

Step Guide to Updating Your State’s Essential Health Benefits Benchmark Plan

By [Hayley Penan](#)¹

Date: May 9, 2018

As part of 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 States define EHBs through a benchmark approach where states may select a base-benchmark plan, which serves as a reference plan to define EHBs in the state.

EHB 10 Statutory Categories of Benefits

- ambulatory patient services
- emergency services
- hospitalization
- maternity and newborn care
- mental health and substance use disorder services (MH/SUD), including behavioral health treatment
- 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

On April 17, 2018, the U.S. Department of Health and Human Services (HHS) published an updated rule governing EHBs, making significant changes to the process for states to select base benchmark plans for the 2020 plan year and beyond.²

This Guide will help state advocates review and analyze their states’ benchmark plan and identify concerns to raise with state policy-makers as states select their benchmark

¹ National Health Law Program Staff Attorney [Candace Gibson](#), Staff Attorney [Héctor Hernández-Delgado](#), Senior Attorney [Wayne Turner](#), and Health Policy Fellow [Alexis Robles](#) contributed to the development of this Step Guide.

plans going forward. Advocates may also raise concerns with HHS before the agency's final approval of the benchmark plans (although the 2019 Final Rule does not provide a formal public comment process at the federal level).

Advocacy Timeframe:

States seeking to update their EHB benchmark for plans sold in 2020 must submit their selection to HHS by **July 2, 2018**. If a state does not select a new benchmark plan, or if its selected benchmark plan does not satisfy federal requirements, the state will keep its existing 2017 benchmark plan.

Under the 2019 Final Rule, states must provide “reasonable public notice and an opportunity for public comment” on EHB benchmark plan selection, including posting notice and information on opportunities for public comment on a relevant State Web site.³ This may present opportunities for advocates to weigh in on what kind of public process should be established (**see Step 1**).

The 2019 Final Rule also allow states to change their EHB benchmark annually, instead of at intervals specified by HHS. However, HHS does not specify a timeline or deadline for benchmark updates after the 2020 plan year.

Background on Base-Benchmark Plan Selection:

In 2013, HHS finalized a rule allowing states to define each category of EHBs by selecting a base-benchmark plan (BBP) to be used by health plans as a framework. While HHS generally reaffirmed the statutory requirement that coverage of EHB must be equal to the scope of benefits provided under a typical employer plan, it nonetheless allowed states to select a BBP for plan year 2014 from the following ten options:⁴

<p style="text-align: center;">EHB Base-Benchmark Plan Options Pre-2019 Final Rule</p> <ul style="list-style-type: none">• 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.

States that did not select a BBP were assigned the default benchmark, which was the largest small group plan, by enrollment, in the state. HHS maintained the BBP selection process outlined in the Notice of Benefit and Payment Parameters for 2017 rule. In the 2019 Final Rule, HHS established that if a state does not make an EHB benchmark

selection using the new BBP options discussed below, then the state's EHB benchmark plan for the 2017 plan year continues to apply. Because the current 2017 benchmark plans are based on 2014 plans, some of them may not comply with existing EHB requirements (e.g., preventive services) or with EHB standards that went into effect in 2016 and 2017 (e.g., prescription drug requirements).

Changes to BBP Process in the 2019 Final Rule:

In the 2019 Final Rule, HHS made sweeping changes to the EHB standard. It established the following new benchmarking options for states to select their BBPs for plans sold in 2020:

- (1) using the EHB benchmark plan used by another state in 2017,
- (2) replacing one or more categories of EHBs under its EHB benchmark plan used for the 2017 plan year with the same category or categories of EHB from the BBP that another state used for the 2017 plan year, or
- (3) selecting new benefits that would provide the state's EHB benchmark.

These changes provide states with more flexibility to reduce benefits, but less flexibility to establish more generous benefits. States can choose to do nothing and keep their 2017 BBP by default. Also, while the 2019 Final Rule does not contemplate the use of the BPP options available to states in 2014 and 2017, states may still select one of those BPP options using the third option above. State advocacy in the benchmarking process will largely depend on whether your state plans to maintain, improve, or weaken its BBP. The steps below provide advocates with tips and considerations for states electing to keep their default plan and for states looking to change their BBP for 2020. The steps depend on which of the three options your state is using to select its 2020 BBP.

Step 1: Determine whether your state must establish notice and comment procedures for making changes to its BBP.

Under the 2019 Final Rule, states seeking to change their BBPs must provide public notice and the opportunity to comment on changes to EHB benchmarks.⁵ HHS did not specify requirements for this public process, other than that states must post public notice of the opportunity for public comment on a relevant state website. Some states, like California, have used a legislative process to select their BBP. If these states want to change their EHB benchmarks, they have to go through the legislative process before July 2, 2018. For these states, it may already be too late to complete the requisite legislative process in time.

Advocates may have difficulty determining who in their state is responsible for making the BBP selection. Twenty-six states made no base benchmark selection for the 2014 plan year.⁶ Other states may have varying administrative processes whereby the Governor or State Insurance Commissioner makes the selection. Some states may not have any public notice and comment processes for EHBs in place.

States that do not already have a process would have to establish a process and complete it before July 2, 2018. This may be too truncated of a timeline for many states, particularly if states are to establish a meaningful public process with sufficient time for public comment and analysis of the impact of BBP selections. If your state does not yet have a process in place for notice and public comments on the state's BBP selection, advocates should work to ensure that an adequate public process is established. Whether or not your state will be selecting a new BBP for 2020, it will be important to have this process in place for future years.

What advocates should look for:

- Figure out who the decision-maker is in your state for EHBs.
- Ensure there is sufficient public notice.
- Ensure the state provides plan documents, delineating which benefits count towards each EHB category.
- Ensure the state holds hearings that allow public testimony.

➤ **NOTE:**

- It is important that advocates first determine what process your state has in place for BBP selection. This will provide a better sense of the advocacy timeline and whether your state will have time to make changes to its BBP for 2020. If the state is unable to complete the requisite process before the deadline, then it will default to keeping its 2017 BBP for 2020.
- Because the 2019 Final Rule may pit patient groups against each other in determining which services are eliminated and which are expanded or enhanced, it is important that advocates, wherever possible, form coalitions and coordinate their responses during the state EHB benchmark process.

Step 2: Identify & review your state's 2017 EHB benchmark plan information.

Regardless of whether your state is planning to change its BBP, you should identify the state's 2017 BBP, which will be the default if the state does not select a new BBP using

one of the three new options. The HHS Center for Consumer Information and Insurance Oversight (CCIIO) website lists the 2017 EHB benchmark plans ([available here](#)) for the 50 states and the District of Columbia (DC), which includes state selected benchmark plans or the default benchmark (for states that did not select a plan for 2017). Also provided are the 2014-2016 summary of EHB benefits and information on state required benefits. Each state's "[2017 EHB Benchmark Plan Information](#)" link contains two documents for the 2017 plan year: (1) a benchmark benefits chart, and (2) a supporting plan document.

Benchmark Benefits Chart

The first document listed is the Summary of Benefits and Coverage (SBC) document, which provides an overview of the state's EHB BBP, but does not include details. The first page of this document provides a summary of the BBP, 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) specify covered benefits, limits, and exclusions. Finally, there is a separate section with the prescription drug coverage offered by the BBP organized by categories and classes based on version 6.0 of the United States Pharmacopeial Convention (USP) Medicare Model Guidelines classification system. (See NHeLP, [Essential Health Benefits Prescription Drug Standard - United States Pharmacopeia Classification System](#) (July 27, 2015)).

Supporting Benefits Document

Since the SBC only provides a list of the covered benefits without much detail, it is important to look at the Evidence of Coverage (EOC) to see how the benefits are covered by the BBP. HHS posts one or more EOC documents for each state.⁷ These are supporting plan documents that provide more detailed information on what is covered in the plan, such as coverage limits and utilization controls, including prior authorization and exclusions. The documents will not always have the benefits neatly categorized in a way that tracks the list of benefits in the SBC. For example, if you are looking in the EOC for what is included in the state's maternity and newborn care benefit category, you will not necessarily find all the benefits in this category in one place in the EOC.

What advocates should look for:

- What benefits align with each of the ten EHB categories?
- Are there visit limits or service caps?
- Does the plan require prior authorization, step therapy, or other utilization controls for key services?
- Are benefits balanced between the categories?
- Does the state need to supplement any EHB benefits not covered by the benchmark?

➤ **NOTE:**

- The ACA requires plans to provide women’s preventive services and screenings, as identified by the HHS Health Resources Services Administration (HRSA).⁸ However, plans are permitted to use “reasonable medical management techniques” to determine the frequency, method, treatment or setting for any of the required preventive services to the extent not already specified in the HRSA guidelines.⁹ Medical management techniques generally include step therapy (requiring patients to try one method before accessing another), prior authorization, cost-sharing, and quantity limits. Thus, there can be significant variation in scope and access to women’s preventive services in the different benchmark options.
- Limits on MH/SUD benefits must comply with the Mental Health Parity and Addiction Equity Act (“Parity Act”), discussed in detail in Step 5 below.¹⁰ Some current BPPs may impose benefits on MH/SUD benefits that contravene the Parity Act requirements. Accordingly, it is important that advocates analyze current state BPPs to determine whether limits imposed on MH/SUD benefits are permissible.

Step 3: Determine whether your state prohibits benefit substitution, and if not advocate for state prohibitions or limitations on substitution.

Issuers offering EHBs were previously allowed 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.¹¹

The 2019 Final Rule expanded existing benefit substitution by allowing issuers to substitute benefits *between* different EHB categories, as long as the state notifies HHS of its intention of allowing substitution.¹² As a result, issuers may now 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. Prescription drugs are exempt from substitution.¹³

Advocates should determine whether their states prohibit or limit substitution. California, for example, has statutorily prohibited issuers from substituting benefits for those required to be covered.¹⁴ For states that do not prohibit substitution, advocates should work to get their states to enact statutes or regulations that prohibit or limit substitution. The public processes for selecting a new benchmark plan may be an opportune time to share concerns about substitution and try to compel state action to protect against it.

What advocates should look for:

- Is benefit substitution currently permitted under state law?
 - Did the state properly notify HHS of its benefit substitution policy?
- **NOTE:** In response to comments on the 2019 Final Rule, HHS deferred to states to provide guidance to issuers on what benefit substitution is allowed because states are typically responsible for enforcing the prohibitions on discrimination.¹⁵ This can be used to support comments and advocacy efforts to get states to engage in protective statutory or regulatory measures to prevent benefit substitution.

Step 4: Determine whether your state will change its BBP for the 2020 plan year, and, if so, which option it will use.

Keep an eye out for notice on state health websites about potential EHB changes and public process. Even before these are posted, you may know whether your state is likely to focus on improving, maintaining, or weakening its EHB benchmark plan. Under the 2019 Final Rule, states have four choices in selecting their BBP for 2020:

- A. Keeping the state's existing (2017) benchmark plan (default),
- B. Selecting the EHB benchmark plan used by another state in 2017,
- C. Replacing one or more categories of EHBs under its EHB benchmark plan used for the 2017 plan year with the same category or categories from the EHB benchmark plan that another state used for the 2017 plan year, or
- D. Selecting new benefits that would provide the state's EHB benchmark.

➤ **NOTE:**

- Options B through D provide opportunities to either improve or weaken EHB BBPs. Because of the generosity requirements (discussed below), it will be very difficult for states to offer more robust benefit plans than they had for the 2017 plan year. The next section provides a detailed discussion of these three new plan selection options.
- While the BPP options available to states in 2017 are not contemplated in the 2019 Final Rule, states may select one of those options under Option D, which allows the state to establish a new BPP altogether. All options available to the state in 2017 are already in compliance with the generosity requirement under the new rule.

Requirements for States Selecting New Benchmark Plans:

Benchmark plans under all three new options in the 2019 Final Rule must:

- (1) provide a scope of benefits equal to or greater than the scope of benefits under a “typical employer plan,”
- (2) not exceed the generosity of the most generous plan among a set of comparison plans, and
- (3) comply with EHB “safeguards.”

Typical employer plan definition (establishing EHB floor)

The 2019 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.¹⁶ Under the latter option, the plan 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 exempt under the rules, and have been in effect for a plan year beginning after December 31, 2013. States can choose which of these options to use as the typical employer plan definition for comparison purposes. *The typical employer plan requirement serves as a floor for the types of services that must be covered within each EHB category.*

➤ **NOTE:**

- While states selecting new benchmark plans under any of the new selection options 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.
- The comparison between a proposed BPP and the typical employer plan the state selects is performed on an actuarial value basis. This means that a proposed BPP does not need to mirror the typical employer plan for every EHB category, as long as the overall actuarial value of both plans is comparable. For example, a state's BPP may provide less comprehensive hospitalization coverage than the typical employer plan selected by the state, but in order to maintain a comparable actuarial value, the BPP will need to offer more benefits in other categories than the typical employer plan.

Generosity analysis (establishing EHB ceiling)

The 2019 Final Rule imposes a maximum scope of benefits for all BBPs for 2020 and beyond, discouraging states from including more generous benefits than the most generous of the state's 2017 benchmark plan options. This includes:

- (1) the state's benchmark plan used for the 2017 plan year, and
- (2) any of the state's ten base benchmark plan options for the 2017 plan year, supplemented as necessary.

If a state chooses to expand its coverage requirements beyond its most comprehensive coverage option for 2017, any additional or expanded benefits will be considered state mandates and the state will have to bear the entire cost of the expansion.

➤ **NOTE:**

- Because of the short timeline and potential cost implications of expanding benefits, many states, particularly those with more generous BBPs, may choose to keep their existing BBPs. If states are considering changes to their current BBP, there are different steps and considerations for advocates to impact the BBP selection process depending on which of the three plan selection options the state chooses.
- The comparison between a proposed BPP and the most generous of the 2017 BPP options is performed on an actuarial value basis. This means that a proposed BPP does not need to provide equal benefits for every EHB category to the most generous 2017 BPP option, as long as the overall actuarial value of both plans is comparable. For example, a state's BPP may

provide more comprehensive maternity and newborn care coverage than the most generous 2017 BPP option, but in order to maintain a comparable actuarial value, the BPP will likely need to offer less comprehensive coverage in other categories than the most generous 2017 BPP option.

Compliance with EHB “Safeguards”

HHS cites to various safeguards in its response to comments expressing concern that the new benchmark selection rules will create a race to the bottom for the BBPs. These safeguards require BBPs to:

- (1) reflect balance among categories,
- (2) account for diverse health needs across populations, and
- (3) not discriminate against individuals because of age, disability, or expected length of life.¹⁷

The requirement that there be a balance among categories prevents states from eliminating or gutting entire EHB categories. For example, if your state provides extensive benefit coverage in rehabilitative and habilitative services and devices but sparse coverage for maternity and newborn care, this would not reflect balance among categories and would run afoul of the new rules. Be sure to look out for BBP’s that do not account for diverse health needs across populations. If your state significantly cuts services for persons with disabilities, women, children, communities of color, or low-income populations, this would be prohibited under the rules.

- **NOTE:** If your state’s proposed BBP for 2020 has an imbalance among categories or fails to account for diverse health needs across populations, emphasize in your comments to the state that the BBP is not compliant with the 2019 Final Rule.

Before the 2019 Final Rule, the ACA and implementing regulations already prohibited issuer discrimination in benefit design or implementation. An issuer cannot 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.”¹⁸ Coverage gaps can lead to discrimination against certain populations. For example, if the new mix of benefits results in a dramatic cut to benefits that individuals with disabilities rely on, this would violate the discrimination protections. If this occurs, your comments to states should reflect these concerns and emphasize that the newly created BBP does not comply with the 2019 Final Rule.

What advocates should look for:

- What process has your state decided to use for 2020?
- What is your state using as its typical employer plan for comparison purposes?
- Is your state seeking to cut benefits by using a less comprehensive plan than the current BBP as typical employer?
- Can your state's current BBP be improved based on the generosity test?
- Is the current or proposed BBP in compliance with the EHB safeguards?

➤ **NOTE:**

- There may be opportunities for advocates to get involved in the decision-making process or provide feedback on which option the state uses for selecting its BBP.
- Factors such as whether your state was amenable to Medicaid expansion or has taken steps to ensure the ACA protections are maintained regardless of actions taken at the federal level may indicate that your state is likely to be focused on protecting or strengthening its EHBs. If your state did not expand Medicaid or put up a fight to prevent expansion, it is more likely going to be focused on reducing its EHB benchmark requirements.

Option A: State keeps its 2017 BBP (default option).

States have the option of keeping their existing benchmark plan (2017 BBP) to use as their 2020 BBP. If states want to keep their existing BBP, they should do nothing as the default option is to use the state's 2017 BBP as its BBP for 2020.

Pros: The default option maintains the status quo. If your state was generous in selecting its 2017 BBP, it makes sense to advocate that your state not update its EHB BBP. Under this option, no one in your state should experience a reduction EHB coverage under the current BBP (provided that substitution does not occur).

Cons: This option prevents states from shifting or expanding benefits in response to changes in the state. For example, if your state has experienced an increase in the prevalence of opioid use disorders since 2014 (upon which the 2017 BBP was created), and a state would like to include more robust benefits for SUD, it will not be able to do this if it keeps the existing BBP.

- **NOTE:** Some default plans may not comply with existing EHB requirements (e.g., preventive services), or with EHB standards that went into effect in 2016 and 2017 (e.g., prescription drug requirements). If your existing BBP fails to meet these requirements, you should advocate for your state to provide compliant coverage. Your state's existing BBP must comply with all safeguards and discrimination protections included in the rule.

Option B: State selects the EHB benchmark plan used by another state in 2017.

States may choose the benchmark plan **actually used** by another state in 2017 (that is, not any benchmark plan **available** to another state). States selecting another state's BBP will be responsible for paying the cost of any new benefits in the benchmark.¹⁹

The BBP taken from another state will still have to comply with the typical employer plan and generosity requirements included in the 2019 Final Rule.²⁰ The generosity requirement will deter states from improving or expanding coverage through the benchmarking process by forcing states to pay for more generous benefits. Under option B, the BPP from another state must not exceed, in terms of overall actuarial value, the generosity of the most generous of the selecting state's 2017 BPP options.

Example: If Washington wants to use Delaware's 2017 plan as its BBP and Delaware's 2017 plan exceeds the generosity (in terms of actuarial value) of the most generous of Washington's ten BBP options for the 2017 plan year because it includes coverage for artificial limbs and Washington's 2017 plan did not, then Washington will have to bear the cost of benefits in excess of the actuarial value of its most generous plan option for 2017.

On the other hand, if Delaware's 2017 plan provides less coverage (in terms of actuarial value) than Washington's least generous option from the 2017 year or the largest plan by enrollment within one of the five largest large group health insurance products in the state, then Washington is prohibited from using Delaware's 2017 plan as its BBP for 2020.

Pros: Your state could select another state's BBP that has more generous coverage than your state's 2017 BBP overall. This is more likely to apply if your state's 2017 BBP was based on one of the less generous typical employer plans out of the ten plan options. Your state could also select another state's BBP that is equally generous to your state's 2017 BBP but that provides a different selection of benefits that are more in line with your state's shifting needs. For example, if New Jersey has seen a substantial increase in pregnancies and wants to offer more robust maternal and newborn care coverage and Connecticut has more robust maternal and newborn coverage but slightly less robust coverage in other categories, New Jersey could take Connecticut's 2017 BBP for 2020 as long as the actuarial value of Connecticut's 2017 plan does not exceed the most generous of New Jersey's 2017 BPP options.

Cons: For states looking to improve their existing BBP, they will be unable to select another state's BBP that has more robust benefits than the selecting state's most generous 2017 BBP options, unless the plan they're taking has trade-offs in other categories that reduce the overall actuarial value of the BBP or unless the overall actuarial value is less than the most generous of the state's 2017 BBP options. States that chose the most generous BBP for 2017 would not be able to choose a more generous BBP from another state unless the new state's BBP unless the state is willing to pay for the additional costs associated with the added benefits.

- **NOTE:** Advocates should look out for states using the largest plan by enrollment within one of the state's five largest large group health insurance products as the baseline typical employer plan. These plans may offer less coverage than any of the other ten plan options the state had for 2017. If your state wants to use this new typical employer plan option to reduce its coverage baseline, advocate against this proposal during the public comment process and try to persuade the state to use one of the more generous plan options from the list of ten options that the state had available for the 2017 plan year.

Option C: State replaces one or more EHB categories under its BPP with the same category or categories from the 2017 EHB benchmark plan used by another state.

States can select one or more of the ten EHB categories from the BBPs used by other states for 2017 to use in place of the same category or categories in the state's BBP. These new benchmark plan combinations cannot be more generous (in terms of overall actuarial value) than the most generous of the state's benchmark plan options for 2017. States selecting this option are similarly required to pay the cost of additional benefits

that exceed the generosity ceiling, thus penalizing states wishing to establish more generous EHB standards.

In states looking to improve or make changes to their current BBPs that would not cut benefits, the final array of benefit category selections may not exceed the most generous of the state's 2017 benchmark options for 2017 unless the state is willing to pay for the added coverage. Thus, states seeking to improve or expand benefits in one EHB category will need to reduce or cut benefits in another. Under the 2019 Final Rule, requiring new or additional benefits would be considered a new mandate, for which states are required to defray the cost.

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. If your state chooses to select less generous benefits for individual categories, it will be important to look at the benefits offered in each category that is being kept and each category being taken from another state, and assess whether the complete benchmark plan is comparable to the "typical employer plan" definition chosen by the state. If the newly formed benchmark plan is not equal in scope to the typical employer plan selected by the state, it does not comply with EHB rules.

Again, look out for whether your state is choosing to use one of the less generous typical employer plan definition options as its baseline (particularly using the largest plan by enrollment within one of the five largest large-group health insurance products in the state). These plans may offer less coverage than any of the state's ten 2017 plan options. If your state plans to use this new typical employer plan option as its baseline (or any of the less generous typical employer plan options), advocate for the state to use one of the more generous plan options from the state's list of ten 2017 options instead.

Pros: This option allows states to swap out categories of benefits for more generous coverage, instead of creating an entire plan from scratch or taking on all of another state's plan. This may enable states to improve their benefit standards, particularly if there have been demographic or other changes that would make it beneficial to shift some of the benefits to provide more robust coverage in certain categories.

Cons: Your state will not be able to select the best versions of the different categories because of the generosity limits. This option also could enable states to select categories from other states that have the least coverage in each category, as long as the plan does not dip below the actuarial value of the typical employer plan selected by the state. This is particularly troubling for states using the largest plan by enrollment as their typical employer plan.

- **NOTE:** This option may be particularly challenging to analyze since plan documents often do not delineate benefits according to the EHB categories.

Option D: State selects new benefits that would provide the state's EHB benchmark.

This option allows states to change their current benchmark plan by selecting a new set of benefits altogether for 2020. If your state is planning to select a new set of benefits, the following steps (Steps D1-3) will help you ensure the new BBP complies with the EHB requirements and offers the most robust possible coverage.

New plans selected for 2020 must comply with the typical employer plan and generosity requirements (see Step 4). Be wary if your state is using a less generous typical employer plan option, especially if the state is using the new typical employer plan definition as its baseline (largest plan by enrollment within one of the five largest large-group health insurance products in the state). These plans may offer less coverage than any of the ten plan options the state had for 2017.

Pros: This option enables states to use the most generous of the ten 2017 BBP options as a comparison and build a set of benefits that's best suited to the state's current needs.

Cons: For states that previously selected generous benefit offerings, it is unlikely that the new selection will be able to provide more robust coverage than the state's 2017 BBP. This option could also allow states to select a benefit plan that offers less coverage than any existing plan, particularly if they opt for the largest plan by enrollment as their typical employer plan definition. Further, given the short timeframe to select the BBPs, it may not be feasible to do the requisite assessments to determine what new selection of benefits would be most beneficial for the state's population.

- **NOTE:** If your state is trying to use a less generous typical employer plan definition, advocate that the state uses one of the more generous plan options from the list of ten options that the state had available for 2017.

Step 5: Ensure the 10 EHB statutory benefit categories are covered.

Review your state's proposed 2020 BBP and make sure it includes services and items in the 10 EHB categories. Any missing categories must be added or supplemented.

When reviewing your state's proposed BBP, also identify any EHB categories where there is only minimal coverage. If coverage is inadequate, include these examples in your comments to the state and propose additional benefits that would provide sufficient coverage.

- **NOTE:**
 - Make sure to work with other advocates when making determinations on what benefits need to be added or reduced so that there is better alignment among various interest groups.
 - Take into account that any limits in the EHB BBP will become part of the new EHB definition in your state. Comment on any harmful limits that will negatively impact access to care and make sure any such limits are in compliance with federal requirements, such as the Parity Act.

EHB Standards unchanged by the 2019 Final Rule

Habilitative, preventive, and MH/SUD services are three areas where the benefits listed in the current BBP may not be in compliance with federal requirements so monitor compliance with these standards in the selection process for the new BBP. It is also important to monitor individual market plan compliance with these requirements. Plans are required to comply regardless of whether the selected BBP is in compliance.

Habilitative Services

In the Notice of Benefit and Payment Parameters for 2016 Final Rule (2016 Final Rule), HHS established a uniform definition of habilitative services, to be used beginning with the 2016 plan year.²¹

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.

States may define the benefit coverage for habilitative services, but must use the uniform definition as a minimum standard. The Final Rule for 2017 *removed* issuers' flexibility to define this benefit or impose limits on coverage of habilitative services and devices that are less favorable than any limits imposed on coverage of rehabilitative services and devices.

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

The Parity Act prevents most health plans that provide MH/SUD services from imposing less favorable benefit limitations on those benefits than on medical and surgical benefits (See NHeLP, [Mental Health Parity and Addiction Equity Act of 2008](#) (Jan. 31, 2014)). Because individual market plans are required to provide coverage for MH/SUD services pursuant to the EHB mandate, all plans are also required to comply with the parity requirements. Parity Act regulations were finalized in 2013 and generally apply to plans

beginning on or after July 1, 2014. Because the 2017 EHB benchmarks were based on 2014 plans, many may not be in compliance with the requirements of the Parity Act. It is important for states to make sure that new BBPs and individual plans comply with these requirements.

- **NOTE:** If your state creates a new BBP with insufficient habilitative services and preventive services coverage, or if the BPP imposes impermissible limits on MH/SUD services, this will be important to address in your comments.

Step 6: Ensure benefit categories are supplemented correctly.

The 2019 Final Rule did not make any changes to supplementation. If a selected BBP does not provide coverage in one or more categories of EHB, the state must supplement coverage for the category according to the regulations.²² If the 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. Advocates should ensure EHB categories are supplemented appropriately if they are not included in the proposed BBP.

➤ **NOTE:**

- It is unlikely that states would choose to create an entirely new BBP and leave out an entire category to be supplemented. However, the 2019 Final Rule left open this possibility by leaving in the supplementation parts of the regulatory guidance. Advocates should examine the BBP for this and ensure that all ten EHB categories are covered—either through creating a new BBP with coverage in all ten categories, or through supplementation.
- There were fewer states that supplemented pediatric oral and vision services in 2017 than in 2012. Advocates should ensure that pediatric oral and vision services are adequately covered if a state selects a BBP under this option. If there is insufficient coverage, you should address this in your comments.

Step 7: Review your state's EHB BBP prescription drug coverage.

In 2013, HHS chose the USP Medicare Model Guidelines classification system as the comparison tool to determine EHB prescription drug coverage²³. This requires health plans, at a minimum, to cover *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.

The benchmark benefits charts for the 2017 plan year that HHS posted on the CCIIO website included 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.

- **NOTE:** When reviewing the chart, identify any areas where coverage is inadequate. Since January 1, 2017 issuers must use of the existing USP standard and a Pharmacy and Therapeutics (P&T) committee to help ensure health plans' formulary drug lists cover a broad array of prescription drugs. (See NHeLP, [Essential Health Benefits Prescription Drug Standard - Pharmacy and Therapeutics Committees](#) (July 28, 2015)). No changes were made to the prescription drug standards in the 2019 Final Rule.

Conclusion

Overall, the 2019 Final Rule provides the first significant changes to the selection and definition of EHBs since they were created by the Affordable Care Act. If your state will be selecting a new BBP, make sure that there is an adequate process in place for public notice and comment on the proposed benchmark.

States have four options moving forward: (1) do nothing and default to their 2017 BBP, (2) select another state's 2017 BBP for its 2020 plan, (3) select EHB categories from other states' 2017 BBPs to substitute for EHB categories in its existing BBP, or (4) create an entirely new set of benefits to be its 2020 BBP. If your state is opting to change its BBP, verify that the new BBP complies with the generosity ceiling and typical employer plan floor and advocate that your state use the most generous of its typical employer plan options. Finally, confirm that your state's BBP complies with safeguards (balance among benefit categories, covers services for diverse populations, and non-discrimination provisions).

Advocates should strongly oppose state attempts to offer less comprehensive coverage in the BBPs. In light of the 2019 Final Rule, it will be equally important for advocates to support states in their efforts to improve their existing BBPs.

Other Resources:

NHeLP, [Overview of Changes to the Essential Health Benefits Standards in NBPP 2019](#) (April 23, 2018).

NHeLP, [Trump Rule Targets Landmark Health Care Law by Weakening Essential Health Benefits' Standards](#) (April 23, 2018).

¹ This Guide 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.

² 2019 Notice of Benefit and Payment Parameters Final Rule, 83 FR 16930 (Apr. 17, 2018), (“2019 Final Rule”), <https://www.federalregister.gov/documents/2018/04/17/2018-07355/patient-protection-and-affordable-care-act-benefit-and-payment-parameters-for-2019>.

³ 45 C.F.R. § 156.111.

⁴ 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. The 2019 Final Rule has established for the first time a definition of a “typical employer plan,” discussed in Step 4.

⁵ 45 C.F.R. § 156.111(c).

⁶ Sabrina Corlette, Kevin W. Lucia, and Max Levin, The Commonwealth Fund, Implementing the Affordable Care Act: Choosing an Essential Health Benefits Benchmark Plan (March, 2013), <http://www.commonwealthfund.org/~media/files/publications/issue->

[brief/2013/mar/1677_corlette_implementing_aca_choosing_essential_hlt_benefits_reform_brief.pdf](#).

⁷ These are available under the “2017 EHB Benchmark Plan Information” link for each state. Once you click on the link, a zip file will download containing two or more documents: (1) the Summary of Benefits and Coverage document, labeled as “2017 BMP Summary_State abbreviation,” and (2) an Evidence of Coverage document, labeled as “State BMP.” Some states may also include additional plan documents, such as those for supplemental plans in this zip file. *Information on Essential Health Benefits (EHB) Benchmark Plans*, CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html#ehb> (last visited Apr. 30, 2018).

⁸ 42 U.S.C. § 300gg-13(a)(4). See also, NHeLP, *The ACA and Preventive Screenings and Services* (July 2016), <http://www.healthlaw.org/issues/medicaid/services/2016-7-health-advocate#.WuDgssgvxPY>.

⁹ HHS Ctr. for Consumer Information & Insurance Oversight, *ACA Implementation FAQs - Set 18*, available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.html; 45 C.F.R. § 147.130(a)(4).

¹⁰ Pub. L. No. 110-343, 122 Stat. 3765 (2008) (codified in scattered sections U.S.C. titles 26, 29, 42).

¹¹ 45 C.F.R. § 156.115(b)(1).

¹² 83 Fed. Reg. 17020, to be codified at 45 C.F.R. § 156.115(b)(1)(ii).

¹³ Preventive services and screenings are not expressly exempt from this requirement. However, the ACA requires plans to cover specified preventive services and screenings without cost sharing.¹³ This means that the preventive services and screenings required by the ACA cannot be eliminated through substitution. 42 U.S.C. § 300gg-13(a)(1); 29 C.F.R. § 2590.715-2713; 45 C.F.R. § 147.130.

¹⁴ Cal. Health & Safety Code § 10112.27(c).

¹⁵ 83 Fed. Reg. 17021.

¹⁶ 45 C.F.R. § 156.111(b)(2).

¹⁷ 45 C.F.R. § 156.111.

¹⁸ 45 C.F.R. § 156.125. In the preamble of the 2016 Final Rule, HHS gave three examples of discriminatory benefit design/implementation: (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. HHS Notice of Benefit and Payment Parameters for 2016 Final Rule, 80 Fed. Reg. 10,750, 10,813 (Feb. 27, 2015) (“2016 Final Rule”), <http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf>.

¹⁹ This includes any benefits in the benchmark plan that were not previously offered in the state’s 2017 benchmark plan.

²⁰ See HHS, Center for Consumer Information & Insurance Oversight, 2017-2019 EHB-benchmark plan documents by state, *available at* <https://www.cms.gov/ccio/resources/data-resources/ehb.html> (last visited April 13, 2018).

²¹ 80 Fed. Reg. 12,867; codified at 45 C.F.R. § 155.115(a)(5)(i).

²² *Id.*

²³ HHS, Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834 (Feb. 25, 2013), <https://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf>.