OLIVER WYMAN

JANUARY 2019

2020 NOTICE OF BENEFIT AND PAYMENT PARAMETERS

DRAFT RULE

On January 24, 2019 HHS published its Draft Notice of Benefit and Payment Parameters for 2020.[1] The Notice contains rules and parameters that would apply to the individual and small group health insurance markets in 2020, and modifications to previously promulgated rules. This document represents a summary of our interpretation of the Notice but does not constitute, nor is it a substitute for, legal advice.

1. Department of Health and Human Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020; Draft Rule," January 24, 2019 https://www.govinfo.gov/content/pkg/FR-2019-01-24/pdf/2019-00077.pdf

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HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

- HHS is proposing to allow issuers to make mid-year formulary changes in the individual, small group, and large group markets, beginning with plan years on or after January 1, 2020
  - Changes may include adding a newly approved generic drug, and either removing the equivalent brand drug(s) from the formulary or moving them to a different cost sharing tier
  - Changes must be consistent with standards applicable to uniform modifications, and comply with any applicable state laws
  - Enrollees must be notified 60 days prior to the change, and the notification must disclose the name of the new generic drugs, whether the equivalent brand drug(s) would be removed from the formulary or placed on a different tier, the effective date of the change, and the appeals process for requesting access to the brand drug when clinically appropriate and not otherwise covered by the plan
  - This change would place limitations on large groups which do not exist today, specifically a requirement that mid-year formulary changes conform with uniform modification provisions

STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS, AND RISK ADJUSTMENT

1. Sequestration

- In accordance with the Office of Management and Budget (OMB) Report to Congress on the Joint Committee Reductions for Fiscal Year 2019, payments made from the risk adjustment and transitional reinsurance programs using fiscal year 2019 resources would be sequestered at a rate of 6.2%
  - Transitional reinsurance payments made in fiscal year 2019 reflect program close-out activities

2. Provisions and Parameters for the Permanent Risk Adjustment Program

HHS Risk Adjustment (§155.320)

- HHS did not receive any requests from states to operate risk adjustment programs for the 2020 plan year; therefore, HHS will operate risk adjustment programs in every state and the District of Columbia for the 2020 plan year
- For the 2020 plan year, HHS is proposing to recalibrate the risk adjustment model with a blend of separately solved coefficients from the 2016 and 2017 plan year enrollee-level EDGE data and the 2017 MarketScan data
  - The 2020 plan year risk adjustment model coefficients included in the Proposed Rule are based on a blend of coefficients based on 2016 MarketScan data and 2016 and 2017 benefit year enrollee-level EDGE data. If the proposed recalibration is finalized, HHS intends to update the coefficients to reflect 2017 MarketScan data in place of 2016 MarketScan data, with the final coefficients for the 2020 benefit year published after the publication of the final rule, consistent with 45 CFR 153.320(b)(1)(i)
  - Beginning with the 2021 benefit year's recalibration, HHS intends to calibrate the risk adjustment model using the three most recent calendar years of enrollee-level EDGE data

- HHS is not proposing to make changes to the hierarchical condition categories included in the HHS risk adjustment model for the 2020 benefit year, relative to the 2019 benefit year model
  - HHS is seeking comment on its proposal to adjust the Hepatitis C RXC coefficients to reflect the average expected costs of Hepatitis C drugs for benefit year 2020 to account for rapidly changing drug prices
- HHS is proposing to maintain the high-cost risk pool adjustment parameters (i.e., $1 million threshold with an issuer coinsurance rate of 40%) for the 2020 benefit year
- HHS is proposing to maintain the cost-sharing reduction factors for the 2020 benefit year, unchanged from the 2019 benefit year factors

Overview of the Payment Transfer Formula (§155.320)

- HHS provides states the flexibility to request a reduction in the otherwise applicable risk adjustment transfers calculated under the HHS-operated risk adjustment methodology for the state's individual, small group, or merged markets by up to 50 percent
  - HHS is proposing that if the state requests that HHS not make publicly available certain supporting evidence and analysis because it contains trade secrets or confidential commercial or financial information within the meaning of the HHS Freedom of Information Act (FOIA) regulations at 45 CFR 5.31(d), HHS would do so, making available on the CMS Website only the supporting evidence submitted by the state that is not a trade secret or confidential commercial or financial information
  - HHS is proposing that state requests for individual market risk adjustment transfer reduction would be applied to both the catastrophic and non-catastrophic individual market risk pools, unless the state regulators request otherwise
  - HHS is seeking comment regarding the State of Alabama's request to reduce the applicable risk adjustment transfer amounts in the small group market for the 2020 benefit year by 50%. No other states requested the flexibility to reduce the applicable risk adjustment transfer amounts for the 2020 benefit year
- HHS is proposing to maintain the current risk adjustment payment transfer formula and the total transfer formula for the 2020 benefit year, unchanged from the 2019 benefit year formulas

Risk Adjustment Issuer Data Requirements (§155.610, §153.710)

- HHS is proposing to make enrollee-level EDGE data publicly available, beginning with the 2016 benefit year EDGE data, as a "Limited Data Set" file under §164.514(e); a public use file would not be published
  - This limited data set file would not include the direct identifiers of the individual or of relatives, employers, or household members of the individual
  - Requestors wishing to access the information would be required to sign a data use agreement
  - The limited data set file would be available on an annual basis
  - HHS seeks comment on whether to extract state and rating area information for enrollees as part of the enrollee-level EDGE data and to provide this level of detail on the proposed limited data set
  - HHS seeks comment on whether additional data elements should be collected as part of the enrollee-level EDGE dataset (e.g., provider identifier, provider geographic location, etc.)
  - HHS seeks comment on the advantages and disadvantages of using state and rating area information for recalibration of the HHS-operated risk adjustment model, the AV Calculator and methodology, and other HHS individual and small group market (including merged market) programs

Risk Adjustment User Fee for 2020 Benefits (§153.610(f))

- HHS is proposing a risk adjustment user fee of $2.16 per billable member per year for the 2020 benefit year, pro-rated on a monthly basis, which represents an increase from $1.80 per billable member per year for the 2019 benefit year

3. Risk Adjustment Data Validation Requirements When HHS Operates Risk Adjustment (§153.630(b), §153.630(d)(2))

Varying Initial Validation Audit Sample Size (§153.630(b))

- Under the current initial validation audit sampling approach, the population is categorized into nine age-risk strata, with a tenth stratum for enrollees without HCCs. Enrollees without HCCs make up one-third of all sampled enrollees. For the remaining two-thirds of enrollees sampled, the number of enrollees sampled in each age-risk strata is determined using a Neyman approach. HHS is proposing to extend the Neyman approach to all ten strata to increase the precision of the initial validation audit
- Beginning with the 2019 benefit year, HHS is proposing to vary the individual validation audit sample size based on issuer characteristics such as issuer size and prior year HCC failure rates using 2017 benefit year data validation results. Several different approaches are being considered
  - Under one approach outlined, the sample size would vary by issuer size and would be increased for issuers with higher or lower than average prior year HHC failure rates. Any issuer with a failure rate of more than 1.644 standard deviations away from the mean (i.e., a 90 percent confidence interval, meaning 90% of issuers would not have their sample sizes adjusted) would be subject to an increased sample size relative to the minimum sample size established based on a precision metric using HCC failure rates for the benefit year being evaluated. The minimum sample size would be increased to 400 enrollees for issuers with more than 50,000 enrollees for the benefit year being validated (large issuers). For issuers with 3,000 to 49,999 enrollees in the benefit year being validated (smaller issuers), the minimum sample size would be 200. For issuers with less than 3,000 enrollees (very small issuers), the sample size would remain 200 enrollees, regardless of prior year HHC failure rates (i.e., there would be no variation in sample size for very small issuers). HHS seeks comment on whether multiple years of HCC failure rates should be used to determine an issuer's sample size
  - Under a second approach outlined, the sample size would be based on issuer size alone and would continue to be based on a precision analysis using Medicare Advantage risk score error rate data. Issuers would be placed into one of four groupings based on the total number of enrollees across all risk pools nationwide in a benefit year, except for states where there is only one issuer in the risk pool. Under the proposed groupings, outlined below, larger sample sizes would be required for most issuers
    - Issuers with 51-3,000 enrollees – sample size of 90 enrollees
    - Issuers with 3,001 to 20,000 enrollees – sample size of 250 enrollees
    - Issuers with 20,001 to 100,000 enrollees – sample size of 400 enrollees
    - Issuers with more than 100,000 enrollees – sample size of 500 enrollees
- HHS is considering allowing issuers to request a larger sample size before the initial validation audit begins
- HHS would not increase the sample size above 200 for the second validation audit pairwise means test

Second Validation Audit and error Rate Discrepancy reporting (§153.630(d)(2))

- HHS is proposing to shorten the time period to confirm or file a discrepancy report related to the second validation audit from 30 days to 15 days for the 2018 benefit year risk adjustment data validation

Default Data Validation Charge

- HHS is proposing to calculate the default data validation charge based on the enrollment during the benefit year being audited rather than the benefit year during which the transfers will be made, as is the case under existing rule
- HHS is proposing to allocate the data validation charge to issuers that were part of the same benefit year risk pool in proportion to their respective market shares and risk adjustment transfer amounts, though plans owing a data validation charge would not receive an allocation
- HHS is proposing to clarify that the data validation charge applies if the plan fails to provide an initial validation audit results and is separate from the default risk charge. Therefore, the issuer could owe both charges for a given benefit year

Second Validation Audit Pairwise Means Test

- Under current rule, HHS conducts a second validation audit using a subsample of enrollees from the initial validation audit sample to verify the accuracy of the initial validation audit findings. If the second validation audit produces a statistically different result than the initial validation audit, a second validation audit is conducted on a larger subsample of the data (up to 100 enrollees). HHS is proposing that if the larger second validation audit results are determined to be statistically significantly different from the initial validation audit findings based on a precision analysis, the second validation audit sample would be expanded further to include the full initial validation audit sample. Additionally, HHS is proposing that if the second validation audit sample is expanded further to include the full initial validation audit sample, the resulting error estimation rate would be applied in adjusting the plan average risk score

Error Estimation for Prescription Drugs

- Under current rule, HHS calculates failure rates for three groupings of HCCs with low, medium, and high failure rates, with approximately an equal number of HCC observations in each group, and applies statistical tests (means and confidence intervals) to determine outlier failure rates. HHS is proposing to incorporate the 12 RXCs into the calculation of failure rates, beginning with the 2018 benefit year, under several different approaches
  - One method would be to add the RXCs to the current methodology (e.g., instead of creating three groups for the 128 HCCs, the three grouping would be created from the 128 HCCs and 12 RXCs). Under this approach, HHS would consider applying an adjustment to account for the RXC-HCC interaction factors by either adding the RXC-HCC interaction factor to both the HCC and RXC coefficients or creating a modified RXC-HCC interaction coefficient.
  - A second method would be to combine all RXCs into an additional grouping so that failure rates would be calculated across four groupings
- HHS is also considering treating RXC errors as a data submission issue, similar to how demographic and enrollment errors are addressed in the risk adjustment data validation process

Risk Adjustment Data Validation Adjustments in Existing and Single Issue Markets and Negative Error Rate Outlier Markets

- If an issuer exits all markets and all risk pools in a state, HHS is proposing to not make payments to the exiting issuer in the event they are owed money as a result of a negative error rate under the risk adjustment validation process, but HHS would collect money owed as a result of the risk adjustment data validation process. This would be effective for the 2017 benefit year risk adjustment data validation process and beyond

Exemptions from Risk Adjustment Data Validation

- HHS is proposing to finalize in rule that issuers with 500 billable member months or fewer, statewide across all risk pools, would be exempt from the risk adjustment data validation process
- HHS is proposing to finalize in rule that issuers with less than $15 million in total annual premiums for risk adjustment covered plans would not be subject to the annual initial validation audit requirements but would be subject to an initial validation audit approximately once every three years through a random targeted sampling approach. Issuers under the materiality threshold may still be required to make records available for HHS review.
- HHS is proposing to make exempt from the data validation process issuers in liquidation as of April 30 of the year the transfer adjustments are made e.g., two years after the benefit year being audited. For the 2018 benefit year and beyond, the exemption would not apply if the issuer has a positive error rate outlier in the prior year's risk adjustment data validation process

EXCHANGE ESTABLISHMENT STANDARDS

1. General Functions of an Exchange

Consumer Assistance Tools and Programs of an Exchange (§155.205)

- Due to extremely low FF-SHOP call center volume, states that have adopted a leaner approach that uses direct enrollment through issuers and agents may eliminate the requirement to operate a call center and instead operate a toll-free hotline
- The toll-free hotline must provide information about eligibility and the enrollment process, pre-recorded FAQs, and direct consumers to the federally operated call center or HealthCare.gov

Navigator Program Standards (§155.210)

- New training standards are proposed for navigators related to the range of QHP options and affordability programs
- Navigators operating in FFEs under grants awarded in 2018 were required to provide assistance on certain topics not specifically mentioned in statute; it is proposed that for grants awarded in 2019 navigators would be authorized but not required to perform these duties
  - HHS is requesting input on the number of hours and percent of time navigators currently spend to provide assistance with these topics, and how they would reprioritize their work if they were not required to provide this assistance, in order to understand the impact of removing this requirement
  - HHS proposes to eliminate the requirement for navigator training on these additional topics

Ability of States to Permit Agents and Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (§155.220)

- HHS proposes to define "direct enrollment technology providers" as a type of web-broker that is not a licensed agent or broker but has been engaged by a licensed agent or broker to provide technology services that facilitate direct enrollment
- References to agents and brokers in regulation would:
  - Be revised to include web-brokers in those cases where FFE requirements also extend to web-brokers
  - Be replaced with reference to web-brokers where certain requirements do not apply to agents and brokers that do not host or develop non-Exchange websites
- Web-brokers would be prohibited from displaying recommendations for QHPs based on compensation they or other agents and brokers receive from QHP issuers, including commissions, fees, or other incentives
- Web-brokers would be required to provide HHS with a list of agents and brokers that use the web-broker's non-Exchange website to assist consumers with QHP selection and/or eligibility application
- HHS proposes to remove the requirement that a licensed agent and broker registered with the FFE as a non-individual business complete training on behalf of the non-individual entity given licensed agents and brokers that are part of the non-individual business are also required to complete the training as individual agents and brokers
- HHS would be able to immediately terminate an agent's or broker's agreement with the FFE if they fail to comply with the requirement to maintain the appropriate license under state law
  - The agent or broker would be able to request reconsideration
  - The agent or broker would be required to continue to protect any personally identifiable information accessed during the term of their agreement with the FFE
- HHS would be able to immediately suspend an agent's or broker's ability to transact information with the Exchange if they pose an unacceptable security risk to Exchange operations or information technology systems, until the incident or breach is remedied or sufficiently mitigated
  - This ability already applies to web-brokers and issuers, and is intended to provide uniformity and to protect sensitive consumer data
- HHS proposes to regulate web-brokers differently from agents or brokers in new areas which could result in their agreements being suspended or terminated for cause, or they would be denied the right to enter into agreements with the FFE, based on the actions of its officers or if they are under common ownership or control or are affiliated with another web-broker that had its agreement suspended or terminated
- Navigators and certified application counselors (i.e., assisters) participating in FFEs and SBE-FPs would no longer be prohibited from using web-broker websites to assist with QHP selection and enrollment
  - Websites must meet conditions that allow assisters to meet their contractual requirements to provide fair, accurate, and impartial information and assistance to consumers
  - SBEs may continue to prohibit assisters from using web-broker websites
  - Web-brokers interested in making their non-Exchange websites available to assisters may obtain certification from the Exchange that it meets standards for an assister to be able to use the site, including display of all QHP data provided by the Exchange
- HHS is proposing to prohibit web-broker websites from explicitly displaying QHP recommendations based on compensation received from QHP issuers

Standards for Third Party Entities to Perform Audits of Agents, Brokers, and Issuers Participating in Direct Enrollment (§155.221)

- Requirements for enhanced direct enrollment are proposed to be expanded beyond QHP issuers and web-brokers to apply to all types of direct enrollment entities, where direct enrollment entities are defined as any entity that an Exchange permits to assist consumers with direct enrollment in QHPs offered through the Exchange in a manner considered to be through the Exchange
  - Third-party entities that conduct annual reviews of direct enrollment entities would be required to demonstrate operational readiness and would be required to be independent of the entities they are auditing
  - An initial audit along with subsequent annual audits would be required to be conducted, and they must include a review of the entity's compliance with applicable direct enrollment requirements
  - Direct enrollment entities would be required to demonstrate operational readiness prior to the direct enrollment entity's website being used to complete Exchange eligibility applications or make QHP selections
  - Direct enrollment entities would be required to execute a written agreement with their auditor stating that the auditor will comply with requirements of §155.221(f)
- HHS proposes to define the types of entities the FFE would permit to assist consumers with direct enrollment in QHPs offered through an Exchange in a manner that is considered to be through the Exchange, which would be subject to the following new requirements
  - QHPs and non-QHPs would be required to be displayed and marketed on separate website pages
  - A standardized disclaimer in a form and manner provided by HHS would be required to assist consumers in distinguishing between website pages that display QHPs and non-QHPs, and for which products APTCs and CSRs are available
  - Marketing of non-QHPs during the Exchange eligibility and QHP selection process would not be allowed, however marketing of non-QHP products could occur after QHP selection but before the shopping experience is completed

2. Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

Allowing Issuer Application Assisters to Assist with Eligibility Applications (§155.415)

- HHS proposes to allow all direct enrollment entities to employ or contract with application assisters
- Direct enrollment entity application assisters would be required to comply with the same requirements as those currently in place for issuer application assisters
- Both issuer and direct enrollment entity assisters would be permitted to assist individuals in the individual market apply for a determination or redetermination of eligibility for coverage and affordability programs
- Application assisters providing assistance in the FFE and SBE-FP would be required to complete an annual registration and training process similar to what is required for agents and brokers
- Application assisters would be required to comply with applicable state laws related to sale, solicitation, and negotiation of health insurance products
- Direct enrollment entities participating in FFEs and/or SBE-FPs would be permitted to use application assisters, to the extent permitted by state law

Special Enrollment Periods (§155.420)

- Individuals enrolled in off-Exchange individual market coverage would be eligible for a special enrollment period if they meet the following requirements:
  - Become newly eligible for APTCs during the year
  - Were enrolled in minimum essential coverage, pregnancy Medicaid, CHIP unborn child, or Medically Needy Medicaid for at least one day during the 60-day period prior to the change in circumstances
  - Enroll within 60 days from the date of the financial change
  - Provide evidence of change in income and prior health coverage within 30 days of plan selection, if not verified electronically
- Individuals who qualify for the proposed special enrollment period would be allowed to enroll in the same QHP that others in their household are already enrolled in, or allow all members of the household, including the newly eligible individual, to enroll in another QHP within the same metal level of coverage (or one metal level higher or lower if no such QHP is available)

3. Eligibility Standards for Exemptions

Eligibility for Exemption Through the IRS (§155.605(e))

- For the 2018 tax year, individuals claiming a hardship exemption under the categories outlined in §155.605(d)(1) would be able to do so through the IRS tax filing process without having to obtain an exemption certificate number from an Exchange

Required Contribution Percentages (§155.605(d)(2))

- Individuals above the age of 30 without access to minimum essential coverage (MEC) that costs 8.39% of their income or less would qualify to enroll in catastrophic coverage

HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

1. FE and SBE-FP User Fee for the 2020 Benefit Year (§156.50)

- The user fee rate for issuers offering coverage through the FFE in 2020 is proposed to be 3.0% of premium, a reduction from the 2014-2019 fee rate of 3.5%
- The user fee rate for issuers offering coverage through the SBE-FP in 2020 is proposed to be 2.5% of premium, a reduction from the 2019 fee rate of 3.0%

2. Silver Loading

- "Silver loading" is being defined as the practice of increasing premiums only for silver level QHPs to recoup the loss of CSR funding
- Shifting the CSR funding from direct reimbursement to premium loading has had the effect of increasing premium tax credits borne by taxpayers by more than the amount of lost CSR funding, thus also increasing the federal deficit
- The Administration supports a legislative solution that appropriates funding of CSR payments and an end to silver loading, and is seeking comment on ways in which CSR loading could be addressed in 2021 or later in the absence of Congressional action

3. Essential Health Benefits Package

State Selection of Benchmark Plan for Plan Years Beginning on or After January 1, 2020 (§156.111)

- The 2019 Payment Notice provided states the ability to choose between three new EHB benchmark options starting in 2020 (in addition to the existing EHB benchmark options)
  - Option 1: A state may select the EHB benchmark plan that was used by another state for plan year 2017
  - Option 2: A state may replace one or more EHB categories of benefits in its EHB benchmark plan used for the 2017 plan year with the benefits for the same category from another state's EHB benchmark plan that was used for the 2017 plan year
  - Option 3: A state may select a set of custom benefits to serve as the benchmark plan as long as they do not exceed the value of the most generous of a) the state's benchmark plan used for the 2017 plan year or b) any of the three largest small group products in the state (by enrollment) that were available to the state to be used as benchmark plan options for the 2017 plan year, supplemented as necessary
- States are encouraged to explore whether a modification to the EHB benchmark plan would be helpful in fighting the opioid epidemic; Illinois made changes to its EHB benchmark plan for 2020 to include alternative therapies for chronic pain, restrict access to prescription opioids, and expand mental health and substance use disorder treatment and services
- The proposed deadline for states to submit required documentation for the EHB benchmark plan selection is May 6, 2019 for the 2021 plan year and May 8, 2020 for the 2022 plan year
- It is recommended states submit applications at least 30 days prior to the submission deadline to ensure completion of all documents by the deadline, and states are reminded that they must have completed the required public comment period by the deadline

Provision of EHB (§156.115)

- The 2019 Payment Notice provided states the ability to allow greater flexibility starting in 2020 to issuers to make EHB substitutions, not only within the same EHB category as previously allowed, but also between EHB categories, as long as the substituted benefit is actuarially equivalent to the benefit being replaced and is not a prescription drug benefit
- States must opt-in for this flexibility and the proposed deadline to opt-in is May 6, 2019 for the 2021 plan year and May 8, 2020 for the 2022 plan year
  - The election must be done through the EHB Plan Management Community

Prescription Drug Benefits (§156.122)

- It is proposed that QHP issuers in FFEs be required to notify HHS annually, in a format specified by HHS, of any mid-year formulary changes made in the prior plan year
  - QHP issuers would be required to report the name of the drug being removed from the formulary, dosage, name of the generic equivalent, the Rx Norm Concept Unique Identifier (RxCUI) associated with the brand and generic drug, and if the brand drug was moved to a higher cost sharing tier or removed from the formulary
  - The information is intended to be used to understand how QHP enrollees would be affected by the change(s)
- HHS is seeking comments on whether therapeutic substitution (substituting chemically different compounds within the same therapeutic class) and generic substitution policies should both be pursued, as well as whether certain drug categories and classes are better suited to therapeutic substitution than others

- HHS is also seeking comments on the risks and opportunities of implementing or incentivizing use of reference-based pricing, whereby patient cost sharing is linked to the price of a specific reference drug within a group of similar drugs, such as within the same therapeutic class, and the patient pays any difference in cost between the drug being taken and the reference drug (i.e., if the cost of the drug being taken exceeds the cost of the reference drug)

Prohibition on Discrimination (§156.125)

- There are four prescription drugs that treat opioid addiction as part of Medication-Assisted Treatment (MAT), and QHPs are encouraged to cover all four even if not required to do so in order to satisfy EHB requirements
  - For plan year 2018, 95% of QHPs in FFE and SBE-FP states covered all four, 4% covered three, and less than 1% covered two
- Issuers would not be considered to comply with EHB requirements if MAT drugs are excluded from coverage when prescribed for MAT while being covered for other medically necessary purposes, unless the exclusion can be justified to not be discriminatory based on clinical guidelines and medical evidence
  - Such a practice may also violate the nonquantitative treatment limitation requirements of the Mental Health Parity and Addiction Equity Act of 2008 or the Americans with Disabilities Act

Premium Adjustment Percentage (§156.130)

- The maximum annual limitation for cost sharing, the required contribution percentage for MEC, and the large employer penalty were adjusted annually for plan years 2015 through 2019 by the percentage by which average per capita premium for employer-sponsored health insurance in the National Health Expenditure Accounts (NHEA) for the prior year exceeded the average per capita premium for health insurance for 2013
- For the 2020 benefit year and beyond, HHS proposes to instead use an adjusted private individual and group market premium measure for calculating the premium adjustment percentage
  - The adjustment is to remove Medigap insurance and the medical portion of accident insurance from the NHEA's private health insurance measure, leaving the adjusted measure to be based on employer-sponsored and individual market insurance
- The resulting percentage is 29.7%, an increase over the 2019 percentage of 25.2%
  - Using a measure that results in faster premium growth such as that being proposed results in an increased maximum cost sharing limitation, a higher required contribution percentage (and lower premium tax credits), higher employer penalties, and an increase in the Health Insurance Providers Fee
- Maximum out-of-pocket (MOOP) limits for 2020 using the new measure would be $8,200 for self-only coverage and $16,400 for other than self-only coverage, increases from the 2019 values of $7,900 for self-only and $15,800 for other than self-only coverage or about a 3.8% increase

Reduced Maximum Annual Limitation on Cost Sharing (§156.130)

- It is noted that, for benefit year 2020, no states submitted a state-specific dataset to HHS for use as the standard population to calculate actuarial values (AVs)
- The Secretary may adjust cost-sharing limits to ensure the resulting limits do not cause the AVs of the plans to exceed the required AVs of the CSR plans; based on the results of HHS' testing, the reduction percentages are remaining the same as the 2019 benefit year
  - CSR plan variations would be subject to the same 3.8% increase in the maximum annual limitation on cost sharing as non-CSR plans

Exhibit 1: MOOP limits for CSR plans are proposed to be as follows:

FPL	AV	REDUCTION IN MOOP	2019 MOOP SELF-ONLY	2020 MOOP OTHER THAN SELF-ONLY
100–150%	0.94	2/3	$2,700	$5,400
150–200%	0.87	2/3	$2,700	$5,400
200–250%	0.73	1/5	$6,550	$13,100

Applications to Cost-Sharing Requirements and Annual Lifetime Dollar Limitations (§156.130)

- Cost Sharing Requirements for Generic Drugs
  - Self-insured plans and issuers of large group coverage must choose a definition of EHB to determine which benefits are subject to the annual out-of-pocket limits and the prohibition on lifetime and annual dollar limits; therefore, it is noted that the proposals in this section are relevant to all health plans, including self-insured and large group plans
  - HHS proposes that individual and small group plans that cover both brand drugs and their generic-equivalents would be able to consider a brand drug to not be EHB if a generic-equivalent is available and medically appropriate for the enrollee, unless coverage of the brand drug is determined to be required under an exception process at §156.122(c)
    - If the enrollee purchases the brand drug when the generic is available and medically appropriate, the issuer would be permitted to not count the difference in cost sharing between the brand and generic drugs toward the out-of-pocket maximum, provided there is an exception process in place for the enrollee to request the brand drug
    - This would provide more consistency across all health plans, since this cost sharing limitation practice was already permitted in the self-insured and large group markets by a FAQ published in 2014 by the Departments of Labor, HHS, and Treasury
    - Lifetime and annual dollar limits could also be applied on the non-EHB brand drugs
    - HHS is considering an alternative whereby the entire amount of the brand drug could be excluded from the out-of-pocket maximum and could be subject to lifetime and annual dollar limits
    - Since premium tax credits may not be applied toward premium for non-EHB benefits, QHP issuers would be required to calculate that portion and report it to the applicable Exchange
    - HHS is seeking comment on whether this practice should be required rather than permitted
- Cost Sharing Requirements for Drug Manufacturers' Coupons
  - Cost sharing amounts that are defrayed for enrollees through use of a drug manufacturer coupon to purchase certain brand name drugs that have a generic equivalent would not be required to be counted toward the out-of-pocket maximum
    - Comments are requested related to several aspects of this proposal, including whether states should be able to decide how coupons are treated and if issuers' information technology systems could be easily updated for this purpose

4. Segregation of Funds for Abortion Services (§156.280)

- Issuers that offer one or more QHPs providing coverage for non-Hyde abortions would be required to offer at least one "mirror QHP" that omits coverage for non-Hyde abortions; a mirror QHP must be available throughout the entire service area in which the issuer offers a QHP
  - The issuer would be able to choose at which metal level to offer the mirror QHP; however, comments are sought on whether this would inhibit access to the plans
- HHS seeks comments on ways the Exchanges, and Healthcare.gov in particular, can differentiate between plans that cover non-Hyde abortions and those that do not, since the mirror QHP would otherwise appear identical to the original plan with the exception of the premium and benefit description

5. Quality Standard (§156.1120, §156.1125, §156.1130)

- QHP issuers are encouraged to use performance measures aligned with the Meaningful Measures Initiative in fulfilling their certification requirement to implement a Quality Improvement Strategy that provides incentives for improving enrollees' health outcomes

6. Direct Enrollment with QHP Issuer in a Manner Considered to be Through the Exchange (§156.1230)

- The changes proposed here are to conform with changes to other sections of the Payment Notice related to direct enrollment entities, both QHP issuers and web-brokers

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