Overview of Changes to the Essential Health Benefits Standards in NBPP 2019

By Candace Gibson, Héctor Hernández-Delgado, Hayley Penan, and Wayne Turner

INTRODUCTION

New regulations by the U.S. Department of Health and Human Services (HHS) allow states to erode coverage standards for Essential Health Benefits (EHB), a key consumer protection in the Affordable Care Act (ACA). The final Notice of Benefit and Payment Parameters (NBPP) for 2019 ("Final Rule") makes significant changes to the benchmarking process, in place since 2013, whereby states set minimum EHB standards.[1]

The following summary highlights the changes made to the EHB regulatory scheme under the Final Rule, which states may enact for plans sold in 2020.

A. Background

The Affordable Care Act established a set of ten health care service categories that certain health plans must cover — the Essential Health Benefits (EHBs).[2] The ten EHB categories of benefits are:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Laboratory services
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Pediatric services including oral and vision care
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices

The EHB requirement applies to most health plans offered in the individual and small group markets (both inside and outside the Marketplace). The Secretary also must ensure the EHBs: (1) reflect balance among categories; (2) account for diverse health needs across populations; and (3) do not discriminate against individuals because of age, disability, or expected length of life.[3]

The ACA assigned the authority to define the EHBs to the Secretary of HHS.[4] In 2013, HHS published a final rule establishing a state "benchmarking" process. Each state selects a "reference" plan to define both the scope of services commensurate with a "typical employer plan" in the state.[5]

Under the existing process, states may select their EHB base benchmark plan from among ten options:

- 3 largest federal employee plans,
- 3 largest state employee plans,
- 3 largest small group plans in the state, or
- the largest commercial HMO operating in the state.[6]

The Secretary of HHS must also periodically review the EHBs and provide a publicly available report to Congress.[7] In the Final Rule, HHS makes drastic changes to the EHB standard without having completed the required review of the current standard.[8]

B. New EHB Benchmark Options

The Final Rule eliminates the ten benchmark options listed above and establishes new benchmarking options for states that wish to redefine their EHBs. For all benchmarking options, the Final Rule imposes a "generosity cap" which enables states to weaken EHB minimum standards, but penalizes states seeking to improve and strengthen EHB.

States have three ways of selecting a new EHB benchmark:

1. Selecting the EHB benchmark plan used by another state in 2017.

States may choose the benchmark plan actually *used* by another state (that is, not merely any benchmark plan *available* to the other states).[9] States selecting another state's benchmark will be responsible for defraying the cost of any state-mandated benefit not covered by the choosing state's requirements. Under the 2013 NBPP, states must defray the cost of new mandates enacted after December 31, 2011.[10] According to the Final Rule, if the mandated benefit is embedded in the state's newly selected EHB benchmark plan, the choosing state must defray the costs as if it were a new mandate in the choosing state.

For example, Delaware mandates coverage of artificial limbs, whereas Washington state does not. If Washington selected Delaware's benchmark plan, Washington would be required to pay for the cost of artificial limb coverage.[11]

In addition to defraying the cost of benefits provided pursuant to another state's mandates, the state selecting another state's benchmark must conduct an actuarial analysis and demonstrate that the new benchmark is no more generous than a set of comparison plans (explained below in Section C.2 Generosity Analysis).

2. Replacing one or more categories of EHBs under its 2017 benchmark plan with the same categories from another state's 2017 EHB benchmark plan.

States can select the benefits from one or more of the ten EHB categories from the benchmark plans used by other states.[12] This option may be particularly challenging since plan documents often do not delineate benefits according to the EHB categories. For example, Washington could chose to use Delaware's benchmark plan's coverage of ambulatory patient services, Mississippi's coverage of laboratory services, and Utah's coverage of mental health and substance use disorder services.

States selecting this benchmarking option are similarly required to defray the cost of benefits, thus penalizing states wishing to establish more generous EHB standards.

However, states seeking to erode consumer protections could select the least generous benefits for each category, thus creating a standard that does not resemble any existing plan in the market today. HHS dismissed these concerns raised by commenters, stating that "safeguards" like the typical employer plan EHB floor (explained below in Section C.1 Typical Employer Plan definition) and supplementation will "not allow a state to substantially reduce the level of coverage."[13]

3. Selecting new benefits that would provide the state's EHB benchmark.

This option allows states to create a new benchmark plan by designating benefits for the ten EHB categories beginning in plan year 2020.[14] This very broad, build-your-own benchmark approach provides the greatest opportunity to weaken current standards. However, pursuant to the Final Rule, a benchmark plan selected under this option must: (1) "include an appropriate balance" of all ten EHB categories; (2) provide a scope of benefits equal to or greater than the scope of benefits under a *typical employer plan*; and (3) not exceed the generosity of the most generous plan among a set of comparison plans.[15]

C. Limits on New Benchmark Options

The ACA requires that EHBs must be equal to the scope of benefits provided under a "typical employer plan."[16] The Final Rule defines, for the first time, "typical employer plan." The Final Rule also establishes a new "generosity standard" which limits state flexibility to improve or expand its EHB standards.

1. Typical employer plan definition establishing EHB floor.

The Final Rule defines typical employer plans as either one of the ten benchmark-plan options available to the state in 2017 or the largest plan by enrollment within one of the five largest large-group health insurance products in the state. To be used as a typical employer plan, the employer-plan product must have at least ten percent of the total enrollment of the five largest group products, provide minimum value as currently defined in the regulations, not include

benefits that are exempted under the current rule, and have been in effect for a plan year beginning after December 31, 2013.

While states selecting new benchmark plans under any of the three new categories must comply with the requirement that the plan is at least as comprehensive as a typical employer plan, the new definition is particularly relevant to states selecting a new set of benefits under the third option (selecting new benefits for the state's EHB). The typical employer plan requirement serves as a floor for the types of services that must be covered within each EHB category. Thus, states devising new benefits as EHBs need to be aware that those benefits must be equal in scope to either one of the 2017 benchmark options or one of the largest group plans in the state.

2. Generosity analysis establishing EHB ceiling.

The Final Rule also imposes, for the first time, a ***maximum*** scope of benefits that applies to all state benchmark plans for plan years starting in 2020. A state's benchmark plan for 2020 and beyond may not include more generous benefits, in terms of its actuarial value, than the most generous of the ten benchmark-plan options the state had available for 2017. The state must include a certification of the plan's actuarial value when submitting its new benchmark selection to HHS.

Thus states seeking to improve or expand benefits in one EHB category will need to reduce or cut benefits in another. Under the Final Rule, requiring new or additional benefits would be considered a new mandate, for which states are required to defray the costs.

D. Substitution of Benefits

Issuers offering EHBs are currently permitted to substitute benefits within an EHB category, unless prohibited by state law, which are: (1) actuarially equivalent to the benefits replaced; and (2) not a prescription drug benefit.[17]

The Final Rule expands benefit substitution by allowing issuers to substitute benefits between different EHB categories.[18] As a result, issuers may substitute services that certain populations (e.g., individuals with chronic conditions) need and replace them with actuarially equivalent services, which may be less costly and more likely to attract healthier populations.

The Final Rule does not expressly exempt preventive services and screenings from substitution. However, the ACA requires plans to cover specified preventive services and screenings without cost sharing so they should continue to be available.[19]

HHS acknowledges concerns raised by advocates that plans could, in effect, eliminate certain EHB categories through substitution. HHS argues that existing requirements, including EHB non-discrimination protections, and requirements to maintain an appropriate balance of coverage for EHB categories of benefits, would prevent this from occurring.[20]

E. New Default Benchmark

The 2013 Notice of Benefit and Payment Parameters rule established that if a state did not select an EHB base benchmark plan, the largest small group plan would serve as the default. Under the Final Rule, if a state does not make an EHB benchmark selection by the annual selection date for the applicable plan year, the state's EHB benchmark plan for the prior year continues to apply.

F. Stand Alone Dental Plans (SADPs)

The Final Rule eliminated the high and low actuarial value (AV) level designations for Stand Alone Dental Plans (SADPs). Under the prior final rule, SADPs were required to designate plans as low or high value, with low value plans required to cover at least 70 percent of the cost of covered services and high value plans 85 percent of these costs (plus or minus two percent). By eliminating these designations, the Final Rule no longer requires SADPs to cover the cost of a minimum percent of covered services, enabling these plans to offer substantially less robust coverage and making it much more difficult for consumers to differentiate between SADPs offered in the Marketplace. In response to comments about these concerns, the Final Rule also codified a requirement that SADPs report plans' actuarial value to the exchange (already required as part of the qualified health plan (QHP) certification process). The pediatric EHB and cost-sharing requirements remain intact.

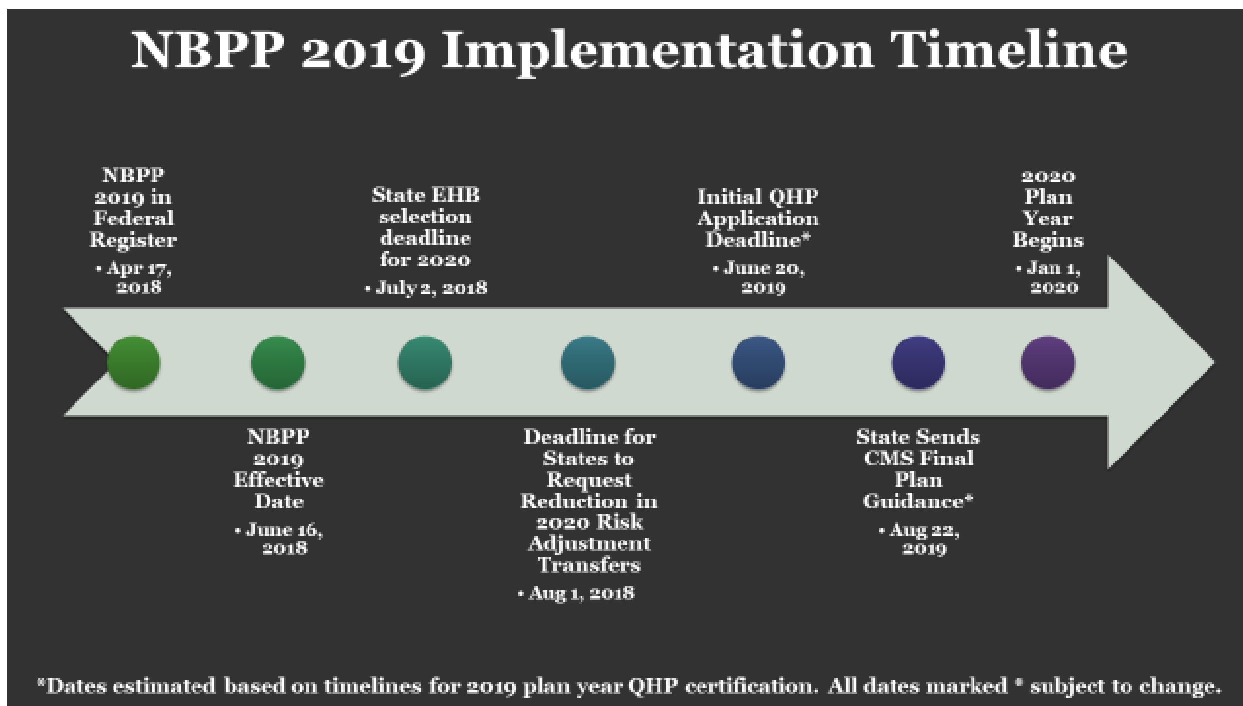
G. Public Process for Benchmark Selection

The Final Rule requires states to provide public notice and the opportunity to comment on changes to the EHB benchmark.[21] NHeLP and other advocates urged HHS to require a robust public process, including hearings, a public comment period, and the publication of plan documents and analysis in usable and understandable formats, along with data (such as actuarial certifications and reports) that must be submitted to HHS. However, HHS declined to specify requirements for the public process.

H. Implementation Timeline

In the NBPP rule for 2016, HHS gave states the opportunity to update their base benchmark plans for the 2017 plan year. States selected their 2017 benchmark plans from plans offered in 2014.

The Final Rule allows states to update their benchmark plans annually, and not just in years specified by HHS.[22] States wishing to change their EHB base benchmark for plans sold in 2020 must submit their new benchmark selection and supporting documentation by July 2, 2018.[23] (See chart below).



Conclusion

Overall, the Final Rule provides the first significant changes to the selection and definition of EHBs since they were created by the ACA. This will likely result in many consumers receiving less comprehensive coverage options. While HHS touts the Final Rule as providing more state flexibility and consumer choice, ultimately, it only provides states with sufficient flexibility to require less robust base benchmark plans than prior versions of the rule and takes significant steps backwards in terms of consumer empowerment and clarity.

ENDNOTES

[1] HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16930 (April 17, 2019)(hereinafter "Final Rule").
[2] 42 U.S.C. § 18022.
[3] 42 U.S.C. § 18022(b)(2).
[4] 42 U.S.C. § 18022(b)(1).
[5] HHS Notice of Benefit and Payment Parameters Rule for 2014, 78 Fed. Reg. 15409 (March 22, 2013). In the original rule, however, HHS did not define typical employer plan for purpose of setting a minimum coverage of the ten EHB categories.
[6] 45 C.F.R. § 156.100(a).
[7] 42 U.S.C. § 18022(b)(4)(G). HHS' review must contain an assessment: (1) of whether enrollees are experiencing barriers to needed services, (2) of whether services should be modified or updated to account for changes in medical evidence or scientific advancement, (3) addressing gaps in access or changes in evidence base, and (4) of whether existing benefits need to be expanded or reduced and the impact on cost.
[8] HHS acknowledges its statutory obligation to review and report EHB coverage gaps, but states "We do not believe that a report on EHB at this time will provide conclusive results on the assessments required under section 1302(b)(4)(G) of the PPACA, as a large portion of plans required to comply with EHB are QHPs offered both on and off of the Exchanges." 83 Fed. Reg. 17011.
[9] 45 C.F.R. § 156.111(a)(1).
[10] 45 C.F.R. § 156.170.
[11] See HHS, Center for Consumer Information & Insurance Oversight, 2017-2019 EHB-benchmark plan documents by state, *available at* https://www.cms.gov/cciio/resources/data-resources/ehb.html.
[12] 45 C.F.R. § 156.111(a)(2).
[13] 83 Fed. Reg. 17011.
[14] 45 C.F.R. § 156.111(a)(3).
[15] 45 C.F.R. § 156.111(b).
[16] As determined by the Secretary and informed by a report conducted by the Department of Labor on employer-sponsored coverage across different employers throughout the country. 42 U.S.C. § 18022(b)(2)(A). The DOL released its report on employer-sponsored coverage in 2011. This report captured data from about 36,000 employers, including private employers and state and local governments, and produced comprehensive information on the services typically covered by employers. While the previous administration did not explicitly define a typical employer plan, the 2011 report informed the subsequently adopted benchmark approach and served as a floor for EHB coverage in the Marketplace.
[17] 45 C.F.R. § 156.115(b)(1).
[18] 83 Fed. Reg. 17020, to be codified at 45 C.F.R. § 156.115(b)(1)(ii).
[19] 42 U.S.C. § 300gg–13(a)(1); 29 C.F.R. § 2590.715-2713; 45 C.F.R. 45 C.F.R. § 147.130..
[20] 45 C.F.R. §§ 156.111(b)(1),156.125 & .200(e).
[21] 83 Fed. Reg. 17017, to be codified at 45 C.F.R. § 156.111 (c).
[22] 45 C.F.R. § 156.111(a).
[23] 83 Fed. Reg. 17020.