



Step Guide to Reviewing Your State's 2017 Essential Health Benefits Benchmark Plan

Prepared By: Michelle Lilienfeld

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Introduced by the Affordable Care Act (ACA), Essential Health Benefits (EHB) are a set of ten health care service categories that certain health plans must cover.¹ The EHBs are defined through a benchmark approach where states either select or get assigned a benchmark plan which serves as a reference plan to define EHBs in the state.

On August 28, 2015, the Department of Health and Human Services (HHS) posted on the Center for Consumer Information and Insurance Oversight (CCIIO) website a list of the proposed 2017 EHB benchmark plans for the 50 states and the District of Columbia (DC). The list includes state selected benchmark plans or the default benchmark (for states that did not select a plan). Also included are supporting plan documents with benefit coverage details for each benchmark plan.

HHS has set forth a short 30-day public comment period regarding the proposed EHB benchmark plans with comments due by 11:59pm EDT on September 30, 2015. HHS will post a list of final 2017 benchmark plans later this year. This EHB Step Guide is designed to help state advocates review and analyze their state's benchmark plan, and raise any concerns to HHS before there is final federal approval.

Step 1: Identify your state's proposed 2017 EHB benchmark plan

HHS asked states to submit their 2017 EHB benchmark plan selection by June 1, 2015, with some states getting an extension. The list of proposed 2017 EHB benchmark plans for each state and DC is available [here](#).

Background:

States select one of ten coverage options (referred to as a "base-benchmark" plan) to define EHBs in the state. When selecting a base-benchmark plan (BBP), the state is not

¹ This publication focuses on EHBs as they apply to the private market. The EHB requirement applies to non-grandfathered health plans offered in the individual and small group markets (both inside and outside the Marketplace). Self-insured group health plans, large group market plans, and grandfathered health plans are not required to provide EHBs.

selecting the actual plan, but rather the list of benefits that health plan offers. States that do not select a BBP get assigned the default benchmark, which is the largest small group plan, by enrollment, in the state. For the 2017 plan year, the BBPs are based on 2014 plans.

EHB Base-Benchmark Plan Options

- the three largest Federal Employees Health Benefits Program plans,
- the three largest state employee plans,
- the three largest small group plans in the state, or
- the HMO plan with the largest commercial, non-Medicaid enrollment in the state

- **Note:** On the CCIIO website where the proposed benchmark plans are posted, HHS stated that 2017 benchmark plans will apply in 2017 “**and beyond**” confirming that the 2017 benchmark plans will set the EHB standard in each state for *more* than one year.
- **Trend:** Most states have a small group market plan as the 2017 proposed EHB benchmark plan.

Step 2: Review the 2017 EHB benchmark plan information for your state

In addition to posting the list of proposed benchmark plans selected by states or assigned by default, HHS also posted for each state two documents for the 2017 plan year: 1) a benchmark benefits chart, and 2) a supporting plan document. Those documents are available [here](#) under the “2017 EHB benchmark plan information” for each state.

Background:

In 2012 HHS posted a list of the proposed EHB benchmark plans for each state and DC along with a summary of benefits, limits, prescription drug coverage, and state-required benefits. But HHS did not include any supporting plan documents for the proposed benchmarks, which made it difficult for advocates and stakeholders to provide meaningful comments since they were missing necessary benefit coverage details.

This time HHS required states (or issuers in states with default benchmarks) to submit plan documents with data and information regarding all health benefits in the plan, treatment limitations, drug coverage and exclusions.² HHS posted these plan documents along with the benchmark list. Below is the type of information provided for the proposed 2017 EHB benchmark plans.

² 45 C.F.R. § 156.120(b)(2).

Benchmark Benefits Chart

The first page of this document provides a summary of the state's EHB benchmark plan, which includes plan type, issuer name, product name, plan name, and supplemented categories. Next is a template list of benefits where states (or issuers in states not selecting a benchmark) specified covered benefits, limits and exclusions. Finally, there is a separate section with the prescription drug coverage offered by the EHB BBP organized by categories and classes based on version 6.0 of the United States Pharmacopeial Convention (USP) Medicare Model Guidelines classification system.

Supporting Benefits Document

HHS also included a supporting plan document for each state, which provides additional details regarding coverage, limits and exclusions for the EHB BBP. These are generally certificates of coverage or evidence of coverage documents. Since the benchmark benefits chart only provides a list of the benefits covered by the BBP without much detail, it is important to look at the plan document to see how the benefits are covered by the BBP.

Step 3: Ensure the 10 EHB statutory benefit categories are covered

Review your state's proposed 2017 EHB BBP and make sure it includes services and items in the 10 EHB categories. Any missing categories should have been supplemented (see Step 4 of this Guide.)

EHB 10 Statutory Categories of Benefits	
<ul style="list-style-type: none">• ambulatory patient services• emergency services• hospitalization• maternity and newborn care• mental health and substance use disorder services, including behavioral health treatment	<ul style="list-style-type: none">• prescription drugs• rehabilitative and habilitative services and devices• laboratory services• preventive and wellness services (including chronic disease management)• pediatric services, including oral and vision care

When reviewing your state's EHB BBP, also identify any EHB categories where there is only minimal coverage. If coverage is inadequate, make sure to include these examples in your comments to HHS. In addition, take into account that any limits in the EHB BBP will become part of the EHB definition in your state; therefore comment on any harmful limits that will negatively impact access to care.

- **Note:** A robust and comprehensive EHB is critically important for children, and in many states the EHB benchmark approach has led to inadequate coverage of

pediatric services.³ If this is an issue in your state and the proposed 2017 BBP does not improve it, make sure to raise it in your comments to HHS.

Special considerations:

Habilitative services, preventive services, and mental health and substance use disorder services are three areas where the benefits listed in the EHB BBP may not yet be in compliance with federal requirements so monitor compliance with these standards.

Habilitative Services

In the Notice of Benefit and Payment Parameters for 2016 final rule ([Final Rule 2016](#)), HHS established a uniform definition of habilitative services, to be used beginning with the 2016 plan year, in order to minimize: 1) variability in how the benefit is covered, and 2) lack of coverage of habilitative services versus rehabilitative services.

Uniform Definition of Habilitative Services

Health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

If the EHB BBP selected does not provide coverage of habilitative services or provides inadequate coverage, states may define the benefit, but must use the uniform definition as a minimum standard. If the state does not define the benefit, issuers will cover habilitative services and devices as defined in the uniform definition. The Final Rule 2016 **removed** issuers' flexibility to define this benefit.

In addition, issuers required to provide EHB cannot impose limits on coverage of habilitative services and devices that are less favorable than any such limits imposed on coverage of rehabilitative services and devices. Beginning in plan years on or after January 1, 2017, issuers will be required to impose separate limits on habilitative and rehabilitative services and devices.

Preventive Services

The EHB BBP may not offer the preventive services described in 45 C.F.R § 147.130.

³ See Wakely Consulting Grp., *Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified Health Plans* (July 2014), available at <http://www.wakely.com/wp-content/uploads/2014/07/FINAL-CHIP-vs-QHP-Cost-Sharing-and-Benefits-Comparison-First-Focus-July-2014-.pdf>.

However, EHB regulations independently require coverage of these preventive services by all health plans and issuers that are required to cover the EHBs.

Mental Health and Substance Use Disorder Services (Including Behavioral Health Treatment Services)

The 2017 EHB benchmarks are based on 2014 plans which may not be in compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) final regulation that generally applied to plans beginning on or after July 1, 2014. Yet health plans and issuers required to cover EHBs are expected to comply with all effective regulations, including the MHPAEA final rules.

Step 4: Ensure benefit categories are supplemented correctly

States retain the ability to supplement the EHB BBP, and determine whether the BBP covers an EHB category or whether supplementation is warranted.⁴ Therefore ensure EHB categories are supplemented appropriately.

If the EHB BBP selected by a state does not include items or services in any one of the 10 EHB categories, the BBP must be supplemented by adding that particular category in its entirety from one of the other EHB BBP options. There are some exceptions to this general supplementing rule; for example, pediatric oral and vision care have their own supplementing methodology.

Pediatric Oral Care

Supplement with:

- the Federal Employees Dental and Vision Program (FEDVIP) dental plan with the largest enrollment, or
- dental benefits available under the state's separate Children's Health Insurance Program (CHIP) plan.

Pediatric Vision Services

Supplement with:

- the FEDVIP vision plan with the largest national enrollment, or
 - vision benefits available under the state's separate CHIP plan.
- **Trend:** Based on the list of proposed 2017 EHB benchmark plans, there are fewer states supplementing pediatric oral and vision services than in 2012. If there is no need to supplement these services, they should be covered by the

⁴ HHS Notice of Benefit and Payment Parameters for 2016 Final Rule, 80 Fed. Reg. 10,750, 10,813 (Feb. 27, 2015) (to be codified at 45 C.F.R. pts 144, 147, 153, 154, 155, 156, and 158), available at <http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf> [hereinafter Final Rule 2016].

EHB BBP, but make sure pediatric oral and vision services are adequately covered, and if not raise this in your comments to HHS.

Default Benchmark Supplementing Methodology:

For default benchmarks missing coverage in any EHB statutory category, HHS should have supplemented the BBP with the first of the following options that offers benefits in that particular EHB category:

- 1) the second largest small group market plan in the state (except for pediatric oral and vision benefits),
- 2) the third largest small group market plan in the state (except for pediatric oral and vision benefits),
- 3) the largest national Federal Employees Health Benefits Program plan (except for pediatric oral and vision benefits),
- 4) the FEDVIP pediatric oral care benefits, and
- 5) the FEDVIP pediatric vision care benefits.

- **Note:** For both the state-selected and default benchmarks, include in your comments to HHS any concerns regarding how a benefit is currently supplemented, or not supplemented when it should be. Make sure to include any recommendations on how to best address any supplementing issues.

Step 5: If possible, compare the selected EHB BBP to other EHB BBP options and identify the best choice for your state

Some states made available to advocates and stakeholders plan documents (like evidence of coverage documents) *for all ten* EHB BBP options in the state for the 2017 plan year. If so, review those documents to ensure your state selected the EHB BBP that best meets the health needs of enrollees in your state.

If you believe there is a better benchmark choice than the one selected by your state, include the reasons in your comments to HHS. Make sure to highlight any important benefits not covered by your state selected BBP.

Step 6: Review your state's EHB BBP prescription drug coverage

In the EHB Final Rule from February 2013 (Final Rule 2013), HHS chose the USP Medicare Model Guidelines classification system as the comparison tool to determine EHB prescription drug coverage. Per the Final Rule 2013, health plans must cover at least **the greater of** 1) one drug in every USP therapeutic category and class **or** 2) the same number of drugs in each USP category and class as the state's EHB BBP.

As mentioned in Step 2 of this Guide, the benchmark benefits charts for the 2017 plan year that HHS posted on the CCIIO website include the prescription drug coverage offered by the EHB BBP organized by categories and classes based on version 6.0 of

the USP Medicare Model Guidelines classification system. When reviewing the chart identify any areas where coverage is inadequate. Keep in mind that the Final Rule 2016 adopted a new approach that will go into effect beginning with plan years on or after January 1, 2017 and combines the use of the existing USP standard with a Pharmacy and Therapeutics (P&T) committee to help ensure health plans' formulary drug lists cover a broad array of prescription drugs.

- **Note:** The Final Rule 2016 significantly modified EHB prescription drug requirements. Please see [NHeLP's EHB Prescription Drug Series](#) for an overview of changes made to the EHB prescription drug standard and advocacy opportunities and strategies to help ensure that low-income and underserved populations can obtain the prescription drugs they need.

Step 7: Raise any concerns regarding discriminatory benefit design

With respect to EHBs, the ACA and implementing regulations prohibit issuer discrimination in benefit design or implementation. An issuer does not provide EHBs if “its benefit design, or the implementation of its benefit design, discriminates based on an individual’s age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.”⁵

In the preamble of the Final Rule 2016, HHS gave three examples:

(1) attempts to circumvent coverage of medically necessary benefits by labeling the benefit as a “pediatric service,” thereby excluding adults; (2) refusal to cover a single-tablet drug regimen or extended-release product that is customarily prescribed and is just as effective as a multi-tablet regimen, absent an appropriate reason for such refusal; and (3) placing most or all drugs that treat a specific condition on the highest cost tiers.

HHS stated that these practices are potentially discriminatory, especially if there is no appropriate non-discriminatory justification for the plan design.⁶ Coverage gaps can lead to discrimination against certain populations. If there are examples of such discriminatory practices or gaps in your state’s proposed EHB BBP include them in your comments.

Conclusion

HHS published the list of EHB BBPs for each state for the 2017 plan year, along with plan documents and provided a short 30-day public comment period. This public review period offers advocates an opportunity to review their state’s EHB benchmark and raise any concerns identified before there is final federal approval. Use this Step Guide to help you comment on your state’s EHB benchmark plan.

⁵ 45 C.F.R. § 156.125.

⁶ Final Rule 2016, *supra* note 4, at 10,822-23.