Proposed HHS Notice of Benefit and Payment Parameters for 2020
Fact Sheet

In the HHS Notice of Benefit and Payment Parameters for 2020 proposed rule released today, CMS proposes standards for issuers and Exchanges, which would be generally effective for plan years beginning on or after January 1, 2020.

Overall, the proposed rule minimizes the number of significant regulatory changes to provide states and issuers with a more stable and predictable regulatory framework that facilitates a more efficient and competitive market. The changes proposed in the rule are targeted to further the goals of lowering premiums, enhancing the consumer experience, increasing market stability, and reducing regulatory burdens.

The actions in this proposed rule build on other steps CMS has taken to strengthen the health insurance markets and expand consumer choice including the 2017 Market Stabilization Rule which focused on improving the risk pool by encouraging individuals to maintain continuous coverage, as well as the 2019 Payment Notice rule that gave states a set of new tools to stabilize their health insurance markets.

Exchange and Qualified Health Plan (QHP) Provisions:

Direct Enrollment
Direct enrollment (DE) is a mechanism for QHP issuers and web brokers to enroll QHP applicants through a non-Exchange website in a manner considered to be through the Exchange. DE was created to provide consumers with different options to shop for and enroll in QHPs offered through Exchanges. For plan year 2019, CMS is implementing an enhanced DE pathway, which will allow approved DE partners to host the Exchange eligibility application and enrollment service for QHP applicants on their non-Exchange websites without redirecting to HealthCare.gov. We also proposed streamlining and updating DE requirements to better address the complex and evolving nature of DE and to accommodate innovation, promote fair competition, and ensure program integrity.

Navigator Program
We proposed providing more flexibility related to the duties and training requirements for Navigators operating in Federally-facilitated Exchanges (FFEs) by: streamlining 20 existing specific training topics into four broad categories; and making post-enrollment duties for FFE Navigators permissible, but not required.

Prescription Drug Benefit
In furtherance of the Administration's priority to reduce prescription drug costs and to align with the President's American Patients First blueprint, we are proposing a series of changes to the prescription drug benefit, to the extent permitted by applicable state law, that are designed to encourage enrollees' use of lower-cost drugs. These proposals include allowing individual market, small group market, and large group market health insurance issuers to adopt mid-year formulary changes to incentivize greater enrollee use of lower-cost generic drugs; and allowing such issuers and self-insured group health plans to except certain cost-sharing from the maximum out-of-pocket limit if a consumer selects a brand drug when a medically appropriate generic drug is available, and to except drug manufacturer coupons for specific prescription brand drugs that have a generic equivalent from the maximum out-of-pocket limit.

Segregation of Funds for Abortion Services

To the extent that potential enrollees are discouraged from enrolling in QHPs because all plans available in their service area cover non-Hyde abortion services, we wish to offer them additional plan options to encourage QHP enrollment. Therefore, we propose that, beginning with the 2020 plan year, QHP issuers that provide coverage of non-Hyde abortion services in one or more QHPs must also provide at least one "mirror QHP" that omits coverage of non-Hyde abortion services throughout each service area in which it offers QHP coverage with non-Hyde abortion services through the Exchange, to the extent permissible under state law.

Silver Loading

We included language alerting stakeholders that the Administration supports a legislative solution that would appropriate CSR payments and end silver loading. In the absence of Congressional action, we seek comment on ways in which HHS might address silver loading, for potential action in future rulemaking not sooner than plan year 2021.

Payment Parameter Provisions:

Risk Adjustment

In order to continue our efforts to use data from issuers' individual and small group populations, for the 2020 benefit year, we propose recalibrating the risk adjustment models using a blended average from 2017 MarketScan® data and 2016 and 2017 enrollee-level EDGE data. This is consistent with prior years' recalibrations, as it uses three years of the most recent data available. It also continues our efforts to recalibrate the risk adjustment models using actual data from issuers' individual and small group populations and it continues our transition away from the MarketScan® commercial database that approximates individual and small group market populations.

Risk Adjustment State Flexibility

HHS received a request to reduce risk adjustment transfers for the Alabama small group market for the 2020 benefit year by 50 percent, and we seek comment on this request.

Risk Adjustment Data Validation (RADV) Audits

RADV audits are performed to validate the accuracy of the diagnosis codes submitted by issuers for the risk adjustment transfer calculation. In this rule, we propose various approaches for HHS to incorporate prescription drugs into risk adjustment data validation processes. We also propose to codify the existing exemptions to HHS-RADV for issuers under the materiality threshold as defined by HHS (currently $15 million in total annual premiums) and for issuers with under 500 billable member months. We also propose a new exemption from HHS-RADV for issuers in liquidation or entering liquidation if certain criteria are met. Finally, we also propose policies related to the application of issuer risk score error rates when issuers leave a market or when an issuer joins a previously single-issuer market.

RADV Initial Validation Audit Sample Size

In order to further increase the predictability and accuracy of the RADV program and incorporate feedback from stakeholders, we seek comments on a proposed approach and solicit comment on several different approaches to refine the initial validation audit sample size. The current enrollee

sample size selected for the initial validation audit is 200 enrollees for each issuer's Health Insurance Oversight System (HIOS) ID. The current 200 enrollee sample size is based on sample size precision analyses using proxy data from the Medicare Advantage program. Beginning with the 2019 benefit year of RADV, we propose to vary the initial validation audit sample size and outline several different approaches that would do so based on issuer characteristics, such as issuer size and/or prior year HCC failure rates. For example, to account for the possibility of large variation in HCC failure rates, we propose to increase the precision of initial validation audit samples above 200 enrollees for issuers with high HCC failure rates. We also propose to require a minimum sample size of 400 enrollees for large issuers (defined as an issuer with 50,000 or more enrollees calculated statewide based on the benefit year being validated), as we believe that more precise measurements of variability in larger samples could significantly influence our calculation of average HCC failure rates, and that larger issuers will be less sensitive to the increased burden. Additionally, in response to comments we received on the 2019 Payment Notice from issuers that believed that larger sample sizes would improve their RADV results, we solicit comment on whether to allow issuers of any size and sample precision to request a larger sample size before the initial validation audit for the applicable benefit year commences, with the understanding that issuers requesting a larger sample size must adhere to RADV timelines.

Federally-facilitated Exchange (FFE) and State-based Exchanges on the Federal Platform (SBE-FP) User Fees

For the 2020 benefit year, we propose to lower the user fee rate from 3.5 percent to 3.0 percent of premium for qualified health plans sold on the FFEs, and to set the user fee for qualified health plans sold on SBE-FPs at 2.5 percent, down from 3.0 percent of premium for the 2019 benefit year.

Premium Adjustment Percentage

Section 1302(c)(4) of the PPACA requires the Secretary to provide an annual update to the proposed premium adjustment percentage, which drives several other PPACA calculations including the maximum annual limitation on cost sharing, the required contribution percentage used to determine whether individuals over the age of 30 qualify for an affordability exemption which would enable them to enroll in catastrophic coverage, and the assessable employer shared responsibility payment. The premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013. We propose to change the premium index for the 2020 benefit year to use CMS Office of the Actuary (OACT) estimates of projected private individual and group market health insurance premiums (excluding expenditures for Medigap and property and casualty insurance), instead of using employer-sponsored insurance premiums which were used for prior benefit years. Based on the proposed change in the premium index, we propose a premium adjustment percentage of 1.2969721275, which is an increase in private individual and group market health insurance premiums of approximately 29.7% over the period from 2013 to 2019.

Maximum Annual Limitation on Cost Sharing

Using the proposed premium adjustment percentage of 1.2969721275 for 2020, and the 2014 maximum annual limitation on cost sharing of $6,350 for self-only coverage which was published by the IRS on May 2, 2013, we propose a maximum annual limitation on cost sharing of $8,200 for self-only coverage and $16,400 for other than self-only coverage for the 2020 benefit year. This represents an

approximately 3.8% increase above the 2019 parameters of $7,900 for self-only coverage and $15,800 for other than self-only coverage.

Reduced Maximum Annual Limitation on Cost Sharing

The proposed reduced maximum annual limitation on cost sharing is a PPACA-required annual calculation to reduce maximum out-of-pocket costs for individuals enrolled in the various cost-sharing reduction plan variations by the amount prescribed in statute. We propose that the 2020 reduced maximum annual limitation on cost sharing be $2,700 for self-only coverage and $5,400 for other than self-only coverage for individuals with household incomes between 100-200% of the Federal poverty level (FPL), and $6,550 for self-only coverage and $13,100 for other than self-only coverage for individuals with household incomes between 200-250% FPL.

Required Contribution Percentage

An individual is exempt from the requirement to have minimum essential coverage (MEC) if the amount that he or she would be required to pay for MEC (the required contribution) exceeds a particular percentage (the required contribution percentage) of his or her projected household income for a year. The required contribution percentage is used to determine whether individuals over the age of 30 qualify for an affordability exemption which would enable them to enroll in catastrophic coverage. For plan years after 2014, the required contribution percentage is the percentage determined by HHS that reflects the excess of the rate of premium growth between the preceding calendar year and 2013, over the rate of income growth for that period. We propose a required contribution percentage for 2020 of 8.39 percent, an increase of 0.09 percentage points from 2019 (8.39042 – 8.30358).

Eligibility and Enrollment Provisions:

Special Enrollment Periods (SEPs)

We proposed to create a special enrollment period (SEP), at the option of the Exchange, for off-Exchange enrollees who experience a decrease in household income and are newly determined to be eligible for advance payments of the premium tax credit (APTC) by the Exchange.

Exemptions

We proposed to amend existing regulations to allow individuals to claim hardship exemptions within the categories described in §155.605(d)(1) through the tax filing process without having to obtain an exemption certificate number from an Exchange.

Automatic Re-enrollment

We are seeking comment on the automatic re-enrollment processes and capabilities as well as additional policies or program measures that would reduce eligibility errors and potential government misspending for potential action in future rulemaking not sooner than plan year 2021.