB for purposes of calculating premium tax credits (PTCs).

	Questions posed in NBPP: • Comment on reporting deadline and cut-off date? Should the cut-off date be shortened to 30 days before report submission? • Should this report be required every other year, instead of annually? • Should HHS require any additional information from states as part of the annual reporting submission on state-required benefits? • Would there be any benefit to offering a public comment period for documents posted to the CMS website? • What is the extent to which states are not appropriately identifying and defraying state-required benefits in addition to EHB? • Are states the appropriate entities to continue making these determinations? Should exchanges be the responsible entity (making the federally-facilitated exchange (FFE) the default reporting entity for most states)? Should HHS be responsible?
EHB-benchmark plan selection	• States must select EHB benchmark for plan year 2023 by May 7, 2021. On this date, states must also notify HHS of any intentions to permit between-category substitution for the 2023 plan year. • Clarifies that the typical employer plan and the generosity standard requirements are two separate tests that an EHB-benchmark plan must satisfy. • Recommends that states submit applications at least 30 days prior to the submission deadline to ensure completion of their documents by the proposed deadline.
Changes to medical loss ratio (MLR) calculations	• Allows issuers to include wellness incentives as part of quality improvement activities. • Requires issuers to deduct prescription drug price concessions, including rebates and incentive payments from MLR-incurred claims that have been secured and retained by entities providing pharmacy benefit management services, typically a pharmacy benefit manager (PBM). To date, such rebates and other drug price concessions retained by PBMs administering an issuer's pharmacy benefit have not been required to be reflected in the MLR reporting and calculation, only those concessions received directly by the issuer have been explicitly required. This change extends fiduciary responsibility to the PBM through the issuer. • Requires enhanced reporting by issuers of outsourced functions for the purposes of improving integrity of MLR calculations.

Premium adjustment percentage and annual limitations on cost sharing	• Sets premium adjustment percentage as 1.3542376277, representing a 35.4% increase in private health insurance premiums from 2013-2020 (~5% increase from 2020). Uses same methodology as 2020 for premium adjustment calculation. • Sets maximum annual limitation on cost sharing as $8,550 for self-only coverage and $17,100 other than self-only coverage. This is a 4.9% increase from 2020. • Lowers maximum annual limitation on cost sharing for enrollees with a household income between 200 and 250 percent of FPL by ~1/5. This is consistent with the approach taken for benefit years 2017 through 2019. • Lowers the maximum annual limitation on cost sharing for enrollees with a household income between 100 and 200% of the federal poverty level (FPL) by approximately two-thirds as specified in the statute.
Flexibility in how to apply direct support for prescriptions toward cost sharing	• Permits, but does not require, issuers to count amounts paid using any form of direct support offered by drug manufacturers toward reducing the cost sharing incurred by an enrollee. Maintains deference to state law regulating application of direct support toward cost sharing. Maintains ability to incentivize use of generics by excluding drug manufacturer coupons from cost sharing where generic alternatives are available. • Sets expectation that issuers prominently include this information on their websites and in brochures, plan summary documents, and other collateral material consumers may use to select, plan, and understand their benefits.
Encouraging value-based payments	Encourages issuers to adopt value-based insurance design, particularly designs that offer high-value services to consumers with little-to-no cost sharing including: o Chronic disease management services and equipment, and o Provision of certain high-value generic and branded drugs. Recommendations are modeled after work conducted by the University of Michigan Center for Value-Based Insurance Design.
Excepted benefit HRA notice requirements	• Requires non-federal government employers offering excepted benefit HRAs to provide participants with an annual notice describing the conditions pertaining to eligibility to receive benefits, annual or lifetime caps or other limits on benefits, and a summary of benefits available under the HRA. This is similar to a requirement already in effect for plans governed by the Employee Retirement Income Security Act of 1974 (ERISA).

	• Notice must be provided in a manner in which it can be reasonably expected that the participants receive it. • Notice must be provided 90 days after the first day of the HRA plan year, or after a new employee becomes a participant in the plan. **Questions posed in NBPP:** • Should a different timing standard be applied? Would a timing change lead to any logistical or cost challenges? • Solicits comments on proposed applicability date and how to mitigate cost burden of this notice requirement. • Should the notice be required annually? If not, what changes should trigger another notice? Changes in dollar amount or a type of medical care expense?
Quality improvement	• Affirms flexibility for state-based exchanges (SBEs) to use the FFE system for quality rating displays.
Eligibility and Enrollment	
Proposal to eliminate or reduce advance premium tax credit (APTC) for certain automatic re-enrollees	Suggests exploration of a policy to eliminate or significantly reduce APTC for certain consumers who do not actively re-enroll in coverage. Change would apply to consumers that pay $0 out-of-pocket for premiums after APTC is applied. **Questions posed in NBPP:** • Should HHS modify the automatic re-enrollment process for enrollees who would be automatically re-enrolled with APTC that cover the enrollee's entire premium? • For state exchange or all exchanges?
Lessens flexibility of effective date in the event a consumer is eligible for retroactive coverage	• If a consumer receives delayed approval for coverage, and becomes eligible for retroactive coverage, eliminates flexibility for consumer to choose effective date of retroactive coverage so that consumers must either elect the full period of retroactive coverage, or to have coverage begin prospectively. • Currently, if a consumer qualifies for retroactive coverage, the consumer may opt to discard one month of that retroactive coverage — lessening the burden on consumers to pay at once the full amount of premiums owed for all months of retroactive coverage.
Eliminates requirement for	Currently, exchanges must use random sampling to verify whether applicants are eligible for or enrolled in eligible employer-sponsored insurance (ESI). Future changes could allow exchanges to design their own verification process based on the exchange's assessment of the risk of inappropriate eligibility due to availability of ESI.

random sampling to verify applicant eligibility for employer-sponsored coverage	HHS is conducting a study to further assess this issue. Results will be released in 2020, after which HHS will propose new regulations related to ESI verifications. No enforcement will be taken against states that do not conduct random sampling pending further regulations.
	
	Questions posed in NBPP:
	• Encourages exchanges to consider conducting research to:
	  ○ Determine unique characteristics of populations with ESI;
	  ○ Compare premiums and out-of-pocket costs of coverage available through the exchange versus coverage available through ESI; and
	  ○ Identify incentives that drive consumers to enroll in exchange coverage rather than ESI.

Policies addressing consumers who are dually eligible or enrolled in coverage	• Eliminates requirement for exchanges to redetermine APTC/CSR eligibility before terminating coverage in case of consumers found dually enrolled in minimum essential coverage (MEC) and an exchange QHP or in the case of consumers who have not responded to requests from the exchange for updated eligibility data. • FFE will continue to end QHP coverage automatically for consumers eligible for or enrolled in Medicare and a QHP. Suggests HHS will instigate similar terminations for consumers eligible for Medicaid/CHIP pending availability of appropriate data and in consideration of income fluctuations that may affect eligibility during the calendar year. • Eliminates requirement that exchanges must initiate QHP termination in case of a consumer who was found to be enrolled in Medicare via periodic data matching.
Evaluation of policies related to eligibility pending appeal	In the event a consumer is appealing a determination decision made by an exchange, the consumer may opt for eligibility pending appeal, during which an exchange must continue the consumer's enrollment, APTC, and CSR pending the results of the appeal. HHS is considering issuing future regulations to provide greater clarity on this process that may: • Address situations where redeterminations of APTC or CSR eligibility would result in the consumer choosing a different metal level (e.g., silver instead of bronze in the case the consumer is eligible for greater APTC or CSR); • Set timelines for eligibility pending appeal; • Address how changes in life events that occur during the appeal process should impact the appeal; and • Address effective date of coverage after appeal has been finalized. **Questions posed in NBPP:**

	• Should appellants who request and are granted eligibility pending appeal be permitted to enroll in any plan or otherwise be limited in any way to a particular issuer or plan category?
	  ○ If consumers are allowed to change metal level, should they be required to stay with the same issuer?
	  ○ If a change is allowed, should it apply retroactively or only prospectively based on date the appeal is granted?
	• Is it advisable for HHS to establish a timeliness standard for consumers to request eligibility pending appeal?
	  ○ Should exchanges have the flexibility to determine their own timeliness standards?
	  ○ What would be a reasonable timeliness standard?
	• How to facilitate administration of changes to eligibility that occur during the appeal process.
	• What, if any, limitations are appropriate when eligibility pending appeal has been granted (e.g., coverage effective dates, addressing burdens to issuers caused when consumers are granted or denied appeals)?
	• How should these policies relate to current policies governing non-payment of premiums? What should policies be for consumers who are in a grace period for non-payment at the time an appeal is granted?

Raises the required contribution percentage to 8.27%	While percentage is less relevant without the federal mandate, the threshold is still necessary for determination of eligibility for enrollment in catastrophic coverage. The required contribution percentage began at 8% percent in 2014, and was 8.24% in 2020.
Effective dates for termination of coverage	• Terminations in the event of enrollee death will be retroactive to the date of death (unless contested within a 30-day window). • Terminations initiated by a consumer may be effective retroactive to the date the termination was initially attempted by a consumer (at the option of an exchange).
Termination notices	Requires issuers to send termination notices for all termination events. This broadens a prior requirement that only required notices in the case of loss of eligibility for QHP coverage, non-payment of premiums, and rescission of coverage.
Data reconciliation	• Requires issuers to submit last enrollment information in enrollment reconciliation submission, to update enrollment records per direction of the exchange, and inform exchanges of any errors within 30 days. • Lengthens reporting time for payment errors from 15 to 90 days.
Special Enrollment Periods	

Changes coverage effective date to the first of the month following plan selection	Intends to expedite effective date of coverage for consumers who qualify for a special enrollment period (SEP). Currently, if consumers enroll in coverage after the 15th of the month, they may have to wait until the first of the month *after* the month immediately following his or her enrollment into coverage. SBEs may maintain current SEP effective date rules.
Allows consumers to switch metal level in the event they become ineligible for CSR	Applies in the case of a consumer whose change in income renders them no longer eligible for CSR. Would allow consumer to choose a plan that is either one metal level above or below their current plan.
Allows enrollment into a dependent's current plan	Applies in the case of a consumer who has dependents who are currently enrolled in a marketplace QHP. If the consumer qualifies for an SEP, the consumer may enroll in the same QHP as their dependent. This is meant to parallel current policies that allow a dependent to enroll in the consumer's QHP in the case that the dependent becomes eligible for an SEP.
New special enrollment period for non-calendar year QSEHRA	Establishes an SEP triggered in the event that individuals and their dependents become eligible for a QSEHRA outside of the typical calendar year.
FFM User Fees	
Maintains an assessment rate – 3% for the FFM and 2.5% for SBM-FPs	**Questions posed in NBPP:** • Should the user fee be lowered? • Solicits input on trends in usage of federal platform functions, potential efficiencies in federal platform operations, and premium and enrollment projections.
Risk Adjustment Methodology	
Data source for risk adjustment (RA) calculation	HHS will fully transition to use of EDGE data for use in RA calculations in 2021 and beyond. In previous years, RA had been calculated using a blend of MarketScan data (calculated based on data from the entire commercial market) and EDGE data (which includes actual use data from the individual and small group markets). **Question posed in NBPP:**

	Should HHS still use a blend of three separately solved coefficients for each year?
Risk adjustment calculation changes	• Redefines Hierarchical Condition Categories (HCCs) used to calculate RA to conform with ICD-10 diagnosis codes (update from prior use of ICD-9) and to conform with EDGE data. • Recalibrates RXC coefficient to account for new hepatitis C drugs/costs. • Calculations will now include pre-exposure prophylaxis (PReP) as an HIV preventive service. • Proposes adding age-sex coefficients for enrollees over age 65 in future regulation. • Will discard issuer failure rates in the case of issuers with fewer than 30 HCC examples. • Will treat the 2019 benefit year as a second pilot year for testing incorporation of RXCs into RA validation (RADV). • Notes that HHS has been testing variations of count and non-linear model specifications for subpopulations, and that early results show promise that modification could improve the risk adjustment models. **Questions posed in NBPP:** • Request for comments on all HCC updates. • General request on options to modify risk adjustment models to improve prediction for enrollees without HCC, with low actual expenditures, or to improve the predictive ability of the model for certain subgroups of enrollees. • Should HHS incorporate alternative modeling approaches (such as count and non-linear model variations) as part of the 2022 RA recalibration? • Should HHS explore changes to enrollment duration factors as part of RA calculations?
Risk adjustment program fee	Risk adjustment program fee raised from 18 cents per member per month to 19 cents PMPM.