WHITE PAPER

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

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On April 18, 2019, the Department of Health and Human Services (HHS) published the final Notice of Benefit and Payment Parameters for 2020.[1] 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 final notice, and other related information recently released by HHS.

Overview

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

1. **Plan Benefits:** HHS did not finalize a proposal to require issuers that provide plans covering certain abortion services to also offer one plan without such services for the 2020 benefit year. The proposal may be implemented for future benefit years.
2. **Formulary Changes:** HHS is not finalizing the proposal 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 finalized changes to the risk adjustment coefficients, risk adjustment fee, and changes to the risk adjustment data validation. Also, for the first time HHS approved a state application to reduce transfers (Alabama).
4. **Exchange User Fees:** Exchange User Fees will be reduced to 3.0% (from 3.5%) for FFEs and 2.5% (from 3.0%) of premium for partnership Exchanges.

[1] Department of Health and Human Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020", April 18, 2019 https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-08017.pdf

5. **Indexing:** HHS is changing the methodology for calculating the premium adjustment percentage index by which the contribution rate for those with subsidies, maximum out of pocket, and health insurer tax will increase. As a result of the changes, APTC amounts will decrease and MOOP/HIT collection will increase.

The 2020 NBPP allowed for Silver-loading to continue

6. **Silver-Loading:** HHS had announced it was considering ending Silver-loading for future years (e.g., the 2021 benefit year). After reviewing the comments, HHS announced that it would not take any actions for the 2020 benefit year, but are still considering this for future years.

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.

8. **Other:** HHS also finalized several rules concerning web-brokers, navigators, and assisters.

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.

HHS finalized 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: $8,150/$16,300 (single/family)
- 100%-150% FPL: $2,700/$5,400 (single/family)
- 150%-200% FPL: $2,700/$5,400 (single/family)
- 200%-250% FPL: $6,500/$13,000 (single/family)

Risk Adjustment

HHS finalized several updates to the risk adjustment program 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

Contrary to proposed, HHS finalized recalibrating 2020 risk adjustment model coefficients using equally blended coefficients from 2015 MarketScan (as opposed to 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 finalized an adjustment to the 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 Pooling Adjustment

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

Cost-Sharing Reductions Adjustment

Risk score adjustment for CSR plans will continue for the 2020 benefit year as finalized in the 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.[2] 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 approved Alabama's request to reduce risk adjustment transfers in the small group market by 50 percent (maximum allowed) for the 2020 benefit year.

HHS did not finalize the proposed default to extend a state individual market reduction request to adjust transfers in both the individual catastrophic and non-catastrophic risk pools unless the state regulators request otherwise.

Risk Adjustment Issuer Data Requirements

HHS finalized using the enrollee-level data captured from EDGE files to create and release a limited data set for qualified requestors who seek these data for research purposes. Unlike the proposed notice, HHS will not make this limited data set available to requestors for public health or health care operations activities. HHS is also finalizing allowing HHS to use this data to calibrate and operationalize individual and small group market programs such as HHS risk adjustment program, AV calculator and methodology, the out-of-pocket calculator, and to conduct policy analysis for the individual and small group markets.

In addition, HHS will not extract state and rating area information to include in the enrollee-level data.

Risk Adjustment Default Charge

HHS' calculation of the 2018 benefit year PMPM risk adjustment default charge will be equal to the 90th percentile of the 2018 risk adjustment transfers not adjusted with the results of 2017 risk adjustment data validation.

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

Risk Adjustment Data Validation (RADV)

HHS is finalizing the current methodology for risk adjustment data validation for 2017 and 2018 benefit year RADV. HHS still intends to publish 2017 RADV error rates in May 2019 but intends to publish adjustments based on RADV results in August 2019. The major change from the proposed notice is that collections and distributions of RADV adjustments will be delayed until 2021. HHS will issue guidance on how to include these amounts in premium rate development. For Massachusetts issuers, 2017 RADV will be a pilot year. Furthermore, Massachusetts issuers' failure rates will not be included in the calculation of national metrics for the 2017 RADV results.

HHS is also not finalizing any adjustment to the initial validation audit sample size at this time.

HHS is finalizing extending 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.

In light of comments received, HHS will not shorten the window for discrepancy reporting for second validation audit and error rate discrepancy reporting to 15 calendar days (maintained at 30 calendar days).

Similar to the risk adjustment program, HHS finalized a "default data validation charge" if an 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 doesn't submit EDGE data appropriately). HHS proposed that this charge will be based on enrollment of the benefit year being audited. HHS also proposed that the allocation of this default charge to be allocated to issuers within that benefit year that is being audited. This section was finalized as proposed.

HHS proposed 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. This proposal was finalized.

Regarding the inclusion of RXCs beginning in the 2018 risk adjustment program, HHS is finalizing incorporating RXCs into risk adjustment data validation as a method of discovering materially incorrect EDGE server data submissions in a manner similar to how they address demographic and enrollment errors discovered during RADV. The incorporation of these drugs into the RADV process will be treated as a pilot year for 2018 RADV. At this time, HHS intends to fully implement the incorporation of RXCs into RADV beginning with the 2019 benefit year RADV.

Regarding exemptions from RADV, issuers may be exempted beginning with the 2018 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 was finalized 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. 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 drug coverage. As a reminder these changes not only impact the individual market but also the group market.

Cost-Sharing and Drug Manufacturers' Coupons

HHS has finalized the proposal that issuers may choose to not count cost sharing toward the MOOP if costs were 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 be counted toward the annual limit on cost sharing.

Cost-Sharing for Generic Drugs

HHS did not finalize the proposal 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.

Mid-Year Changes

In the past payment notices, mid-year benefit changes were prohibited, including prescription drug formulary changes. HHS did not finalize the proposal to allow certain mid-year formulary changes.

A few possible changes may be on the horizon as HHS asked for and received 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 asked for and received comments on opportunities and risks of reference-based pricing for drugs. Comments will be taken into consideration for future rulemaking.

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) was finalized 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 the foreseeable future. The maximum MOOP for 2020 is $8,150 for self-only coverage and $16,300 for other than self-only coverage. The higher indexing will also effectively reduce APTC amounts and will increase Health Insurance Provider Fees imposed on issuers.

Plan Offerings and Abortion Coverage

HHS is still reviewing comments on the proposal to require issuers that offer non-Hyde abortions 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. If finalized, this regulation will not take effect before the 2021 benefit year.

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 and Actuarial Value Calculator

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

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