Final 2020 HHS Notice of Benefit and Payment Parameters
Children’s Hospital Association Summary
Internal

On April 18, 2019, the Department of Health and Human Services (HHS) released the final 2020 Notice of Benefits and Payment Parameters (Notice). This annual rule sets standards for qualified health plans (QHPs) in the federally facilitated Exchanges. In some instances, the notice also impacts state-based Exchanges, and the broader insurance markets outside of the Exchanges (individual, small group, and large group, including ERISA self-funded plans).

Key Provisions with Implications for Children’s Health Care

CHA submitted joint comments with allied children’s organizations on the provisions of the Proposed Notice with implications for children’s health and health care. Though the final Notice and supporting guidance do not reflect most of the joint comments, HHS did scale back its proposals aimed at incentivizing the use of generic, rather than brand-name, drugs in response to concerns regarding the potential negative impact on consumers.

Key provisions of the proposed Notice with implications for children, allied children’s organizations’ joint comments on those provisions, and HHS’ actions on those provisions in the final Notice include:

- **Proposed changes to the prescription drug benefit category of the essential health benefits (EHBs) to encourage consumers’ use of lower-cost, generic drugs, when available.**
  
  **Joint Comments:** We expressed strong concerns about HHS’ proposals to eliminate cost-sharing and annual and lifetime limit protections for brand-name drugs and to give insurers more flexibility to make mid-year formulary changes when a generic equivalent becomes available. We also recommended guardrails to better protect children’s health if HHS chose to finalize these proposed changes.
  
  **Final Notice:** HHS will not implement its proposed changes in response to strong concerns, expressed in comment letters, about their impact on consumers.

- **Continuation of the new state EHB selection process, established in the 2019 Notice, which gives states and insurers more flexibility in the design of the EHB benchmark plan and benefit package, beginning with plan year 2020.**

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1 The changes would apply to the individual, small group and large group insurance markets (including self-insured ERISA plans), which are subject to cost-sharing and annual and lifetime limit protections for covered benefits that are included in the essential health benefits package.

2 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. States that do not select a benchmark plan use the “default plan” (the largest plan by enrollment in the largest product in the state’s small group market).
**Joint Comments:** We urged HHS to reconsider this approach given our concerns that this new flexibility could leave children, particularly those with serious, chronic or complex conditions, worse off and their families with higher out-of-pocket costs.

**Final Notice:** HHS did not make any changes to its current policy.

- **Continuation of the new policy, established in the 2017 Notice, that shifts responsibility from CMS to the states for the review of network adequacy in plans sold through the federally facilitated Exchanges.**
  
  **Joint Comments:** We urged CMS to restore the federal role in plan network adequacy oversight and assessment and expressed our concerns that the absence of a federal minimum set of network standards could lead to a patchwork of state standards and processes, reduce children’s access to needed pediatric specialty care, and leave families with high out-of-pocket expenses when they must seek out-of-network care for their child because there is no appropriate in-network provider.

  **Final Notice:** HHS did not make any changes to its current policy.

- **Elimination of the requirement that Navigators provide post-enrollment counseling and that Navigators receive training in post-enrollment activities.**
  
  **Joint Comments:** We asked CMS to retain the post-enrollment counseling responsibilities of Navigators.

  **Final Notice:** HHS finalized its proposed changes.

- **A change in the indexing methodology used to determine the amount of premium tax credits and the annual limit on out-of-pocket costs.**
  
  **Joint Comments:** We urged HHS to reconsider its proposed methodology change, which would result in higher premium costs for QHP enrollees and raise the out-of-pocket maximum for all commercial health plans (including ERISA self-funded plans). We noted that the higher out-of-pocket cap would be especially harmful for families of children with a serious, chronic or complex condition who require frequent health care interventions throughout the year.

  **Final Notice:** HHS finalized its proposed changes.

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**Detailed Summary of Provisions with Implications for Children’s Health Care**

**Key Dates for Plan Year 2020**

- June 19, 2019: Initial QHP application deadline
- June 20 – Aug. 2, 2019: CMS review of QHP applications
- Sept. 27, 2019: CMS posts list of approved plans
- Nov. 1 – Dec. 15, 2019: Open enrollment

**Prescription Drugs**

- **Drug discount coupons for brand-name drugs and cost-sharing limits** – Beginning in plan year 2020, HHS will allow individual, small group, large group and ERISA (self-insured) health plans to exclude drug manufacturer coupons from counting toward the annual cost-sharing limits when a medically appropriate generic drug is available. According to HHS, this provision is intended to promote prudent prescribing and
purchasing choices by physicians and patients based on the true costs of drugs, as well as price competition in the pharmaceutical market.

- The amount paid toward cost-sharing while using a drug manufacture coupon must be counted toward the annual cost-sharing limit when the enrollee is determined through an appeals or drug exception process to require a brand-name drug because the generic is not available or medically appropriate.
- HHS clarifies that “generic equivalent” drugs are defined under the Federal Food, Drug, and Cosmetic Act.

**Mid-year formulary changes** – HHS clarifies that all issuers (individual, small and large group, including ERISA self-insured plans) that make mid-year formulary changes, if allowed under state law, must provide reasonable advance notice of the removal, or change in cost-sharing tier of, a drug from the formulary.

- Affected individuals must have access to an appeals or exceptions process to gain access to a non-formulary drug when clinically appropriate and not otherwise covered by the health plan.

**EHB Benchmark Plan Selection**

HHS is maintaining the new state EHB selection process, which it established in the 2019 Notice and allows states to update or change their EHB benchmark plan annually, beginning with plan year 2020. States may also 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.

- The final Notice establishes May 6, 2019 as the deadline for states to submit amendments to their current EHB benchmark selections for the 2021 plan year and May 8, 2020 as the deadline for the 2022 plan year.

**Network Adequacy**

- HHS maintains its current approach, adopted for plan year 2018, which gives states the responsibility for network adequacy reviews of QHPs in the federally facilitated Exchanges. Under this approach:
  - A plan’s network is adequate when it meets the “reasonable access” standard, as defined in the ACA and subsequent regulations.

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3 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. States that do not select a benchmark plan use the “default plan” (the largest plan by enrollment in the largest product in the state’s small group market).

4 The EHB benchmark submission deadline for plan year 2020 was July 18, 2018. HHS notes in the final Notice that the earlier deadline would give issuers more time to develop benchmark compliant plan designs. States must comply with public notice and comment requirements.

5 HHS made this change for plan year 2018 through the April 2017 Market Stabilization Rule and then continued it for 2019 and beyond in the 2019 Notice.

6 QHPs must have a provider network that has “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.” States with state-based Exchanges can use stronger standards.
States are not required to use any specific metrics (e.g. time and distance, etc.) in their assessments. 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, HHS will rely on issuers’ commercial or Medicaid accreditation from a recognized accrediting entity (NCQA, URAC, etc.) as the indicator that the issuer has met the network adequacy requirements. Unaccredited issuers are required to submit an access plan to HHS that demonstrates that they have a process in place to maintain an adequate network consistent with the NAIC Model Network Adequacy Act. HHS will coordinate with states to monitor network adequacy through complaint tracking.

**Out-of-Network Cost-sharing**

HHS maintains the current cost-sharing requirements for QHPs, established in the 2018 Notice, when an EHB service is provided at an in-network facility by an out-of-network practitioner (e.g., anesthesiologist, radiologist, etc.).

- These requirements allow insurers to choose whether to:
  - Count cost-sharing paid by the enrollee toward the enrollee’s annual out-of-pocket limit; or
  - Provide written notice to enrollees that additional out-of-pocket costs may be incurred for services provided by an out-of-network provider in an in-network setting.

- These requirements apply to plans in the small and individual markets on and off the Exchange, regardless of whether the plan covers out-of-network services.
- This provision does not affect balance billing, but more protective state “surprise billing” requirements supersede these requirements.

**Essential Community Providers**

HHS maintains all aspects of current essential community provider (ECP) standards and procedures, including:

- The 20 percent minimum threshold for the percentage of available ECPs that must be in a QHP network.7
- The definition of ECPs, 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. HHS does not propose any changes to the current categories, which groups children’s hospitals with all ECP hospitals.
- The use of an annual ECP petition process to compile a list (database) of qualified ECPs with which plans can contract to meet the ECP contracting requirements.

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7 The April 2017 Market Stabilization Rule reduced the ECP minimum threshold to 20 percent for plan year 2018 and the 2019 Notice extended it to 2019 and future years.
• The methodology to calculate whether an issuer has met the ECP threshold, which incorporates counts of full-time equivalents and beds.

Premium Subsidies and Maximum Annual Limitation on Cost-Sharing

HHS is changing the indexing methodology it uses to determine the amount of premium tax credits and the annual limit on out-of-pocket costs. As a result, premium tax credit amounts will decrease and premiums will increase for QHP enrollees. The methodology change will also raise the annual out-of-pocket maximum, more than under the current methodology, for all enrollees of plans in the individual, small and large group (including ERISA self-insured) markets.

• The maximum out-of-pocket limit in 2020:
  – Self-only coverage: $8,200
  – Family coverage: $16,400

Navigators

The final Notice gives Exchanges more flexibility in the requirements for Navigators, by making post-enrollment counseling an option for Navigator programs, rather than a requirement, and reducing Navigator training requirements.

Health Care Cost Transparency

HHS noted in the proposed rule that it is considering ways it can improve consumers’ access to information about health care costs. The agency sought comments on these approaches as well as existing regulatory barriers to private sector initiatives on cost transparency. Specifically, HHS asked for input on:

• Whether to require insurers to disclose a consumer’s anticipated costs for services within a certain time-frame.
• Whether to require insurers to disclose anticipated costs for a number of common services and coverage scenarios.
• The types of data that would be most useful to consumer’s health care decision-making.
• Ways to improve consumers’ access to information about health care costs.

In the final rule, HHS notes that commenters were generally supportive of efforts to increase price transparency, but did not move forward with any policy change in this final Notice.

For more information, contact Jan Kaplan.