2019 HHS Notice of Benefit and Payment Parameters
Children’s Hospital Association Summary

On April 9, 2018, the Centers for Medicare & Medicaid Services (CMS) released its final 2019 Notice of Benefit and Payment Parameters (Notice). This annual rule sets standards for qualified health plans (QHPs) in the federally facilitated Exchanges. In some instances, the notice will also impact state-based Exchanges, the individual and small group markets outside of the Exchanges, and the large group market.

KEY PROVISIONS WITH IMPLICATIONS FOR CHILDREN’S HEALTH CARE

CHA submitted joint comments with allied children’s and disabilities organizations on the provisions of the Proposed Notice with implications for children’s health and health care. The final Notice and supporting guidance do not reflect most of the joint comments.

Key provisions of the Notice with potential implications for children include:

- **Increased state and insurer flexibility to determine the essential health benefits (EHBs).** The Notice changes the EHB benchmark process to provide states and insurers more flexibility in the design of their EHBs.  
  **Comments:** We warned CMS that these changes to the EHB process could leave children, particularly those with serious, chronic or complex conditions, worse off and their families with higher out-of-pocket costs, and urged CMS to reconsider this approach.

- **A shift in responsibility from CMS to the states for the review of network adequacy in plans sold through the federally facilitated Exchanges (FFE).** The Notice shifts responsibility from CMS to the states for network adequacy reviews of QHPs in the FFEs, but retains the Affordable Care Act’s (ACA) “reasonable access” network adequacy standard for the plans. State-based Exchanges retain their role in reviews.  
  **Comments:** We urged CMS to retain a federal role in plan network adequacy oversight and assessment by, at a minimum, maintaining the current regulatory requirements. The absence of a federal minimum set of standards for provider networks could lead to a patchwork of state standards and processes and reduce children’s access to needed pediatric specialty care.

- **A reduction in the minimum percentage of available essential community providers (ECPs) that must be in a QHP network.** The threshold for plan years 2019 and beyond is reduced from 30 percent to 20 percent.  
  **Comments:** We opposed any reduction of the ECP participation standard as it weakens the ECP contracting requirements, and could reduce the likelihood that a plan will contract with an ECP children’s hospital, impeding access for the vulnerable children that ECP children’s hospitals serve.

- **A new special enrollment period (SEP) for pregnant women who lose their pregnancy-related Children’s Health Insurance Program (CHIP) coverage following the birth of their child.** The Notice clarifies that women who will lose their pregnancy-related CHIP coverage can qualify, along with their newborn for an SEP. The Notice also allows the mother and newborn to enroll in the same QHP.

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Comments: We supported the SEP for women with pregnancy-related CHIP coverage.

DETAILED SUMMARY OF PROVISIONS WITH IMPLICATIONS FOR CHILDREN

The following summary addresses updated, revised or new policy guidance for plan year 2019 that was included in the Notice and supporting materials and affects children’s health.

Key Dates
- June 6, 2018: Initial QHP application deadline
- June 21 – Sept. 10, 2018: CMS review of QHP applications
- Sept. 17, 2018: CMS posts list of approved plans
- Nov. 1 – Dec. 15, 2018: Open enrollment for Plan Year 2019

Maximum Annual Limitation on Cost-Sharing for Calendar Year 2019
The maximum out-of-pocket limit on cost-sharing is increased by 7 percent above the 2018 out-of-pocket maximum to:
- Self-only coverage: $7,900
- Family coverage: $15,800

Essential Health Benefits – New State and Insurer Options
The Notice gives states new flexibility to update or change their EHB benchmark plan\(^1\) annually, beginning with plan year 2020. States may choose to retain their 2017 EHB benchmark.
- States that want to change their benchmark can use one of three options:
  - Adopt the benchmark used by any other state in 2017.
  - Retain their 2017 EHB benchmark, but replace one or more benefit categories of the benchmark with the same benefit category from another state’s benchmark plan.
  - Create a completely new EHB benchmark.
- States that change their benchmark must:
  - Ensure that their new benchmark does not exceed the scope/generosity (as certified by an actuary) of a “typical” employer plan. The Notice allows the state to choose among several employer plans to use as the comparison:
    - One of the benchmark plan options from 2017.

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\(^1\) The state’s benchmark plan serves as a reference for the EHBs that plans in the individual and small group markets must cover. Prior to the 2019 Notice, states were required to choose a benchmark plan from among four different plan types: 1) the largest (by enrollment) plan in any of the three largest small group insurance products in the state’s small group market; 2) any of the largest (by enrollment) three state employee health benefit plans; 3) any of the largest (by enrollment) three national Federal Employees Health Benefits Program (FEHBP) plan options; or 4) the largest insured commercial non-Medicaid health maintenance organization operating in the state. In states that do not select a benchmark plan, the “default plan” (the largest plan by enrollment in the largest product in the state’s small group market) serves as the benchmark.
One of the five largest group health insurance plans in the state by enrollment so long as the plan is from 2014 or later; has at least 10 percent of total enrollment among those plans; provides minimum value (as defined in the ACA); and is a major medical plan.

- Supplement the benchmark if it does not provide coverage of all 10 EHB categories.
- Ensure that the benchmark has an appropriate balance of coverage between the 10 EHB categories so benefits are not unduly weighted toward a particular category.
- Ensure that the benchmark provides benefits for women, children, individuals with disabilities and other vulnerable populations. The Notice does not specify the types or scope of those benefits.

States can choose to allow issuers to substitute benchmark benefits between the EHB categories as long as the substituted benefit is actuarially equivalent to the benefit it replaced.\(^2\)

- The Notice does not change other rules regarding benefits substitution, including a prohibition on substitutions affecting prescription drug benefits.
- States can enforce their own rules regarding benefit substitution, including a prohibition of the practice.

### Network Adequacy

The Notice gives states the responsibility for network adequacy reviews of QHPs in the federally facilitated Exchanges in 2019 and beyond. This shift to the states was put into place for plan year 2018 in the April 2017 [Market Stabilization Rule](#). The Notice makes the shift permanent and provides an overall basic framework for state oversight.

- The underlying definition of network adequacy in the ACA and subsequent rulemaking is unchanged. QHPs are required to have “sufficient numbers and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.”\(^3\)

- States are not required to use any specific metrics (e.g. time and distance, etc.) in their network adequacy reviews.

- If a state does not have the authority or capacity to assess whether a plan’s network meets the statutory and regulatory “reasonable access” standard, CMS will rely on issuers’ commercial or Medicaid accreditation from a recognized accrediting entity (NCQA, URAC, etc.) or an issuer’s access plan as the indicator that the issuer has met the network adequacy requirements.

- Issuer access plans must demonstrate that the issuer has a process in place to maintain an adequate network consistent with the [National Association of Insurance Commissioners’ Model Network Adequacy Act](#).

- CMS will coordinate with states to monitor network adequacy through complaint tracking.

- CMS will continue its network breadth pilot program, which provides consumers with information on the breadth of QHP provider networks and identifies integrated delivery systems that meet certain care coordination criteria.

  - The system compares breadth of networks in the same geographic area.

    - In 2019, comparisons will be conducted within counties, rather than within types of counties, such as urban, rural, suburban, etc.

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\(^2\) Previously, issuers were only allowed to substitute benefits within an EHB category. Cross-category substitution was prohibited out of concerns that it would make it more challenging for consumers to compare plans and could result in discriminatory plan design.

\(^3\) States with state-based Exchanges can use stronger standards.
Networks are labelled “Standard,” “Broad” or “Basic,” based on a calculation of the percentage of in-network providers (hospitals, adult primary care, and pediatric primary care) compared to the total number of providers in all QHP networks in that county.

- The program is being piloted in Maine, Ohio, Tennessee, and Texas.

**Essential Community Providers**

- Insurers must include 20 percent of all available ECPs in a QHP network, rather than 30 percent as required under the Obama administration. The 20 percent threshold will apply to plan years 2019 and beyond.\(^4\)
  - Only ECPs that are listed in the federal ECP database count towards the 20 percent threshold. The database is updated every year via an on-line ECP petition.  
  - Issuers may “write in” ECPs that are in their networks, but are not in the federal ECP database. Those providers will count toward the 20 percent threshold if the provider submits a federal ECP petition to CMS before the submission deadline.

- All other aspects of ECP requirements articulated in statute and prior guidance remain in effect, including:
  - The definition of an ECP, which is based on eligibility for the 340B Drug Pricing Program and includes children’s hospitals.
  - The requirement that issuers make a “good faith” offer to at least one ECP in each of six categories. CMS retains the current categories of ECPs, which groups children’s hospitals with all other ECP hospitals.
  - The use of the annual ECP petition process to compile a list (database) of qualified ECPs with which plans can contract to meet the ECP contracting requirements.
  - The methodology to calculate whether an issuer has met the ECP threshold, which incorporates counts of hospital beds.

**Special Enrollment Periods**

- Pregnant women who will lose their pregnancy-related CHIP coverage following the birth of their child are eligible for a “loss of coverage” special enrollment period, which allows them to enroll in a QHP.

- The Notice clarifies that a new dependent can be enrolled in the current enrollee’s QHP or in a separate one.
  - Certain enrollees may change to another QHP with the same level of coverage (i.e. same metal tier) in order to be in the same plan as the new dependent.
    - In the event the enrollee’s plan does not allow the dependent to be added to that plan, both individuals can change to another plan with the same level of coverage or the dependent can be enrolled in a separate plan.

**Pediatric Dental Services**

The final Notice continues to require stand-alone dental plans to offer pediatric dental coverage, but eliminates the requirement that they cover those services at certain actuarial values.

- The plans must also comply with the annual limit on cost-sharing.

\(^4\) The April 2017 Market Stabilization Rule reduced the ECP minimum threshold to 20 percent for plan year 2018.
Review of Premium Rate Increases
The Notice changes the threshold that determines when an issuer’s proposed premium increase triggers a “reasonableness” review by CMS. The review looks at the underlying assumptions of the rate increase to assure they are evidence-based.

- Premium increases of greater than 15 percent (rather than 10 percent as required under prior guidance) will be subject to a review.

Medical Loss Ratio

- The Notice does not change the current medical loss ratio (MLR) of 80 percent in the individual and small group markets and 85 percent in the large group market, but allows states to request a reduction in the MLR to 70 and 75 percent, respectively. CMS assumes that 22 states will request a reduction.
- The Notice changes the standards for the calculation of the MLR to allow issuers to spend more on administrative costs rather than on benefits.