Proposed 2020 Benefit Payment and Parameters Rule

The Centers for Medicare & Medicaid Services (CMS) released a proposed rule for benefit payment and parameters for 2020. CMS also released its draft 2020 actuarial value calculator and draft 2020 actuarial value calculator methodology.

According to CMS, the proposed rule is intended to reduce fiscal and regulatory burdens associated with the Patient Protection and Affordable Care Act (ACA) across different program areas and to provide stakeholders with greater flexibility.

Although the proposed rule would primarily affect the individual market and the Exchanges, the proposed rule addresses the following topics that may impact employer-sponsored group health plans:

- Changes related to prescription drug policy
- Small Business Health Options Program (SHOP)
- Prohibition against discrimination
- Maximum annual limitation on cost sharing for plan year 2020
- Cost-sharing requirements for generic drugs
- Cost-sharing requirements and drug manufacturers' coupons

CMS usually finalizes its benefit payment and parameters rule in the first quarter of the year following the proposed rule's release. February 19, 2019, is the due date for public comments on the proposed rule.

The 2020 open enrollment period will run from November 1, 2019, to December 15, 2019.

Changes related to prescription drug policy

CMS proposes to allow issuers in the individual, small group, and large group markets to update their prescription drug formularies by allowing certain mid-year formulary changes beginning with plan years on or after January 1, 2020, if permitted by applicable state law.

Under the proposed rule, issuers would be allowed to make formulary changes during the plan year when a generic equivalent of a prescription drug becomes available on the market, within a reasonable time after that drug becomes available. The issuer would be allowed to modify its plans' formularies to add the generic equivalent drug. At that time, the issuer would also be permitted to remove the equivalent brand drugs from the formulary or move the equivalent brand drugs to a different cost-sharing tier on the formulary.

Under the proposed rule, before removing a brand drug from the formulary or moving it to a different cost-sharing tier, an issuer would be required to notify all plan enrollees of the change in writing at least 60 days prior to the change. This would allow enrollees to begin working with their health care provider on any exception request process before the change occurs.

This notice would identify the name of the brand drug that is the subject of the change, disclose whether the brand drug would be removed from the formulary or be placed on a different cost-sharing tier, provide the name of the generic equivalent that will be made available, specify the date the changes will become effective, and state that under the appeals process or the exceptions process, enrollees and dependents may request and gain access to the brand drug when clinically appropriate and not otherwise covered by the health plan.

Small Business Health Options Program (SHOP)

CMS proposes to allow certain Small Business Health Options Programs (SHOPs) to operate a toll-free hotline and to eliminate the requirement that the SHOP operate a more robust call center.

Under the proposed rule, the toll-free hotline provided by such SHOPs would consist of a toll-free number linked to interactive voice response capability, including prompts to pre-recorded responses to 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.

Prohibition against discrimination

In the proposed rule, CMS discusses the nationwide opioid public health emergency and encourages every health insurance plan to provide comprehensive coverage of medication-assisted treatment (MAT), even if the applicable essential health benefit (EHB) benchmark plan does not require the inclusion of all four MAT drugs on a formulary.

The proposed rule discusses, at length, the potential for discrimination in plan design. It states that an issuer does not provide EHBs, under the ACA's prohibition against discrimination, if the plan's benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.

The proposed rule reminds issuers 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.

For any EHB, issuers are expected to impose limitations and exclusions on the coverage of benefits to treat opioid use disorder (including the drugs used for MAT), based on clinical guidelines and medical evidence, and are expected to use reasonable medical management. If a plan excludes a certain opioid use disorder treatment, but covers the same treatment for other medically necessary purposes, the issuer must be able to justify such an exclusion with supporting documentation explaining how such a plan design is not discriminatory.

CMS notes that a similar standard is imposed under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Under MHPAEA's regulations, if a drug is offered under a plan for treatment of a medical condition but is excluded for MAT purposes, that is considered to be a nonquantitative treatment limitation.

CMS explains that the issuer must demonstrate that, as written and in operation, the processes, strategies, evidentiary standards, and other factors it applied in deciding that the drug is covered for medical/surgical purposes, are comparable to those it used in deciding that the drug is not covered for MAT purposes, and that there are no limitations that apply only for mental health or substance use disorder benefits.

CMS also notes that federal civil rights laws, such as Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act, prohibit discrimination against individuals who participate in or have completed substance use disorder treatment, including MAT.

Maximum annual limitation on cost sharing for plan year 2020

CMS proposes that the 2020 maximum annual limitation on cost sharing would be $8,200 for self-only coverage and $16,400 for other than self-only coverage.

Cost sharing requirements for generic drugs

CMS proposes to allow a plan that covers both a brand prescription drug and its generic equivalent to consider the brand drug to not be an EHB, if the generic drug is available and medically appropriate for the enrollee, unless coverage of the brand drug is determined to be required under an exception process. Under the proposed rule, the plan must have an exception process in place for the enrollee to request coverage of the brand drug.

Under the proposed rule, if an enrollee purchases the brand drug when the generic equivalent was available and medically appropriate, the issuer would be permitted to not count the difference in cost sharing (between what the enrollee paid for the brand drug and what the employee would have paid for the generic equivalent drug) toward the annual limitation on cost sharing. However, the insurer would still be required to attribute the cost sharing that would have been paid for the generic equivalent toward the annual limitation on cost sharing.

This proposed rule, if finalized, would permit all group health plans and group health insurance issuers to impose lifetime and annual dollar limits on such brand drugs because they would no longer be considered EHBs subject to the prohibition on lifetime and annual dollar limits.

As an alternative, CMS proposes that an issuer would be permitted to except the entire amount paid by an enrollee for a brand drug for which there is a medically appropriate generic alternative from the annual limitation on cost sharing. This proposed rule, if finalized, would also apply to group health plans and health insurance issuers subject to the annual limit on cost sharing provision.

CMS gives the following example to illustrate how these alternate proposals would work:

> Under the alternate proposal, for example, if an enrollee with a 10 percent coinsurance obligation is selecting between a brand drug for which the allowable charge is $100 and an available and medically appropriate generic equivalent for which the allowable charge is $60, if the enrollee selects the generic equivalent, the enrollee would pay $6 in coinsurance (10 percent of the $60 allowable charge) and the issuer would attribute that $6 to the annual limitation on cost sharing. If the enrollee selects the brand drug, the enrollee would pay $10 in coinsurance (10 percent of $100), but the issuer could attribute $6 to the annual limitation on cost sharing under the first proposal (due to the enrollee selecting a brand

name drug when a generic equivalent is available and medically appropriate) or $0 under the alternate proposal to the annual limitation on cost sharing.

CMS proposes that these limits on cost-sharing, if finalized, would be effective for plan years beginning on or after January 1, 2020.

Cost sharing requirements and drug manufacturers' coupons

CMS proposes that the amounts paid toward cost sharing using any form of direct support offered by drug manufacturers (for example, coupons) to insured patients to reduce or eliminate immediate out-of-pocket costs for specific prescription brand drugs that have a generic equivalent are not required to be counted toward the annual limitation on cost sharing.

CMS proposes that this cost sharing restriction, if finalized, would apply for plan years beginning on or after January 1, 2020.

1/22/2019