Final Regulations – 2020 Notice of Benefit and Payment Parameters
April 22, 2019

On April 18, 2019, the Centers for Medicare and Medicaid Services (CMS) issued final regulations and related guidance on a number of Affordable Care Act (ACA) provisions and related health care topics including out-of-pocket (OOP) maximums, Essential Health Benefits (EHBs), the opioid epidemic, and Exchange updates and reforms. These regulations are generally effective for plan years beginning on and after Jan. 1, 2020.

2020 OOP maximums
The 2020 OOP maximums will increase to $8,150 for individual coverage and $16,300 for family coverage. These coverage limits apply to all non-grandfathered plans, regardless of size or funding type.

Prescription drug cost-sharing
Three prescription drug pricing-related provisions were included in the proposed rule issued on Jan. 17, 2019. Due to concerns submitted by commenters, CMS chose to only include one in the final rule. Beginning in 2020, plans are permitted, but not required, to exclude drug manufacturer coupons from counting toward a covered person’s annual OOP maximum if a medically appropriate generic drug is available. This applies to individual, small group, large group and self-funded plans, to the extent permitted by state laws.

Essential Health Benefits (EHBs)
Last year’s regulations gave states more flexibility in selecting EHB benchmark plans beginning with the 2020 plan year. Illinois was the only state to make changes for 2020. The deadline for notifying CMS of 2021 benchmark plan changes is May 6, 2019 and May 8, 2020 for the 2022 plan year.

As a reminder, any health plan that covers EHBs must cover these benefits with no annual or lifetime dollar maximums. This includes both fully insured and self-funded employer-sponsored plans.

Opioid addiction
The regulations encourage states to explore future EHB benchmark plan modifications that would be helpful in addressing the opioid epidemic.

They also encourage, but do not require, insurers to cover all four Medication-Assisted Treatment (MAT) drugs for treatment of opioid use disorder. Furthermore, HHS requires that if a plan excludes MAT for opioid use treatment, but covers it for other conditions, the insurer must justify the exclusion and explain how the benefit design is not discriminatory.
Exchange regulations
The final rule also includes a number of provisions that impact the Health Insurance Exchanges effective Jan. 1, 2020. They include:

- Making a technical change in how subsidies are calculated, which is projected to raise premium costs for some customers and potentially reduce enrollment.

- Maintaining the practice of “silver loading,” which allows insurers to load premium increases into silver-level Exchange plans to make up for the loss of cost-sharing reduction (CSR) payments. Silver loading also increases subsidy amounts available to eligible enrollees in those plans. In the proposed rule, CMS asked for input on whether and how it should end the practice beginning in 2021.

- Creating a new special enrollment period for consumers who are enrolled in individual market coverage off-Exchange who become eligible for subsidies due to a mid-year decrease in income.

- Reducing the user fee for qualified health plan (QHP) issuers by 0.5% on the Federally Facilitated Exchange and state-based Exchanges using the Federal platform. Since this fee is typically included in premiums, this may result in small premium reductions.

- Providing greater flexibility related to Navigator duties, removing certain required functions and requiring fewer trainings.

- Introducing greater flexibility and more oversight for web brokers who facilitate direct enrollment in Exchange plans outside of HealthCare.gov.

- Updating the risk adjustment program for insurers with high-cost enrollees.

Review the information at these links for additional details:

- [Read the Final Regulations](#)
- [Read the HHS Fact Sheet](#)