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What Is Changing in Federal Health Insurance Regulation for 2020

Manatt Health and Milliman

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Today's Presenters

Joel Ario

Managing Director,
Manatt Health

jario@manatt.com

518.431.6719

Jason Karcher

Actuary,
Milliman

jason.karcher@milliman.com

262.796.3437

Michael Kolber

Partner,
Manatt Health

mkolber@manatt.com

212.790.4568

Jeffrey Milton-Hall

Consulting Actuary,
Milliman

jeff.milton-hall@milliman.com

206.504.5835

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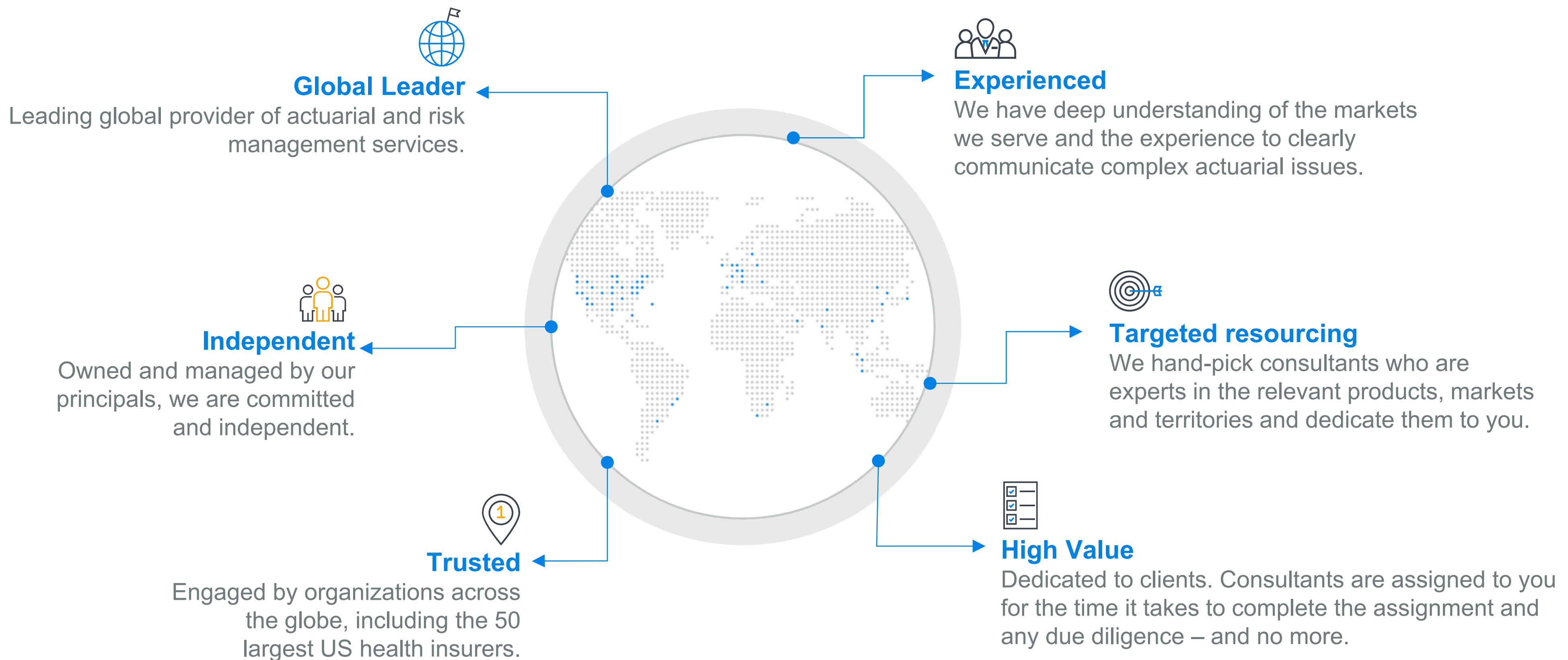

Agenda

- 2020 NBPP Overview
- Federal Premium Subsidies
- Risk Adjustment Data Validation
- HHS's Future Plans
- Prescription Drug Coverage
- Questions & Answers

Overview of the 2020 NBPP

- On April 18, 2019, the Department of Health and Human Services (HHS) issued the 2020 Notice of Benefit and Payment Parameters (NBPP) final rule.
- The NBPP is issued annually and represents the primary federal rule-making document for the Patient Protection and Affordable Care Act (ACA).
- In addition to the topics we will cover in depth, the 2020 NBPP includes several other changes and clarifications, many of which were expected. A partial list is below:
  - Exchange user fees reduced
    - 3% (from 3.5%) for states with Federally Facilitated Exchanges (FFE)
    - 2.5% (from 3.0%) for State-based Exchanges on the Federal Platform (SBE-FP)
  - Risk adjustment user fee increased
    - To $2.16 per billable member per year ($0.18 per month)
  - HHS-HCC risk adjuster model coefficients recalibrated
    - Based on 2015 MarketScan and 2016/2017 Enterprise Data Gathering Environment (EDGE) individual market data
    - Market price adjustment to Hepatitis C RXC coefficient

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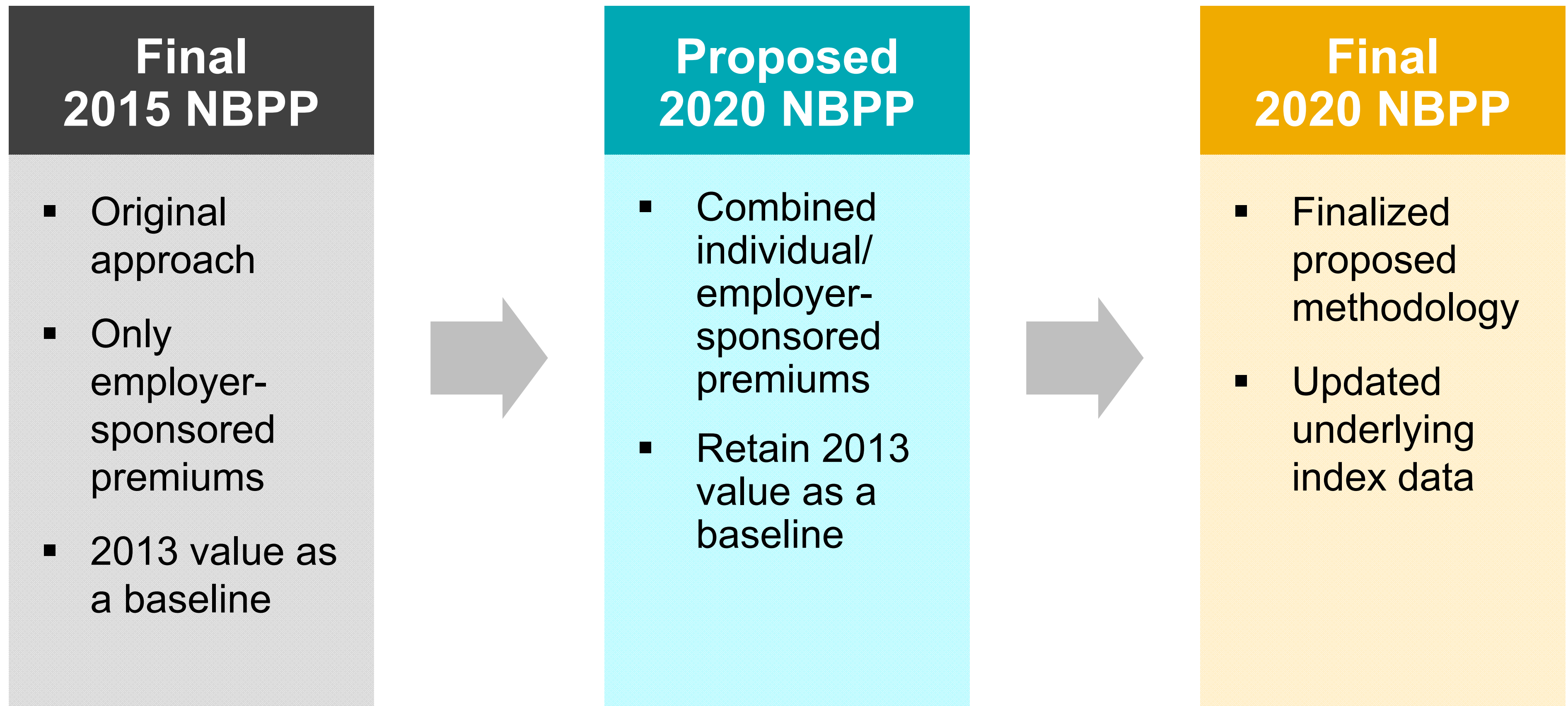
The Premium Adjustment Percentage

- Used to index several quantities used in the ACA
  - Values set by HHS in the NBPP
    - Maximum Annual Limitation on Cost-Sharing
    - Required Contribution Threshold for Hardship Exemption
  - Values published later by the IRS
    - Required contributions by income level for determining premium tax credits
    - Affordability Threshold for Employer-Sponsored Coverage
    - Annual Health Insurance Provider Fee amount
  - IRS typically uses the same index as HHS

Premium Adjustment Percentage Changes



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A Tale of Two Indices

- Most of the difference occurs prior to 2017.
- Change increases the premium adjustment percentage by 2.7%.
- The current premium index was first published in the 2018 Projected National Health Expenditure Accounts (NHEA).

Year	2013	2014	2015	2016	2017	2018	2019
Prior Premium Index	$5,122	$5,282	$5,502	$5,794	$5,942	$6,181	$6,429
Current Premium Index	$4,991	$5,126	$5,387	$5,708	$5,929	$6,195	$6,436
Index Ratio	97.4%	97.0%	97.9%	98.5%	99.8%	100.2%	100.1%

Updated Base Data

- Underlying NHEA projections updated
- Data update reduced premium growth and increased income growth.

	Final 2019[1]	Proposed 2020[1]	Final 2020[1]
Premium Growth Factor	1.2517	1.2970	1.2895
Year-over-Year Change		3.6%	3.0%
Income Growth Factor	1.2059	1.2366	1.2524
Year-over-Year Change		2.5%	3.9%
Premium net of Income	1.0379	1.0488	1.0296
Year-over-Year Change		1.0%	-0.8%

[1] Factors have been rounded for this table, but use 10 digits of precision in the rule

Maximum Out-of-Pocket Limits (MOOP)

- Maximum annual limitations on cost-sharing increased over 2019.
- Family limitations are twice the values shown.
- New index increases the maximum possible MOOP by $200 (about 2.5%), but overall increase is in line with prior years

	Final 2019	Proposed 2020	Final 2020
Standard Plan Variation (Prior Index)	$7,900	$8,000	$7,950
Standard Plan Variation (Current Index)		$8,200	$8,150
73% Silver	$6,300	$6,550	$6,500
87%/94% Silver	$2,600	$2,700	$2,700

Required Contribution for Hardship Exemptions

- Required contributions are indexed by the premium growth in excess of income growth.
- Decrease driven by higher rate of income growth in 2018 NHEA projections.
- Impact is still minor; a household with income of $50,000 would be eligible for exemptions if coverage cost more than $4,120 per year, compared with $4,150 in 2019.

	Final 2019	Proposed 2020	Final 2020
Prior Index	8.30%	8.18%	8.02%
Current Index		8.39%	8.24%

Updated Premium Tax Credits

- Premium Tax Credit Threshold would decrease for 2020

	2019		2020[1]	
Household Income, % of Federal Poverty Level (FPL)	From	To	From	To
Up to 133%	2.08%	2.08%	2.06%	2.06%
133% up to 150%	3.11%	4.15%	3.09%	4.12%
150% up to 200%	4.15%	6.54%	4.12%	6.49%
200% up to 250%	6.54%	8.36%	6.49%	8.29%
250% up to 300%	8.36%	9.86%	8.29%	9.78%
300% up to 400%	9.86%	9.86%	9.78%	9.78%

[1] Estimates assume that the IRS will use projected 2018 NHEA estimates to update required contribution percentages.

Updated Premium Tax Credits (Continued)

- Change in tax credit for a household also depends on change in household income.
- A family of 4 earning $50,200 in 2019 and $51,500 in 2020 (200% of FPL) would be responsible for $59 more in annual premium in 2020.
- Under the prior index, this family would have seen an overall reduction of $33 in annual premium in 2020.

Affordability Threshold for Employer-Provided Coverage

- This threshold triggers the employer mandate penalty.
- An employer is liable for the employer mandate when the net cost of individual coverage for an employee exceeds the threshold above.
- For example, an individual making $50,000 would be considered to have affordable employer-sponsored coverage if the required employee contribution for the least expensive minimum essential coverage exceeds $4,890, down slightly from $4,930.

	Final 2019	Fee Payable in 2020[1]
Prior HHS Index	9.86%	9.52%
Current HHS Index		9.78%

[1] Estimates assume that the IRS uses the projected 2018 NHEA values used by HHS.

Health Insurance Providers Fee

- The Health Insurance Providers Fee amount was set by statute through 2018, but is indexed using premium growth for future years.
- Due to the moratorium on the 2019 fee, the exact methodology used by the IRS is not entirely certain.
- The expected 2020 fee would increase by about $50M or about 0.3%.

	Fee Payable in 2020[1]
Prior HHS Index	$15.47 B
Current HHS Index	$15.52 B

[1] Calculation assumes IRS will index the 2020 fee using the projected 2018 NHEA values for 2017 and 2019.

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ACA Risk Adjustment Data Validation (HHS-RADV) – Introduction

- HHS program to validate ACA risk adjustment results using statistically valid data samples.
- Similar goals to the Medicare RADV program, but significant differences in implementation.
- Two-part audits of EDGE risk adjustment submissions for nearly all issuers, verifying hierarchical condition categories (HCCs) and estimating "failure rate."
- If statistically significant difference in failure rate (either direction), then adjust issuer's subsequent year risk scores.
- Revenue neutral: The risk adjustment formula is revenue neutral, so an adjustment to one issuer affects all issuers in market.
- Program involves a long (and lengthening) timeline, and implementation has been beset by delays.

HHS-RADV – Regulatory History

March 2012:

- Premium Stabilization Rule requires validation of statistically valid sample of risk adjustment data every year.

2013–14:

- Established HHS-RADV program and initial process in 2014/2015 NBPPs.
- Established 2014/2015 as initial pilot years, with 2016 as the first applicable year.

2016–17:

- Pushed pilot years back to 2015/2016, with 2017 as first applicable year.

April 2018:

- Refined program details. Introduced HCC error rate groups and outlier methodology.

April 2019:

- 2020 NBPP extends timeline for payment (to 2021 for 2017 benefit year), and provides guidance for MLR reporting and rate development.
- Additional program refinements.

HHS-RADV – Process

- Initial Validation Audit (IVA)
  - 200-enrollee sample, stratified to increase statistical strength of audit
- Second Validation Audit (SVA)
  - Validate or override IVA results, starting with small subset
- Validate submission accuracy, including HCCs (based on medical records)
  - HCC "failure rate" = % difference between submitted and validated HCCs
  - HCCs are grouped into low/medium/high failure rates based on nationwide results
- Identify outlier issuers for each group and prospectively adjust coefficients
- Translate adjustments into transfer payments, which are settled retroactively

HHS-RADV – 2020 NBPP Changes: Big Ticket Items

- Program Timeline
  - Announce preliminary payment two years after benefit year (2019 for 2017)
  - Collect/disburse payment four years after benefit year (2021 for 2017), to provide time for appeals and incorporation into reporting and rate development
  - Guidance around MLR and rating treatment (account for in payment year)
  - 2017 will still be pilot year for Massachusetts
- Prescription Drug Category (RXC) error estimation
  - Treat as data discrepancy (one-sided for material errors)
- Negative error rate outliers
  - HHS stands behind two-sided nature of program and adjustment to mean (no change)

HHS-RADV – Timeline for 2017 Benefit Year

(Changes/clarifications in red. Similar timeline anticipated for future years.)

Date	Activity
2017	Audited Benefit Year
April 30, 2018	EDGE Submission Deadline for 2017
2018	Applicable Benefit Year
June 2018–January 2019	IVA conducted (on behalf of Issuers)
January 2019–March 2019	SVA conducted (by HHS)
By June 30, 2019 (ETA June 28)	Preliminary risk transfers released for 2018 (before RADV)
By July 31, 2019	Submit 2018 MLR reports for 2018 (based on transfers before RADV)
After June 30, 2019 (ETA August 1)	Preliminary RADV adjustments announced (Note: Error rates are expected to be published sooner, in May 2019)
2019 through 2021	Adjudicate RADV appeals
2020	Rate setting for 2021 (may reflect anticipated 2018 RADV adjustments)
2021 (Two years after preliminary RADV announcement)	Collect/disburse 2018 adjustments Can be reflected in 2021 MLR reports

HHS-RADV – RXC vs. HCC Error Estimation

- RXC errors will be handled differently than HCC errors
  - Treat as data discrepancies rather than using error rate estimation methodology

	RADV Error Rate Estimation	EDGE Data Discrepancy
Applies to	HCCs	RXCs (beginning 2019)[1], enrollment, demographics
Criteria for an Adjustment	Outlier (outside of confidence interval)	"Materially incorrect" data submissions
Sidedness	Two-sided (can increase or decrease risk scores)	One-sided (can only decrease risk scores)
Transfer Year to which Adjustment is Applied	Applicable (subsequent) benefit year	Audited (current) benefit year

[1]The 2018 benefit year will be a pilot year for RXC validation. RXCs were introduced with the 2018 HHS-HCC model.

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HHS-RADV – 2020 NBPP Changes: Other Refinements

- Sample allocation
  - Use Neyman allocation for all ten strata: improved precision/more enrollees w/ HCCs
- Default data validation charge
  - Distinguish from default risk adjustment charge; base on enrollment in audit year
- Second Validation Audit sampling
  - In certain circumstances, extend SVA sample size to the full 200-enrollee IVA sample
- Markets with special circumstances
  - Exiting issuer: Ignore negative error rates; apply to audited year
  - Single issuer: Audit results from other pools apply if/when a new issuer joins
- Codify exemptions
  - Materiality: Full exemption if <500 member months, partial if <$15MM premium
  - Liquidation

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States Retain Flexibility on Silver Loading

- HHS confirmed proposed rule: "We are not finalizing any change in policy for silver loading in this final rule," which leaves the issue to the states.
  - Virtually all states have silver loaded, many with non-loaded silver off-exchange
  - Silver-loaded premiums are typically in gold/platinum range
- However, HHS also reiterated that "the Administration supports a legislative solution that would appropriate CSR payments and end silver loading."
- President's FY 2020 budget would restore CSRs for 2020 and allow payments for 2017(4Q)-2019 to issuers that did not silver load or broad load.
- Discussion noted that "all commenters supported silver loading as an option to maintain consumer affordability and participation."
  - Some commenters opposed broad loading (spreading premium increases across all metal-level plans) because it does not offer unloaded options to unsubsidized
  - Some commenters suggested that "HHS should phase in a limitation on silver loading after permanent and stable funding is provided" to mitigate disruption
- HHS response was noncommittal: HHS will take comments "into consideration in deciding whether future action is appropriate."

Automatic Re-enrollment Retained for 2020

- HHS noted that commenters "unanimously supported retaining automatic re-enrollment processes."
- HHS affirmed case for auto re-enrollment: "We agree that automatic re-enrollment significantly reduces issuer administrative expenses, makes enrolling in health care more convenient for consumers, and is consistent with broader industry practices."
- However, HHS also reiterated interest in stronger program integrity measures.
- HHS response was noncommittal: We "will continue to consider the feedback provided for potential action … not sooner than plan year 2021."
- 2019 enrollment report highlights impact of automatic re-enrollment:
  - 30% of FFM re-enrollments were automatic (3.4M out of 8.7M)
  - With new enrollment declining from 4.9M in 2016 to 2.7M in 2019, high levels of re-enrollment have been critical to minimizing the incremental declines in overall enrollment for the past three years

Rule Changes Lay Groundwork for More Direct Enrollment

- HHS finalized extensive, though mainly technical, changes to rules governing agents, brokers, web brokers and "direct enrollment (DE) entities."
- Purpose of rule changes is to "better address the complex and evolving nature of DE to accommodate innovation, promote fair competition, and ensure program integrity."
- HHS has steadily increased the opportunities for both issuers and web brokers to enroll qualified health plan (QHP) applicants in subsidized coverage through their own non-exchange websites.
- DE pathway now includes enhanced DE which allows qualified DE entities to handle more business, including more eligibility cases and servicing enrollees during the year.
- Direct enrollment pathway has accounted for steadily increasing share of FFM enrollment, approaching 20%.
- None of 12 full SBMs (those with their own IT platform) have adopted similar DE program to date.

Rule Changes Facilitate DE, Establishing State Exchanges (SBMs)

- Rules clarify that DE entities must comply with state agent and broker laws as well as meet specific consumer protection standards when acting in place of FFM.
  - Web brokers must display all QHPs on separate web page from non-QHPs
  - DE entities must comply with security, privacy, confidentiality, and conflict of interest rules
  - DE entities (including technology providers) can work with “application assisters”
- HHS has suggested elsewhere (not in this rule) that DE entities could provide a streamlined exchange option for states, but pathway is vague and no state has pursued this potential option.
- At least two FFM states (PA and NJ) are considering becoming SBMs by establishing a state governance model and contracting with an IT vendor to replace the federal platform.
  - Three SBMs using the federal platform (NV, NM, and OR) are in various stages of becoming full SBMs with their own IT platforms
- Other rule changes relax standards for functionality required to be a full SBM.
  - Navigator standards are made more flexible
  - Telephone hotlines can be used in place of call centers for SHOP

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Copay Card Accumulator Adjustment Programs

- HHS finalizes proposal to permit plans to exclude copay card amounts from accumulator for annual limit on cost sharing … in very limited cases.
  - Applies only to brand-name drugs when a generic is on formulary
  - Must apply copay card to accumulator when generic is not medically appropriate
  - Appears to prohibit copay card "accumulator adjustment" programs in all other cases, which has been a growing trend in commercial specialty drug coverage
  - Federal maximum annual limit on cost sharing applies only to "essential health benefits"
    - Large group health insurance and self-insured group plans have flexibility in defining EHB
  - State could still prohibit accumulator adjustment, even when generic available

Applies to individual health insurance and group health plans (except grandfathered plans)

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HHS Declines to Act on Other Prescription Drug Proposals

- HHS declines to issue rule on midyear formulary changes for generics.
  - Federal “guaranteed renewability” law appears to prohibit midyear benefit changes
  - HHS acknowledges that a wide variety of midyear formulary changes in group and individual health insurance already occur, subject to state law
  - Does not create special right for midyear formulary changes when a generic comes on market, but seems to acknowledge that midyear changes occur
- HHS declines to permit individual and small group health insurance coverage to exclude brand-name drug cost-sharing from annual limit on cost sharing.
  - This standard currently applies for self-insured and large group health plans when a medically appropriate generic equivalent is available on formulary
  - Based on “complexity” of implementation, HHS declines to finalize
  - Appears to preserve rule that all drugs covered in individual and small group markets are considered essential health benefits, subject to annual limit on cost sharing (as well as prohibition on annual or lifetime dollar benefit limits)

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Wrap-Up

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