

## **Final HHS Notice of Benefit and Payment Parameters for 2020 Fact Sheet**

In the HHS Notice of Benefit and Payment Parameters for 2020 final rule released today, the Centers for Medicare and Medicaid Services (CMS) finalizes standards for issuers and Exchanges, which would be generally effective for plan years beginning on or after January 1, 2020.

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

The actions in this final rule build on other steps CMS has taken to strengthen 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 that gave states a set of new tools to stabilize their health insurance markets.

### ***Lowering Premiums***

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

For the 2020 benefit year, we finalized lowering the user fee rate for qualified health plans (QHPs) sold on the Federally-facilitated Exchanges (FFE) from 3.5 percent to 3.0 percent of premium, and lowering the user fee rate for QHPs sold on State-based Exchanges that used the Federal platform (SBE-FPs) from 3.0 percent to 2.5 percent of premiums.

#### **Prescription Drug Provisions**

In furtherance of the Administration's priority to reduce prescription drug costs and to align with the President's American Patients First blueprint, we finalized a change to the prescription drug benefit, to the extent permitted by applicable state law, which is designed to encourage enrollees' use of lower-cost generic drugs. Beginning in 2020, we will allow individual market, small group, large group and self-insured group health plans to except from the maximum out-of-pocket limit cost sharing amounts paid using drug manufacturer coupons for specific prescription brand drugs that have an available and medically appropriate generic equivalent.

### ***Increased Market Stability***

#### **Silver Loading**

We summarized comments on ways in which HHS might address silver loading in the absence of Congressional action appropriating funds to pay issuers for cost-sharing reductions (CSRs). As we did not propose any changes to silver loading in the proposed rule, we are not finalizing a policy related to silver loading, and will take the comments received into consideration in future policymaking.

## **Final HHS Notice of Benefit and Payment Parameters for 2020 Fact Sheet**

### **Automatic Re-enrollment**

We summarized the comments 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. We are not making any changes with respect to these processes in this rule.

### **Risk Adjustment**

To continue our efforts to use data from issuers' individual and small group populations that more closely reflects the relative risk differences in these markets and also maintain stability in factors year-over-year, we finalized recalibrating the risk adjustment models for the 2020 benefit year using a blended average from 2015 MarketScan® data and 2016 and 2017 enrollee-level EDGE data. This is consistent with prior years' recalibrations, as it uses a consecutive three years of data. It also continues our efforts to recalibrate the risk adjustment models using actual data from issuers' individual and small group populations and our transition away from the MarketScan® commercial database that approximates individual and small group market populations.

### **Risk Adjustment State Flexibility**

The final rule announces HHS' approval of Alabama's request to reduce risk adjustment transfers for the small group market for the 2020 benefit year by 50 percent.

### **Risk Adjustment Data Validation (RADV)**

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 finalized a number of provisions to improve the audits and provide issuers with more certainty. We finalized incorporating prescription drugs into RADV as a method of discovering materially incorrect EDGE data submissions and will pilot the process of including prescription drugs into RADV for the 2018 benefit year. We also codified the existing exemptions to RADV for issuers under the materiality threshold as defined by HHS (currently, \$15 million in total annual premiums in the state) and for issuers with under 500 billable member months on a statewide basis. We finalized a new exemption from RADV for issuers in liquidation if certain criteria are met. We finalized policies related to the application of issuer risk score error rates when an issuer exits all markets in a state or joins a previously single-issuer market. Finally, we are not changing the RADV error estimation methodology for the 2017 or 2018 benefit years of RADV, but we are delaying the reporting, collection and payment of the RADV adjustments to risk adjustment transfers and the default data validation charges and allocations. Specifically, for the 2017 benefit year RADV, results will continue to apply to 2018 benefit year risk scores, but those results and the 2017 default data validation charges and allocations will not be published until August 1, 2019. In addition, we will not begin collection or distribution of 2017 RADV adjustments or default data validation charges until calendar year 2021. The purpose of the updated timeline is to provide issuers more options to account for RADV impacts in their rates, thus relieving issuers of the task of trying to estimate these transfers without sufficient information. Additionally, to provide more time for issuers in future years, we intend to seek comments on updates to the timeline for the initial and second validation audits to provide more time for medical records collection during the initial validation audit (IVA) and more time for the completion

**Final HHS Notice of Benefit and Payment Parameters for 2020**  
**Fact Sheet**

of the second validation audit. Additionally, we will operate the 2017 benefit year RADV as a pilot year for Massachusetts issuers, and as such there will be no adjustments to 2018 risk scores or risk adjustment transfers in Massachusetts based on the 2017 RADV.

**RADV Initial Validation Audit Sample Size**

HHS will not increase the IVA sample size at this time, but we intend to revisit these proposals after results from the first non-pilot year of RADV are available and following further consultation with stakeholders. However, we finalized allocating the 10<sup>th</sup> stratum of enrollees in the IVA sample using the Neyman allocation approach. We believe that this would effectively create an increase in the size of the sample actually available to validate the HCCs submitted to the EDGE servers. We also believe this would optimize issuers' IVA, by making it more robust than the one-third/two-thirds approach currently used in the IVA sample.

**Premium Adjustment Percentage**

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 finalized the proposal 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). In the 2015 Payment Notice, we proposed a similarly comprehensive premium index, but finalized a premium index that reflected only employer-sponsored group market health insurance premiums because it reflected trends in health care costs without being skewed by individual market premium fluctuations due to the early implementation of the PPACA market reforms. As we are now past the initial years of implementation, we believe this change to the premium index reflects a more comprehensive and accurate measure of premium costs across the private market. Based on the proposed change in the premium index, we finalized a premium adjustment percentage of 1.2895211380, which is an increase in private individual and group market health insurance premiums of approximately 28.9 percent over the period from 2013 to 2019.

**Maximum Annual Limitation on Cost Sharing**

Using the premium adjustment percentage of 1.2895211380 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 finalized a maximum annual limitation on cost sharing of \$8,150 for self-only coverage and \$16,300 for other than self-only coverage for the 2020 benefit year. This represents an approximately 3.16 percent 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 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 (CSR) plan variations by the amount prescribed in statute. The 2020 benefit year reduced maximum annual

**Final HHS Notice of Benefit and Payment Parameters for 2020**  
**Fact Sheet**

limitation on cost sharing will be \$2,700 for self-only coverage and \$5,400 for other than self-only coverage for individuals with household incomes between 100-200 percent of the Federal poverty level (FPL), and \$6,500 for self-only coverage and \$13,000 for other than self-only coverage for individuals with household incomes between 200-250 percent FPL.

**Required Contribution Percentage**

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. The required contribution percentage for 2020 is 8.24 percent, a decrease of 0.07 percentage points from 2019 (8.23702 – 8.30358).

***Reducing Regulatory Burdens***

**Navigator Program**

We finalized providing more flexibility related to the duties and training requirements for Navigators operating in FFEs by streamlining 20 existing specific training topics into four broad categories and making certain types of assistance, including post-enrollment duties for FFE Navigators permissible, but not required.

**Exemptions**

We finalized an amendment to existing regulations to allow individuals to claim hardship exemptions described in §155.605(d)(1) through the tax filing process without having to obtain an exemption certificate number from an Exchange. This rule is effective only through the 2018 tax filing season.

***Enhancing Consumer Experience***

**Direct Enrollment**

Direct enrollment (DE) is a mechanism for QHP issuers and web brokers (DE partners) 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 implemented an enhanced DE pathway, which allows 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. For the 2020 plan year, we finalized several updates to the DE regulations to better address the complex and evolving nature of DE and to accommodate innovation, promote fair competition, and ensure program integrity.

**Special Enrollment Periods (SEPs)**

**Final HHS Notice of Benefit and Payment Parameters for 2020**  
**Fact Sheet**

We finalized the creation of a special enrollment period (SEP), available at the option of the Exchange, for persons enrolled in off-Exchange individual market coverage that qualifies as minimum essential coverage 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.

**Segregation of Funds for Abortion Services**

We continue to review the comments received on our proposal to require QHP issuers that provide coverage of non-Hyde abortion services in one or more QHPs to 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. We are not finalizing our proposal on this measure at this time.