STATE OF MAINE
DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
BUREAU OF INSURANCE

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# Bulletin 477

## Highlights of the 2025 Federal Notice of Benefit and Payment Parameters

The U.S. Department of Health and Human Services (HHS) issued its *Notice of Benefit and Payment Parameters for 2025 (2025 NBPP)* final rule on April 2, 2024. The purpose of this bulletin is to discuss key provisions in the 2025 NBPP that affect plans offered in Maine.

### Network Adequacy

For plan years beginning on or after January 1, 2026, Qualified Health Plans (QHPs) offered on state-based Marketplaces such as CoverME.gov must meet the same quantitative time and distance standards that HHS requires of QHPs offered on federally facilitated Marketplaces.[1]

- The Bureau of Insurance (BOI) will use the five county type designations, based on population and density, established by the HHS Centers for Medicare and Medicaid Services (CMS): Large Metro, Metro, Micro, Rural, and Counties with Extreme Access Considerations (CEAC).[2] BOI will also use CMS's standards for two types of primary care (adult and pediatric), 32 specialties, and 11 facility types.
- QHPs must provide reasonable access, meeting the applicable time and distance standards unless an exception is granted, to at least one provider of each specialty type for at least 90% of consumers within each county in the service area. These providers must offer in-person services.
- BOI will conduct network adequacy reviews before certifying plans as QHPs. Per federal rules, the BOI will no longer accept a carrier's attestation that a plan complies with network adequacy standards. Carriers requesting an exception must submit justifications for failing to meet a particular standard. BOI will review each justification based on local availability of providers and variables reflected in local patterns of care. The required justification elements are:
    - Why the standard was not met;
    - The frequency of monitoring for new providers in the area;
    - Sources used to identify new providers in the area;
    - Measures to ensure enrollee access;

[1] 45 CFR § 155.1050(a)(2), referencing 45 CFR §§ 156.230(a)(1)(ii), (1)(iii), (2)(i)(A), (2)(ii), (3), and (4).

[2] BOI will provide further guidance once an analysis of census data by county has been completed.

  - Number of enrollee access complaints, by provider type; and
  - The carrier's efforts to recruit additional providers;

- Carriers must submit information to the BOI for each network provider indicating whether the provider offers telehealth services. For each network provider, the carrier must report "yes," "no," or "requested information from the provider, awaiting their response."

- HHS will also require the BOI to impose time and distance standards for access to dentists in Stand-Alone Dental Plans (SADPs), unless BOI finds that at least 80% of Maine's counties (13 or more counties) have either: 1) a significant shortage of dental providers; 2) a significant number of dental providers unwilling to contract with carriers offering SADPs on the Marketplace; or 3) significant geographic limitations impacting consumer access to dental providers.

The BOI will be providing additional guidance regarding its network adequacy review process and data to be submitted by insurers.

## Prescription Drug Benefits

All prescription drugs covered by an individual or small group health plan, even if they are not covered in Maine's EHB-benchmark plan, are considered essential health benefits (EHBs) and therefore will be subject to the annual caps on cost-sharing and restrictions on annual and lifetime dollar limits, unless they are ineligible for EHB status because the coverage of the drug is mandated by state action and the drug is not covered in the EHB benchmark plan.

Carriers' Pharmacy & Therapeutics (P&T) Committees will now be required to have at least one patient representative who must:

- Represent the patient perspective;

- Have relevant experience or participation in patient or community-based organizations;

- Be able to demonstrate the ability to integrate data interpretations with practical patient considerations;

- Have no fiduciary obligations to a health facility or health agency, and no material financial interest in rendering health services;

- Have a broad understanding of one or more conditions or diseases, associated treatment options, and research; and

- Disclose financial interests on their conflict-of-interest statements.

## Essential Health Benefits

The 2025 NBPP has made several significant changes to the standards for state-by-state EHB-benchmark plan requirements that provide more state flexibility:

- Effective for Plan Year 2025, the requirement for states to defray the cost of certain mandated benefits will no longer apply to any benefits that are covered in the state's EHB-benchmark plan, regardless of when the state mandate was enacted.
- Effective for Plan Year 2027, CMS has repealed the existing "generosity" limit for state EHB-benchmark plans and merged it into the "typicality" requirement. Both the upper and lower limits for plan generosity will be set by the range of "typical employer plans" offered in the state that are eligible for selection as state benchmarks (supplemented by the state as necessary to provide coverage within each EHB category).
- Effective for Plan Year 2026, non-pediatric dental benefits may be included in a state's EHB-benchmark plan.

There is no change to the timetable for making changes to the EHB-benchmark plan. States that select new EHB-benchmark plans must still notify HHS by the first Wednesday in May in order for the change to take effect two calendar years later. This means that the deadline to make changes for Plan Year 2027 (the first year that is subject to the revised generosity limits) will be May 7, 2025. If one or more state mandated benefits are subject to the cost defrayal requirement, the state still has the obligation to identify those benefits and report them to CMS.

The BOI plans to submit an application to CMS to update the state's EHB-benchmark plan for coverage effective January 1, 2027.

**Other New Requirements for State-Operated Marketplaces**

In addition, the following new requirements that affect consumers will apply to CoverME.gov:

- The annual open enrollment period must start on November 1 and end no earlier than January 15; and
- A special enrollment period is available in any month in which the enrollee's projected annual household income does not exceed 150% of the federal poverty level ($46,800 for a family of four in 2024).

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