Notice of Benefit and Payment Parameters for 2020
Summary of proposed changes

DISCLAIMER: This is not intended as complete legal analysis of the proposed regulations, but rather a summary guide to assist with future analysis.

Comments are due Feb. 19, 2019. Rule language and submission instructions are found here.

Change	Details
Insurer Plan Management	

Changes premium adjustment factor from a standard based on employer coverage, to one that also includes changes in individual market coverage.
 	
156.130
	Data will be taken from National Health Expenditure Account (NHEA) Data collected by the Centers for Medicare & Medicaid Services (CMS). The changes:
	
	• Will result in:
	  ○ Higher maximum annual limitation on cost sharing;
	  ○ A higher required contribution percentage for individuals (see section below on raising required contribution percentage);
	  ○ Higher employer shared responsibility payment amounts (meaning fewer employed individuals would qualify for the Advanced Premium Tax Credit - APTC);
	  ○ Adjustment in APTC corresponding to revised higher required contribution percentages (to be officially determined by the Department of the Treasury); and
	  ○ Fewer employed individuals who qualify for APTC.
	
	• Set maximum annual limitation on cost sharing at $8,200 for self-only coverage and $16,400 for coverage of two or more people -- this number was $6,350 in 2014, and 3.8 percent higher than in 2019.
	
	• Reduces cost-sharing reduction plan variations to $2,700 for self-only coverage and $5,400 for other coverage for individuals earning less than 200 percent of the federal poverty level (FPL), from $2,600 and $5,200 in 2019, and to $6,550 and $13,100 for individuals earning from 200 to 250 percent FPL ($6,300 and $12,600 in 2019).
	
	This allows for better compliance with actuarial value (AV) standards established under federal law based on the new premium adjustment factor.
	
	It reiterates existing permission for states to submit their own state-specific datasets for AV calculations, subject

Change	Details
	to the Department of Health and Human Services (HHS) approval. ***<u>Rationale</u>*** Premiums for coverage through the exchanges have grown faster than employer-sponsored insurance premiums. The new premium measure would reflect cumulative, historic growth in premiums for private health insurance markets (excluding Medigap and property and casualty insurance) from 2013 onwards. This change would more closely track with changes in the individual market and lower federal spending on APTC. **HHS estimates premium increases of $181 million per year from 2020 to 2023, and decreased federal spending on tax credits of $900 million in 2020 and 2021, and $1 billion in 2022 and 2023. HHS estimates 100,000 individuals would drop exchange coverage.** This is partially aimed at slowing rate of APTC growth caused by silver-loading practices. ***<u>Questions posed in the Notice of Benefit Payment and Parameters (NBPP):</u>*** • General request for comments. • Request for comments on proposed maximum annual limitation on cost-sharing. • Is the NHEA the correct source of premium data to use for the premium adjustment factor? • Should employer-sponsored insurance premiums continue to be the standard?
Allows insurers to make mid-year changes to their drug formulary. 147.106(e)(5) 146.152 148.122	**<u>To the Extent Permitted by Applicable State Law</u>** An insurer *may* make a formulary change upon the new availability of a generic equivalent. An insurer may add the generic and remove the equivalent brand-name drug, or move it to a higher cost-sharing tier. It also: • Requires insurers to make modifications within a reasonable time period. • Insurers must notify enrollees of the change in writing 60 days before it takes place. Notice must include the name of the brand-name drug and the generic alternative, and specify the dates the changes will be effective and the process of appeals; • Changes must meet standards for a uniform modification of coverage, including that it be available at least in a majority of the same service area (further defined under 147.106(e); • Requires insurers to submit an annual report to HHS of any mid-year formulary changes.

Change	Details
	Applies to small group, large group, and individual market insurers and both grandfathered and non-grandfathered coverage. Plans would not lose grandfathered status for this change. Enrollees may appeal to request coverage of a brand drug that was removed. Changes do not preempt state or federal agencies (e.g., Office of Personnel Management for federal benefits) from prohibiting or narrowing the circumstances under which insurers may make mid-year changes. Estimates 37 drug equivalents could have been made available in 2018 if this change had been in effect. Estimated annual costs: • For an insurers to remove a drug mid-year: $8.5 million • For an insurer to change a drug's tier: $8.4 million ***Rationale*** To increase the use of lower-cost prescription drugs, Because generic equivalents are approved by the Food and Drug Administration throughout the year. ***Questions posed in NBPP*** • Should notice to consumers be mandatory 90 or 120 days prior to change (rather than 60)? • Should these changes be limited to individual and small group insurers? • Are the conforming amendments made to grandfathered and non-grandfathered plans appropriate (146.152 & 148.122)? • Should therapeutic substitutions also be allowed, like generic substitutions? Are there any existing standards of practice for therapeutic substitutions and are those standards nationally recognized and readily available for providers to use?
Allows for plans to eliminate coverage of a brand-name drug as an essential health benefit when a generic is available.	**To the extent permitted by applicable state law** In a case where an insurer covers both a brand-name drug and its generic equivalent, the insurer may choose to specify that the generic ONLY qualifies as a benefit covered under Essential Health Benefit (EHB) standards. In this case, the brand name drug would not qualify as an EHB. In opting to do this: • APTC would not apply to any portion of the premium attributable to coverage of the brand name drug.

Change	Details
156.122 156.130	Insurers would be required to calculate the portion of premiums used to cover the brand-name drug and report that amount to the exchange that offers that plan. • The spending on the brand-name drug would not qualify toward annual and lifetime limits. Under the Affordable Care Act (ACA), only benefits classified as EHB can apply toward annual and lifetime limits. HHS proposes two alternative strategies to handle annual and lifetime cost-sharing limits in the case an individual purchases a brand-name drug. In the first, insurers would apply the cost of the generic toward cost-sharing limits; in the other, no amount would be applied to cost sharing. HHS requests comment on these proposed alternates. Changes to calculation of annual and lifetime limits would apply not just to individual market plans, but also group health plans, which are governed by the same laws governing the prohibition of annual and lifetime limits. The policy only applies when the generic drug is available to and medically appropriate for the enrollee. Insurers must establish an appeals process for an enrollee to petition for the brand-name drug. ***<u>Questions posed in the NBPP:</u>*** • Should insurers be allowed to exempt the entire amount paid by a patient for a brand-drug for which there is a medically appropriate generic alternative available from the annual limitation on cost sharing? • What are the limitations imposed on group health plans' and health insurance insurers' information technology systems ability to accumulate the cost sharing consistent with this policy? • Should this be subject to or preempt any state laws? • Should HHS require, instead of permit, insurers to exclude brand-name drugs from being EHB if the generic drug is available and medically appropriate for the enrollee?
Deadlines for states to submit EHB plan selections. 156.115	States must submit EHB benchmark selections for 2021 by May 6, 2019. It sets the deadline as May 8, 2020 for 2022 plan selections. This is earlier than prior years when the deadlines had been set in July. HHS suggest states submit their applications about 30 days in advance of these document submission deadlines. It encourages states to explore flexibility granted in last year's notice to revise EHB benchmarks, particularly as a means to address the opioid epidemic. Any states wishing to take up the new option of making a substitution in benefits between categories, must give notice to HHS by May 6, 2020.

Change	Details
	Questions posed in NBPP: General request for comments on EHB submission timelines.
Limits use of prescription coupons (accumulator adjustment program). 156.130	Insurers do not have to count amounts paid via "direct support offered by drug manufacturers to reduce or eliminate out-of-pocket costs for a brand-name drug when there is a generic equivalent" (e.g., coupons from manufacturers for brand-name drugs) toward the annual limitation on cost sharing. ***Rationale*** Coupons incentivize use of brand-name drugs, increasing overall costs. The intent of the ACA enables CMS to address issues related to enrollee cost sharing. ***Questions posed in NBPP:*** • Should states decide how coupons are treated? • Would it be difficult for insurers to determine these amounts? Are there practical limitations? • Should this be applied to QHPs only?
Requirement that QHP insurers offering non-Hyde abortion coverage offer coverage omitting abortion as well. 156.280	If a QHP insurer provides coverage of non-Hyde abortion services in one or more QHPs, the QHP insurer must also offer at least one "mirror QHP" that omits coverage of non-Hyde abortion services throughout each service area in which it offers QHP coverage through the exchange, **to the extent permissible under state law.** The QHP insurer would only be required to offer at least one "mirror QHP" throughout each service area that the QHP insurer offers plans covering non-Hyde abortion coverage, even if the insurer has multiple plans that offer non-Hyde abortion services in a single service area. QHPs have the discretion to determine the metal level at which the mirror plan is offered. HHS estimates the change will affect 75 insurers in 17 states. ***Rationale*** Some consumers are not enrolling in coverage because they object to having non-Hyde abortion benefits in their plans. HHS acknowledges potential burden for insurers to develop new plans and state-based marketplaces (SBMs) that would have to review more plans. HHS suggests this regulation does not conflict with 42 U.S. Code

Change	Details
	18023, which states that an insurer has authority over whether or not to offer non-Hyde coverage. ***Questions posed in NBPP:*** • Should QHPs have discretion to choose the metal level? Will it inhibit access to plans that do not offer abortion services? • How can exchanges better differentiate between the QHP that covers non-Hyde abortions and the QHP that does not cover non-Hyde abortions? • What is the extent to which direct enrollment entities and agents and brokers should be required to adhere to standards for differential display of non-Hyde abortion and other plans? • What requirements should be put in place to limit confusion of consumers who to not carefully study the differences between available plans.
Cost-sharing reduction payments and silver-loading	No changes made. HHS claims that silver loading is the result of Congresses' lack of appropriating funds for the program and expresses support for a legislative solution to appropriate cost-sharing reduction payments. ***Questions posed in NBPP:*** Seeks comments on what policies HHS should pursue sans a legislative solution. Suggests HHS may take action on this policy in a future rule.
Use of reference-based drug pricing	HHS acknowledges that reference-based pricing is one strategy to address increases in pharmaceutical spending and is seeking comment on the opportunities and risks of implementing or incentivizing reference-based pricing for prescription drugs. Within this proposed rule, HHS defines reference-based pricing as an issuer in a commercial market covering a group of similar drugs, such as within the same therapeutic class, up to a set price, with the enrollee paying the cost difference if the enrollee desires a drug that exceeds the reference price. Note, the reference price would be set by the plan and not based on another state or country's prices; rather, prices are set depending on therapeutic class. (For example, all NSAIDs are covered at a set/reference price, and if enrollees want NSAIDs that cost more than the reference price, they will pay the cost differences.)

Change	Details
	Questions posed in NBPP: Opportunities and risks of implementing or incentivizing reference-based pricing for prescription drugs.
Non-discrimination and how it addresses opioid addiction	HHS encourages insurers to take every opportunity to address opioid use disorder, including increasing access to medication-assisted treatment (MAT) and normalizing its use. For plan year 2018, 2,553 QHPs (95 percent) in these 39 federally-facilitated exchanges (FFE) and state-based exchanges using the federal platform states cover all four of MAT drugs; 105 QHPs (4 percent) cover three; and 25 QHPs (less than 1 percent) cover two. Non-discrimination: The rule includes several reminders that any indication of a reduction in the generosity of a benefit in some manner for subsets of individuals that is not based on clinically indicated, reasonable medical management practices is potentially discriminatory and that the ACA prohibits discrimination against individuals who participate in or have completed substance use disorder treatment, including MAT. This reminder is in response to concerns that insurers are not covering MAT for opioid treatment, even if covering those services for other issues.
Quality improvement	The proposed rule includes a general statement to encourage QHP insurers to use performance measures that are aligned with the CMS Meaningful Measures Initiative in fulfilling Quality Improvement Strategy requirements. The proposed rule states that HHS will continue to assess quality measures to ensure use of a meaningful set of measures.
Eligibility and Enrollment	
New special enrollment period Exchanges are permitted to offer a special enrollment period (SEP) to off-exchange enrollees who experience a decrease in household income.	Applies when a member of the household newly qualifies for APTC based on reduced income AND had minimum essential coverage for at least 1 of 60 days prior to the change in circumstance. Previously, this SEP was only available to those who previously had employer-coverage. Exchange enrollment must occur within 60 days of the financial change. Individuals would be required to submit documentation verifying their change in circumstances within 30 days of plan selection for the FFE.

Change	Details
155.420	Clarifies minimum essential coverage includes pregnancy Medicaid, CHIP unborn child, and medically needy Medicaid. ***Questions posed in NBPP:*** • General solicitation for comments on these changes. • Requests comments on the number of state-based exchanges that will adopt this SEP. • Requests any information on cost-estimates associated with implementation of this SEP for exchanges insurers direct enrollment entities, and consumers.
Allows for greater flexibility in the ability of consumers to claim exemptions in 2018, without a certification from the exchange. 155.605	Exemptions include all those specified in new guidance released in 2018 including: https://www.irs.gov/pub/irs-drop/n-19-05.pdf and https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Authority-to-Grant-HS-Exemptions-2018-Final-91218.pdf ***Questions posed in NBPP:*** General solicitation for comments on these changes.
Raises the required contribution percentage to 8.39 percent. 155.605	While percentage is less relevant without the federal mandate, the threshold is still necessary for determination of eligibility for enrollment in catastrophic coverage. Began at 8 percent in 2014. ***Question posed in NBPP:*** General solicitation for comments on these changes.
Auto-enrollment policies	No change proposed, but proposed rule includes a statement that current automatic re-enrollment practices give rise to many concerns. ***Rationale*** Auto-enrollment makes consumers less aware of their options. Lack of yearly updates due to changes in personal circumstance leads to eligibility errors, tax credit miscalculations, unrecoverable federal spending, and consumer confusion. ***Questions posed in NBPP:*** What are additional policies or program measures that can be used to reduce eligibility errors and potential government misspending (and applicable not sooner than plan year 2021)?

Change	Details
Consumer Assistance	
SHOP toll-free hotline Allows for SHOP exchanges to operate a toll-free hotline rather than a full call center. 155.205	Toll-free hotline includes the capability to provide information to consumers and appropriately direct consumers to the federally operated call center or HealthCare.gov to apply for, and enroll in, coverage through the exchange. A toll-free hotline includes the capability to provide information to consumers about eligibility and enrollment processes, and to appropriately direct consumers to the applicable exchange website and other applicable resources. Consists of a toll-free number linked to interactive voice response capability, with prompts to pre-recorded responses and frequently asked questions, information about locating an agent and broker in the caller's area, and the ability for the caller to leave a message regarding any additional information needed
Navigator requirements Make optional (rather than required) for FFE navigators to provide assistance with certain topics post-enrollment. 155.210 155.215	**Topics include:** • Filing exchange eligibility appeals; • Understanding and applying for exemptions from the individual mandate; • APTC reconciliation processes; • Understanding basic concepts and rights related to health coverage and how to use it; and • Referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice related to exchange application and enrollment process, exemptions from the requirement to maintain minimum essential coverage and from the individual shared responsibility payment, and premium tax credit reconciliations. The proposed rule revises training requirements to conform with navigator changes. The current FFE navigator training for annual certification or recertification might continue to include training on some of the topics. SBEs retain autonomy to require these topics. Eliminates corresponding requirements that exchanges conduct training on these topics. ***Rationale***

Change	Details
	To reduce burden, increased flexibility, enable easier, more cost-effective operations of navigator programs. Helps navigators concentrate their resources on enrollment, rather than post-enrollment activities. ***<u>Questions posed in NBPP:</u>*** • How many hours per month do FFE navigator grantees and individual navigators currently spend providing the assistance on these topics? • What percentage of their work is spent meeting these requirements? • How will their work be impacted, including how would they reprioritize their work?
Increased Transparency	
Enrollee cost-sharing transparency 155.220(d)	No proposed changes, but under current law and regulation, insurers must post and make available to the public, data related to transparency in coverage in plain language and submit this data to HHS, the exchange, and the state's insurance commissioner. HHS is considering different options for disclosure of cost-sharing information, such as: • Whether to require that insurers disclose a consumer's anticipated costs for services within a specific timeframe. • Whether to require insurers to disclose anticipated d costs for a number of common coverage scenarios. ***<u>Rationale</u>*** Consumers would benefit from a greater understanding of what their potential out-of-pocket costs would be for various services, based on which QHP they are enrolled in and which provider they see. Promote consumers' ability to shop for coverage and play an active role in health care. ***<u>Questions posed in NBPP:</u>*** • How can HHS further implement requirements that QHP insurers must make available the amount of cost-sharing the enrollee may incur under his or her coverage plan for specific services by participating providers? • What types of data would be most useful to improving consumers' abilities to make informed health care choices? • How can HHS improve consumers' access to information about health care costs?

Change	Details
	• Are there any existing regulatory barriers that stand in the way of privately-led efforts at pricing transparency? • Are there ways HHS can facilitate or support increased private innovation in price transparency? • How can HHS promote transparency related to value-based insurance design? • How can HHS promote the offering and take-up of high-deductible health plans paired with health savings accounts, especially on Healthcare.gov?
Expansion of Direct Enrollment Pathway	
Formalizes definition of web-broker. 155.220; 155.221	Web-broker is an individual agent or broker, a group of agents or brokers, or an agent or broker business entity, registered with an exchange under §155.220(d)(1) that develops and hosts a non-exchange website that interfaces with an exchange to assist consumers with the selection and enrollment in QHPs offered through the exchange, a process referred to as direct enrollment. Means that any general reference to agent or broker would include web-broker.
Formalizes definition of "direct enrollment technology providers." 155.220; 155.221	A direct enrollment technology provider is a type of web-broker who is not a licensed agent, broker, or producer under state law and has been engaged or created by, or is owned by, an agent or broker to provide technology services to facilitate participation in direct enrollment as a web-broker. References to web-brokers are intended to include direct enrollment technology providers, as well as licensed agents or brokers that develop and host non-exchange websites to facilitate QHP selection and enrollment, unless otherwise indicated.
Streamlines and consolidates the requirements applicable to direct enrollment entities. 155.220; 155.221	Formalizes that both QHP insurers and web-brokers may serve as direct enrollment entities. ***Display of plan information*** • Prohibits web-broker websites from displaying recommendations for QHPs based on compensation the web-broker, agent, or broker receives from QHP insurers. • Prohibits web-broker websites from displaying QHP recommendations based on compensation received from QHP insurers. • Does not prohibit web-brokers from otherwise implicitly making recommendations based on how they display QHPs. • Requires direct enrollment entities to display and market QHPs and non-QHPs on separate website pages. Clarifies requirements for disclaimers that must be posted to assist consumers in distinguishing

Change	Details
	QHP products for which they could be APTC and CSR eligible. A direct enrollment entity could begin marketing and displaying the non-QHP health plans and/or off-exchange products after the consumer completes the exchange eligibility application and QHP selection process, but before he or she has completed the shopping experience. ***Relationships with other entities*** • Requires a web-broker to provide HHS with a list of the agents or brokers who, through a contract or other arrangement, use the web-broker's non-exchange website. Considers reporting on a quarterly or monthly bases, with daily or weekly reporting during the open enrollment period, and a month before. • Allow HHS to immediately terminate an agent or broker's agreement with the FFEs for cause, including not meeting state specific licensure requirements. HHS may also immediately suspend an agent or brokers ability to transact information with the exchange. • Web-broker agreement may be suspended or terminated if it is under common control or affiliated with another web-broker who has had an agreement suspended or terminated. • Enables direct enrollment entities to utilize "direct enrollment entity application assisters" for their programs. Assisters must be trained and certified regarding QHP option and eligibility and enrollment processes (similar to what is required of agents and brokers). These assisters may include insurers application assisters, or employees, contractors, or agents of direct enrollment entities who are not licensed agents, brokers, or producers under state law, but who assist consumers with exchange eligibility. HHS estimates 490,000 applications would be completed by these entities in 2019. This could yield $12.2 million in savings achieved by not paying agent and broker fees. ***Compliance and oversight*** • Auditing agencies for direct enrollment entities must be independent from the entities they are auditing. • A written agreement must be established between the entity and auditor stating compliance with oversight over provisions outlined in federal regulation. • Direct enrollment entities must contract with a third-party entity to certify operational readiness. • Extends authority of HHS to suspend the ability of direct enrollment entities to transact information with an exchange, including in cases where HHS finds that there is unacceptable risk to the accuracy of exchange eligibility determinations.

Change	Details
	Other requirements • Exempts the registering entity for the web-broker from completing training requirements, though all agents and brokers working with the web-broker must complete the training. • Web-brokers who offer enhanced direct enrollment must include the same fields in their applications as required in the application for Healthcare.gov. ***Questions posed in NBPP:*** • What form and manner should submission of agent and broker information take? How frequently should it occur? • What requirements should be adopted in reference to how disclaimers should be displayed on web-broker websites?
Greater flexibility for use of web-brokers by assisters, certified application counselors, and navigators. 155.225	Grants new permission for assisters and certified application counselors to use web-broker websites to assist consumer with QHP selection and enrollment. SBEs have discretion over this permission in their states. Suggests that web-brokers may consider building assister friendly interfaces. Web-brokers must display all QHP data provided by an exchange in order to be used by assisters. If the website does not allow for enrollment in all QHPs, it must provide a prominent disclaimer that a consumer can enroll in those missing QHPs through the exchange. Considering if web-brokers should be prohibited from making plan recommendations or prioritizing plans on their websites if used by assisters. Proposes allowing, but not requiring, navigators and certified application counselors to assist consumers with applying for eligibility for insurance affordability programs and QHP enrollment through web-broker websites under certain circumstances. ***Rationale*** Moving forward, it is essential for assisters to evolve by collaborating with new partners to better accomplish the shared goals of educating consumers and helping them to enroll in QHPs. ***Questions posed in NBPP:***

Change	Details
	• Considers addition of an optional annual certification process for web-brokers related to compliance with these requirements. • Should HHS maintain a public list of web-brokers for assister to find? • Should web-brokers be prohibited from making plan recommendations or prioritizing plans on their websites if the site is used by assisters? • How should disclaimers be displayed in the case of web-brokers that do not enable enrollment in all QHPs? • General solicitation for comment on proposal for how QHP recommendations are displayed as it relates to assister utilization of web-brokers.
FFE User Fees	
Reduces assessment rate from 3.5 to 3.0 percent for FFE and from 3.0 to 2.5 percent for SBE-FPs	Calculated based on the proportion of FFE costs that are associated with the FFE information technology infrastructure, the consumer call center infrastructure, and eligibility and enrollment services. ***Question posed in NBPP:*** General solicitation for comments on these changes.
Risk Adjustment Methodology	
Data for risk adjustment (RA) calculation: Calculations will use 2016-2017 EDGE data in recalibration of risk adjustment, with Market Scan data from 2017 153.320	Proposes use of blended data sourced from both EDGE and Market Scan. This is similar to the approach used for the 2019 benefit year, which also blended data from these two sources. This approach is intended to enable the use of the most recent data available for RA calculations. Caveats that calculations to develop coefficients used for RA in this proposed rule come from 2016 Market Scan (rather than EDGE) data. Indicates this should be a close approximation of what the final numbers will be from the EDGE data. If 2017 EDGE data is not available by the time of publication of the final rule, the coefficients will be published later in guidance. ***Question posed in NBPP:*** Are there any issues with the use of blended data from separate data sets to determine risk adjustment calculations?
Changes to calculation parameters 153.320	No changes in the categories for risk adjustment from 2019. Pricing adjustment to the RXC coefficient for hepatitis C.

Change	Details
	Sets a permanent threshold ($1 million) and coinsurance rate (60 percent) to account for high-cost enrollees in RA calculations -- same as thresholds set for 2018 and 2019 benefit years. Proposes to maintain them for 2020 and beyond. Allows for further amendment in future rules. Maintains cost-sharing reduction adjustment established in 2019. ***Rationale*** Hepatitis C changes are to account for insurer gaming, over-prescribing incentives, and notable increases in the cost of these drugs. Thresholds intended to prevent insurers with disproportionate high risk from skewing risk adjustment calculations. A stable threshold is designed to promote market stability. ***Questions posed in NBPP:*** • Are there ways to better anticipate and more precisely adjust drug categories to account for rapidly changing drug prices and plan liability expenditures? • Are there comments on how the thresholds are determined as a means to mitigate skewed calculations and system gaming? • Are there comments on the current coinsurance and threshold and the decision to maintain each from year to year? • Are there comments on the decision to maintain the same cost-sharing reduction adjustment?
Adds prescription drugs into error estimations 153.320	HHS will begin to add prescription drug categories (RXCs) into its error estimation beginning with data from the 2018 benefit year. **Rationale** To better ensure that prescriptions are fully accounted for in risk adjustment validations.
Process of state requests for risk adjustment modifications	States must submit any requested reductions to risk adjustments by Aug. 1, two years before the applicable benefit year.

Change	Details
153.320	Allows states to request that HHS not make public information and analysis used to support requested RA requests to protect against the release of information that may contain trade secrets, or confidential commercial financial information. States must provide a version of their request for public release that does not include this information. State requests would be applied to both catastrophic and non-catastrophic risk pools unless otherwise requested by states. Alabama was the only state to request a risk adjustment transfer — 50 percent for its small group market. Alabama regulators assessed the transfer would not increase premiums by more than 1 percent. Their full request can be viewed at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/index.html ***Questions posed in NBPP:*** • Solicitation for comments on any part of this process. • Are there comments about Alabama's specific request?
Sequesters the risk adjustment and reinsurance programs at a rate of 6.2 percent.	Funds sequestered in fiscal year 2019 from reinsurance and risk adjustment will be available for payment in FY 2020 without Congressional action. ***Rationale*** To maintain budget neutrality of the program. ***Question posed in NBPP:*** General solicitation for comments on these changes.
Adjusts risk adjustment data validation methodology 153.630	HHS will use the 2017 benefit year risk adjustment data validation results as an initial basis for determining 2019 benefit year initial validation samples. For the initial year of validation, HHS will require a minimum sample of 400 enrollees for large insurers (with 500,000+ enrollees) with larger-than-average failure rates, and 200 of those with lower-than-average failure rates. Sample sizes will be maintained at 200 for smaller insurers. Proposes several alternative strategies for determination of sample size. HHS will not increase a sample above 200 enrollees when it performs its second validation audit.

Change	Details
	Applies the Neyman allocation method to the 10th stratum of enrollees without Hierarchical Condition Categories (HCCs). This is the same of the method used for all other categories of enrollees. Codifies that insurers with total annual premiums of $15 million or less are exempt from annual validation audits. They will be subject to random audits every three years. Insurers in or entering liquidation would also be exempt. ***Questions posed in NBPP:*** • Should another benefit year be used to calculate enrollment for the applicable data validation year? • Are there comments on the proposed methods for varying validation audit sample sizes? Should HHS failure rates be used to determine sample size? Should HHS only use the latest available failure rates, or rates from multiple prior years? • Are there any issues with the extension of the Neyman allocation to the10th stratus of enrollees without HCCs? • Should any insurer be allowed to seek a larger sample size? • Should sample sizes vary by any factors other than insurer size? • Requests comments on the estimates of costs to insurers to conduct sampling as proposed in this rule.
Risk adjustment data availability 153.610 153.710	In the 2018 NBPP, HHS proposed the release of a public use file with enrollee-level EDGE data. Rule proposes the alternative release of an only a limited data set that can include more information such as dates associated with enrollees. The data set would be made available on an annual basis. This data will be available by request for research, public health, or health care operations purposes. Requestors must sign a data use agreement to access the data. Data would be available beginning with the 2016 benefit year. Data would not include direct identifiers of individuals, relatives, employers, or household members. ***Rationale***

Change	Details

	To comply with HIPAA requirements, data cannot include dates (other than the year) and ages of enrollees aged 90 or older.
	
	<u>Questions posed in NBPP</u>
	• Solicitation for comments on any part of this release of EDGE data.
	• Should HHS extract state and rating area information for enrollees as part of the enrollee-level EDGE data?
	  ○ If so, should it be made available as part of the limited data set described above?
	  ○ How can these data elements be used for HHS-operated risk adjustment programs?
	  ○ What would be advantages and disadvantages of using state and rating area information for recalibration of the HHS-operated risk adjustment program, the AV calculator and methodology, and other HHS individual and small group market programs?
	  ○ What are possible research purposes for these data elements?
	  ○ Would the benefits of extracting these elements outweigh risks to insurer proprietary information?
	  ○ Is extraction of this data consistent with the goals of a distributed data environment?
	• How could collection of other data elements, not currently included in EDGE collection, benefit calibration of the risk adjustment program, AV calculator, other HHS programs, research, public health, or health care operations?

Shortens time insurers have to confirm second validation audit findings from 30 to 15 days. 153.630	
Risk adjustment program fee raised from $.15 per member per month (PMPM) to $.18 PMPM 153.610	