MERCER
MAKE TOMORROW, TODAY

LAW & POLICY GROUP | GRIST

HHS PROPOSES 2020 COST-SHARING LIMITS, ESR PENALTIES, MORE EHB CHANGES

By Mercer's Kaye Pestaina, Katharine Marshall and Margaret Berger
March 1, 2019

The 2020 proposed notice of benefit and payment parameters outlines a new method for calculating key Affordable Care Act (ACA) figures that would increase cost-sharing limits by 3.8%. Other key changes aimed at increasing enrollee's use of generic drugs would relax rules around cost-sharing for brand drugs when generic equivalents are available. Issued annually by the Department of Health and Human Services (HHS), the notice sets out policy and payment rules for the coming year. While much of the notice focuses on the individual and small-group insurance markets, some proposals apply to large employer-sponsored plans. After reviewing comments on the proposals, HHS is expected to issue final rules later this year.

PROPOSED METHODOLOGY, PAYMENT PARAMETERS

HHS has proposed a new formula for determining the annual premium adjustment percentage — which is used to calculate key ACA figures affecting large-employer plans, among other things — for the 2020 benefit year and beyond. The percentage, set annually by HHS, has been based on projected estimates of employer-sponsored insurance premiums from the Office of the Actuary at the Centers for Medicare & Medicaid Services. The new methodology is aimed at reflecting the premium trend in all markets by including individual market premiums in the calculation.

The proposed change in methodology is expected to result in higher annual cost-sharing limits and employer-shared responsibility (ESR) assessments for large-employer plans than under the current method used to determine the annual premium adjustment percentage. The percentage proposed for 2020 (1.2969721275) would increase both as follows:

- *Cost-sharing limits.* The proposed 2020 annual out-of-pocket (OOP) maximums for nongrandfathered group health plans would increase to $8,200 for self-only coverage and $16,400 for other coverage — up 3.8% from 2019 levels. These cost-sharing limits apply to all OOP costs for in-network essential health benefits (EHBs).

- *ESR assessments.* Using the new HHS calculation method to determine the proposed premium adjustment percentage, the 2020 play-or-pay assessment for employers not offering coverage is projected to increase to $2,590 per full-time employee — up from $2,500 in 2019 (a 3.6% increase). The 2020 assessment for employers offering coverage that is unaffordable or lacks minimum value is projected to increase to $3,890 per full-time employee who receives subsidized coverage through a public exchange — up from $3,750 in 2019 (a 3.7% increase). The IRS website typically announces the official employer shared-responsibility assessment figures for a future year after HHS finalizes the premium adjustment percentage for that year (Q&A-13, IRS Notice 2015-87).

Adoption by IRS. If adopted by the IRS, the new methodology it is also expected to increase the required contribution percentage used to determine if an offer of employer-sponsored coverage is affordable, increase the portion of the premium that an individual with public exchange coverage will pay, and reduce the amount of the premium tax credit he or she will receive.

EHB CHANGES FOR BRAND NAME DRUGS WITH GENERIC EQUIVALENTS

HHS proposes two policy changes designed to reduce prescription drug costs by encouraging individuals to use lower-cost generic medication. These changes, HHS says, will apply *directly* to large plans — insured and self-insured — giving employers more options regarding coverage of brand name drugs.

- *Brand name drugs with generic equivalents.* The proposal would allow insurers and self-insured health plans that cover both a brand name prescription drug and its generic equivalent to (i) use cost sharing for the generic rather than the brand drug when calculating maximum OOP costs if the generic is available and medically appropriate and (ii) impose annual and lifetime dollar limits on the brand drug. This change would apply to all nongrandfathered coverage. As an alternative, HHS has proposed requiring (rather than simply allowing) all plans to exclude brand drugs with generic equivalents from EHBs. A 2014 triagency FAQ already clarified that nongrandfathered group health plans don't have to count all cost sharing for brand drugs toward cost-sharing limits if certain criteria are met, but the guidance didn't address annual or lifetime dollar limits (Q&A-3, ACA FAQs Part XIX).

- *Manufacturer coupons*. The proposal would allow plans to disregard enrollee cost sharing that uses "any form of direct support offered by drug manufacturers to insured patients to reduce or eliminate immediate out-of-pocket costs for specific prescription brand drugs that have a generic equivalent" when calculating maximum OOP costs. This change is consistent with concerns set out in President Trump's blueprint for lowering drug prices that drug manufacturer coupons and other forms of copay assistance increase overall drug costs. Some employer-sponsored plans and pharmacy benefit managers have "copay accumulator programs" that exclude manufacturer copay assistance from a patient's deductible or out-of-pocket maximum. Although the notice says the proposed change would apply to nongrandfathered large group insured and self-insured plans, HHS sought comments on whether the proposal should be limited to public exchange plans. The agency also sought comments on whether plan information technology systems can implement needed changes, and whether states should be able to decide how coupons are treated (some states prohibit coupon use when there is a generic equivalent).

Options for EHB modifications. Last year, HHS offered states several options for changing their benchmark plan effective in 2020. Just one state, Illinois, did so, making changes that would restrict access to prescription opioids, provide alternative medications for chronic pain and expand access to treatment for certain mental health and substance use disorders. Illinois also added telepsychiatry as an EHB. HHS is encouraging other states to explore modifications to their EHB benchmark plan to fight the opioid epidemic.

MIDYEAR FORMULARY CHANGES

Under current federal law, insurers generally can only make changes to fully-insured group health plan coverage at the time of renewal. The proposal would allow issuers in all markets, including the large-group insurance market, to make midyear formulary changes to replace brand drugs with new generic equivalents (or shift the brand drugs to a higher tier) 60 days after notifying enrollees. States could still limit or narrow when insurers could make midyear changes. HHS says these formulary changes wouldn't affect a plan's grandfathered status. The proposal wouldn't apply to self-insured ERISA plans, which aren't subject to midyear change restrictions, although applicable ERISA disclosure rules would likely apply.

CAUTION ABOUT DISCRIMINATORY COVERAGE

The notice also addresses coverage of Medication-Assisted Treatment (MAT) for opioid use disorders, noting that lack of access to MAT has contributed to the opioid crisis. In some cases, HHS says, insurer plan designs exclude coverage of certain drugs for MAT while covering the same drugs for other medically necessary purposes, a potentially discriminatory practice under the Mental Health Parity and Addiction Equity Act. According to HHS, a drug covered under a plan for treatment of a medical condition but excluded for MAT is a nonquantitative treatment limit (NQTL). Plans with NQTLs must demonstrate that the standards used to determine whether a drug is covered for medical purposes are comparable to those used to exclude coverage of the drug for substance use disorders. While the notice discusses these issues in the context of insurers that provide coverage in the individual and small-group markets, the same parity rules apply to large insured and self-insured plans.

OTHER PROPOSALS FOR REDUCING DRUG COSTS

HHS is weighing whether reference-based pricing for prescriptions drugs is useful for lowering drug costs and asked for feedback on the risks and opportunities associated with that strategy. To employ this mechanism, as described by the agency, a plan sets a price for a group of similar drugs in a therapeutic class. Participants then pay the difference between the drug's cost and the set, or reference, price.

HHS also sought input on the use of therapeutic substitution — substituting a therapeutically different compound with another in the same drug class — as a mechanism for reducing drug costs. The agency is assessing the impact of this practice on quality and access.

NEXT STEPS

Final rules aren't expected until later this year. Until then, employers will want to keep the following in mind.

Cost-sharing limits and ESR assessments. The proposed change in indexing methodology has garnered some negative comments, including concerns that it will lower exchange enrollment in future years. Employers should wait until final rules are issued before relying on the 2020 numbers.

EHBs/MAT. Employers should take note of proposed flexibilities in determining what qualifies as an EHB for purposes of cost-sharing and annual and lifetime dollar limits. In addition, employers may want to review how their plans cover MAT treatment to ensure compliance with the parity law.

Other drug policy proposals. Employers may wish to follow comments and developments concerning referenced-based drug pricing and therapeutic substitution as they consider mechanisms to reduce prescription drug costs.

RELATED RESOURCES

Non-Mercer Resources

Related government, trade group, association and other non-Mercer websites include:

- Proposed 2020 Notice of Benefit and Payment Parameters (Federal Register, Jan. 24, 2019)
- Press Release (HHS, Jan. 17, 2019)
- Fact Sheet (HHS, Jan. 17, 2019)
- Comments on Proposed Regulations (CMS)
- President Donald J. Trump's Blueprint to Lower Drug Prices (White House, May 11, 2018)
- Illinois Becomes First and Only State to Change EHB-Benefit Benchmark Plan (Illinois Department of Insurance, Aug. 27, 2018)
- Notice 2015-87, Q&A 13 (IRS, Dec. 15, 2015)
- FAQs about Affordable Care Act Implementation (Part XIX), Q&A 3 (DOL/HHS/IRS, May 2, 2014)
- Indexing Provision in HHS Proposed Marketplace Regulations Is Not Just Bad Policy, but Could Be Vulnerable to Legal Challenge (Brookings, Feb.14, 2019).
- Final HHS 2017 Payment Notice Sets Some Standards That Affect Large Employers (March 1, 2016)
- HHS Finalizes 2016 Cost-Sharing Limits, Reinsurance, and Other Health Plan Provisions (Feb. 25, 2015)
- ACA's Out-Of-Pocket Limit Leaves Uncertainties for Some Cost-Management Designs (Oct. 1, 2014)
- HHS Rules Finalize Key Transitional Reinsurance Standards, Set 2015 Payment Parameters (June 5, 2014)