Responding to the 2019 Notice of Benefit and Payment Parameters

Overview

The Notice of Benefit and Payment Parameters, or payment notice, is a rule published annually by the Center for Medicare and Medicaid Services (CMS). It establishes requirements for the individual and small group insurance markets under the Affordable Care Act (ACA), including the ACA’s state health insurance marketplaces. The notice typically clarifies the protections and market reforms that apply to qualified health plans (QHPs) and stand-alone dental plans (SADPs). The final rule, published in April, made significant changes to how the ACA’s essential health benefits (EHBs) are treated. It may impact the services required to be covered by insurance plans sold on the marketplaces in upcoming plan years.

Key Changes in the Payment Notice

• **New standards for EHBs:**
  States may now change EHB benchmarks annually and can choose from new options to redefine what services insurers must cover. This could lead states to weaken their pediatric dental benefit requirements. States can now define their EHBs by:

  1. Adopting another state’s EHB benchmark package in its entirety
  2. Adopting individual categories of EHB services from another state’s EHB benchmark
  3. Adopting a “typical employer plan” as their EHB benchmark. However, this rule broadens the definitions of a “typical” plan, which could allow states to choose less common and less comprehensive private plans than has been the standard.

  Any of these options could allow a state to adopt EHB benchmarks that do not meet the needs of children and families (e.g. Utah’s EHB benchmark plan provides for limited pediatric dental coverage). In addition, this rule also prevents states from adopting EHB benchmarks that are more generous than their 2017 standards.

• **Eliminating actuarial value (AV) standards for stand-alone dental plans (SADPs):**
  To date, ACA rules required SADPs to offer “low” and “high” AV plans that, on average, covered 70% and 85% of the cost of covered care, respectively. The payment notice removes these AV standards, which could inhibit consumers’ ability to understand and compare their dental plan options.

• **Eliminating “standard plan” options for federally-facilitated marketplaces:**
  “Standardized options” outlined in previous payment notices can make plan selection easier by establishing insurance packages in each of the marketplace tiers (i.e., bronze, silver, etc.) that meet certain benefit structure and cost-sharing requirements. In addition, some state-based marketplaces (like California, Connecticut, Maryland and DC) incorporated pediatric dental coverage into standardized plans to maximize enrollment and affordability. Without these options, families may
struggle to understand, compare, and determine what plan will best meet their children’s oral and overall health needs.

- **Ending the “meaningful difference” requirement:**
  In addition, this rule eliminates an ACA guideline that required marketplaces to make it as easy as possible for consumers to understand major differences between plans. Removing this protection, the rule leaves families with less support to understand their plan options.

**Other changes of concern:**

1. Reduces federal oversight of marketplace network adequacy standards
2. Reduces the percentage of essential community providers (e.g., community health centers and children’s hospitals) that each plan must have in their network
3. Removes requirements for consumer assistance (i.e., navigator) organizations, including requirements for number, non-profit status, and in-state availability.

**Tips for advocates and opportunities for action**

The changes listed above are federal guidelines, but states can choose to maintain or improve standards for plans sold within their marketplaces. Below are efforts that advocates should watch for and ideas to take action. Overall, now is a critical time to communicate the value of oral health coverage for children and families to state decision makers.

1. **Watch for efforts to make changes to EHBs and engage in the conversation.**
   - Mark your calendar and start mobilizing. Any changes to EHB benchmarks for 2020 must be submitted to CMS by July 2, 2018.
   - Reach the right people. Urge health insurance marketplace decision-makers, such as exchange boards, governors, and state insurance commissioners, to ensure that any review or changes to EHB benchmarks do not weaken dental coverage requirements.
   - Weigh in during comment periods. The rule requires that changes be posted on “a relevant State website” and that states offer “reasonable public notice and opportunity for public comment.”

2. **Keep working with exchange boards and governors to promote the value of standard plan designs that integrate comprehensive pediatric dental coverage and protect families from high deductibles.**

3. **Continue pushing for greater transparency and support for consumer education, especially around differences in the value of oral health plans, including SADPs.**

4. **Work with partner organizations to bolster consumer assistance efforts.** Help families understand the value of their coverage options. For more information on shopping for pediatric dental coverage in the marketplace, see this resource by CDHP and Families USA.