WHITE PAPER

Summary of Provisions of HHS' Proposed 2020 Notice of Benefit and Payment Parameters and Other Key Regulations

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Summary

On January 17, 2019, the Department of Health and Human Services (HHS) published the proposed Notice of Benefit and Payment Parameters for 2020. The notice includes important final rules and parameters for the operation of the individual and small group health insurance markets in both 2020 and potentially 2021. This paper summarizes key provisions of the proposed notice, and other related information recently released by HHS. The comment deadline is February 18, 2019. Typically, it takes at least 30 days for HHS to prepare and finalize the Payment Notice.

Overview

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

1. **Plan Benefits:** HHS proposes to require issuers that provide plans covering certain abortion services to also offer one plan without such services.
2. **Formulary Changes:** HHS proposes to allow issuers to make changes to prescription drug formularies during a plan year when generic drugs become available that are equivalent to formulary brand drugs.
3. **Risk Adjustment:** HHS proposed changes to the risk adjustment coefficients, risk adjustment fee, and changes to the risk adjustment data validation. Also for the first time a state applied to reduce transfers (Alabama).
4. **Exchange User Fees:** User fees will be reduced to 3.0% for FFEs and 2.5% for partnership Exchanges.

5. **Indexing:** HHS proposed to change the methodology for calculating the indexing by which the contribution rate for those with subsidies, maximum out of pocket, and health insurer tax would increase. As a result of the proposed changes, APTC amounts would decrease and MOOP/HIT collection would increase.

The 2020 NBPP proposes greater flexibility and responsibility for issuers to manage their formulary.

6. **Silver-Loading:** HHS announced it is considering ending silver-loading for the 2021 benefit year**.**
7. **Auto-Enrollment:** HHS also announced it was considering ending auto-enrollment or enacting other policies to reduce enrollment errors for those auto-enrolled starting in 2021.

Shop

HHS further reduced SHOP requirements. SHOP is no longer required to have a full service call center.

Eligibility

Direct enrollment is being encouraged by the Department. However, there are additional compliance and oversight requirements. In particular, agents/brokers/web-brokers can be terminated for non-compliance with requirements

There was a change to special enrollment periods (SEP) requirement now allowing off-Exchange enrollees whose income changes such that they are eligible for APTC on-Exchange to claim a SEP. Currently only on-Exchange enrollees are able to have a SEP for income changes that result in APTC eligibility.

Maximum Out of Pocket Updates

The maximum out of pocket standards for standard plans and cost sharing variations for 2020 are increased.

- Standard Plans: $8,200/$16,400 (single/family)
- 100%-150% FPL: $2,700/$5,400 (single/family)
- 150%-200% FPL: $2,700/$5,400 (single/family)
- 200%-250% FPL: $6,550/$13,100 (single/family)

Risk Adjustment

Several updates to the risk adjustment program are included in the payment notice. The updates include:

Sequestration

Reinsurance and risk adjustment program will both be sequestered at a rate of 6.2 percent for payments made from fiscal 2019 resources.

Recalibration using EDGE Data

HHS proposed to recalibrate 2020 risk adjustment model coefficients using equally blended coefficients from 2017 MarketScan and 2016 and 2017 enrollee-level EDGE data. A draft set of coefficients is released with the proposed payment notice using 2016 MarketScan and 2016 and 2017 enrollee-level EDGE data for illustration purposes.

Prescription Drugs

HHS proposed to make an adjustment for Hepatitis C RXC to mitigate overprescribing incentives in the 2020 benefit year adult models. This is done by adjusting plan liability associated with Hepatitis C drugs to reflect future market pricing of Hepatitis C drugs before solving for the adult model coefficients.

High Cost Risk Pool Adjustment

HHS maintained a $1 million threshold and 60 percent coinsurance rate for the high-cost risk pool for 2020 benefit year risk adjustment program.

Cost-sharing reductions adjustments

Risk scores adjustment for CSR plans will continue for the 2020 benefit year as finalized in 2019 payment notice

HHS also confirmed that an adjustment factor of 1.12 will continue to be used for all wrap-around, premium assistance plans for Massachusetts.

Risk Adjustment Payment Transfer Formula

There is no change to the 2020 risk adjustment payment transfer formula from what was finalized in the 2019 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[1]. HHS also finalized that statewide average premium used in the 2020 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 received a request to reduce risk adjustment transfers by 50 percent (maximum allowed) for Alabama's small group market. State regulators noted that having one dominant_carrier in the market precludes risk adjustment program from working as intended. State regulators also stated their review of the risk adjustment payment issuers' (issuers receiving risk transfers) financial data suggested that any premium increase resulting from a reduction to risk adjustment payments of 50 percent in small group

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

market for the 2020 benefit year would not exceed 1 percent. Note that this is the de minimis premium increase threshold set forth in the 2019 payment notice.

Risk Adjustment Issuer Data Requirements

In the 2018 payment notice, HHS stated that they would consider using masked enrollee-level EDGE data to calibrate the risk adjustment model and to produce a public use file. HHS is now proposing to use the enrollee-level data to release a limited data set instead of a public use file as a limited data set would include dates otherwise not available in a public use file. HHS is also proposing to extend use of this data to calibrate and operationalize individual and small group market programs such as HHS risk adjustment program, AV calculator and methodology, and the out-of-pocket calculator.

In addition, HHS is also looking to extract state and rating area information to include in the enrollee-level data.

Risk Adjustment Data Validation (RADV)

HHS is proposing to extend the sampling methodology to the 10th stratum (enrollees with no HCC) instead of defaulting it to one-third of the sample members (current approach). This will likely increase the number of sampled members with HCCs.

HHS is also proposing to vary initial validation audit sample size based on issuer characteristics such as issuer size and prior year HCC failure rates, beginning with the 2019 benefit year of risk adjustment data validation. However, HHS will not increase the sample above 200 enrollees when it performs the second validation audit.

HHS proposes a few ways to vary the initial validation sample size:

1) Varying based on HCC failure rates, sample precision, and issuer size
2) Varying based on issuer size only

While the details in determining the sample size are technical and not included in this summary, we note that the sample size can increase up to 800 enrollees for large issuers with low precision and failure rates significantly higher/lower than national average.

In this proposed notice, HHS is also considering to shorten the window for discrepancy reporting for second validation audit and error rate discrepancy reporting to 15 calendar days (currently set at 30 calendar days).

Similar to the risk adjustment program, HHS is proposing to impose a “default data validation charge” if issuer fails to engage an initial validation auditor or submit initial validation audit results. Note that while it is calculated similarly, the default data validation charge is separate from default risk adjustment charge (if issuer didn’t submit EDGE data appropriately). HHS is also proposing that this charge will be based on enrollment of the benefit year being audited. HHS also proposes that the allocation of this default charge to be allocated to issuers within that benefit year that is being audited.

HHS is proposing to expand their sample of second validation audit from 100 enrollees to the maximum sample (up to 200 enrollees) beginning with the 2017 benefit year data validation audit if the large subsample (of 100 enrollees) indicate a statistically significant difference.

Regarding the inclusion of RXCs beginning in the 2018 risk adjustment program, HHS is proposing to include RXCs into the error estimation methodology beginning with the 2018 risk adjustment data validation. A few alternatives were suggested, including treating the RXCs similarly as the HCCs or to create a fourth group in the "HCC Group" specifically for RXCs.

HHS also noted in the RADV section that there could be a large number of negative error rate outlier issuers affecting numerous state. They are seeking comments on the impact of current approach, the incentives that negative error rate adjustments may create, and potential modifications to the error rate estimation methodology or the outlier adjustment policy, beginning with the 2018 risk adjustment data validation or later.

With regards to exemptions from RADV, issuers may be exempted beginning with the 2017 risk adjustment data validation if they fall under one of these categories:

1) 500 billable member months or lower statewide for the audited benefit year
2) Total annual premiums at or below $15 million for the audited benefit year for all plans covered under individual, small group, and merged markets in the state
3) Issuer is in liquidation state as of April 30th, two benefit years after the benefit year being audited.

Risk Adjustment User Fee

The 2020 risk adjustment user fee is estimated to be $2.16 per billable member per year, or $0.18 PMPM for the 2020 benefit year. This is increased from $1.80 per billable member per year, or $0.15 PMPM in the 2018 benefit year.

EHB Flexibility

States may modify the EHB benchmark plan by using all or part of another state's 2017 EHB benchmark plan, or define their own set of benefits. HHS encourages using EHB to address the opioid epidemic. Deadlines were moved up one month for states to submit documents for EHB plan selection for the 2021 plan year and also for states to notify HHS if they will allow issuers to make between-category substitutions. Proposed deadlines are May 6, 2019, for the 2021 plan year, and May 8, 2020, for the 2022 plan year.

Navigator Changes

The exchanges are being allowed greater flexibility in the management of their Navigator programs. Navigators will have less training requirements and no longer required to perform some functions, such as post-enrollment assistance.

Prescription Drug Benefits

HHS introduced a series of proposed changes to prescription drugs coverage. As a reminder these changes not only impact the individual market but also the group market.

Cost sharing and drug manufacturers' coupons

HHS proposes that issuers do not have to count cost sharing toward the MOOP if costs were covered by a drug manufacturer coupon. HHS is considering pre-empting state law if it conflicts with the final regulation.

Cost sharing for generic drugs

HHS proposes to allow plans that have both brand and generic equivalent drugs on the formulary to be able to exclude either the full amount of the brand cost sharing or the difference between brand and generic cost sharing from MOOP. HHS is not considering pre-empting state law if it conflicts with this proposal.

Mid-Year Changes

In the past payment notices, mid-year benefit changes were prohibited, including prescription drug formulary changes. Now HHS is proposing to allow certain mid-year formulary changes, if permitted by applicable state law, providing flexibility to allow issuers to increase the use of lower-cost drugs. Specifically, issuers will be allowed to make formulary changes when a generic equivalent becomes available, removing or changing drug tiers for the equivalent brand drug. Health issuers would be required to notify enrollees of such changes.

A few possible changes may be on the horizon as HHS is asking for comments on whether both therapeutic and generic substitution policies should be pursued, and whether certain drug categories are better suited to therapeutic substitution. They also ask for comments on opportunities and risks of reference-based pricing for drugs.

Prohibition on discrimination

HHS is encouraging issuers to include all four Medication-Assisted Treatment (MAT) drugs on the formulary for treatment of opioid use disorder. They are also reminding issuers that there should be no discriminatory practices in using MAT drugs.

Change in Indexing

The 2020 premium adjustment percentage index (PAPI) is proposed to be based on the National Health Expenditure estimates put forth by HHS private health insurance premium measures without Medigap and P&C insurance. Previously, individual market premiums were excluded from the indexing. This will result in changes to certain provision indexing for foreseeable future. For example, using the previously methodology the MOOP for 2020 would have $8,000 rather than $8,200. The higher indexing also effectively reducing APTC amounts. The Administration estimates the change could reduce enrollment by 100,000 individuals and decrease Federal spending on APTC by $900 million in 2020. Finally, the higher index will increase Health Insurance Provider Fees imposed on issuers over the long term (approximately $100 million more in 2023).

Plan Offerings and Abortion Coverage

HHS wants to provide consumers with more plan offerings that do not include abortion coverage. Consequently, HHS is proposing to require issuers that offer non-Hyde abortions[2] to offer at least one mirror QHP without coverage of non-Hyde abortion services in each service area where the insurer offers QHP coverage. This would not apply in states that require plans to include non-Hyde abortion services. The mirror QHP would offer the same benefits but omit non-Hyde abortions. Issuers would have flexibility regarding at which plan level the mirror QHP is offered.

2021 Potential Changes

HHS did not make any changes to silver-loading or auto enrollment for the 2020 benefit year. However, HHS did raise concern over silver-loading and auto-enrollment and indicated it may make changes to both of those policies for the 2021 benefit year.

The 2020 Issuer Letter

HHS is introducing a new "Early Bird" QHP Application Window, running from April 25, 2019 to June 19, 2019. Issuers who use this window can submit templates early for review, HHS will review and return feedback prior to regular application time. Any issuer who corrects issues identified by HHS in this window will not receive a correction notice during the full review round.

The initial QHP application deadline is June 19, 2019, however the Rate Template is not due until July 24, 2019

1) The application window will end on September 24, 2019. Corrections after August 21, 2019 will only be allowed at the direction of HHS or the State.

2) The annual Stand Alone Dental Plan MOOPS will remain unchanged at $350/$700

The proposed 2020 Actuarial Value Calculator underlying claims data was not updated. However, there was a change in how occupational therapy and physical therapy benefits affect actuarial value that issuers should be aware of.

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[2] These are abortion services in the cases of rape, incest, or if the pregnancy is determined to endanger the mother's life. A summary of the Hyde amendment can be found here