Opportunities for States to Expand Marketplace Coverage of Essential Health Benefits

Héctor Hernández-Delgado & Wayne Turner

I. Introduction

The Affordable Care Act (ACA) requires non-grandfathered individual and small group plans to provide coverage for services in at least ten categories of Essential Health Benefits (EHBs).[i] The ACA authorized the Secretary of Health and Human Services (HHS) to ensure coverage of the ten established EHB categories and to define the items and services covered within each category.[1]

EHB 10 Statutory Categories of Benefits	
▯ ambulatory patient services	▯ prescription drugs
▯ emergency services	▯ rehabilitative and habilitative services and devices
▯ hospitalization	▯ laboratory services
▯ maternity and newborn care	▯ preventive and wellness services, including chronic disease management
▯ mental health and substance use disorder services	▯ pediatric services, including oral and vision

Through a series of regulations and guidance, HHS delegated the responsibility to define the EHB categories to states. Instead of establishing a federal EHB standard, HHS allows states to

[i] 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.

define the scope and parameters of EHB based on a base-benchmarking process. This process has been significantly modified throughout the years to allow states to either make harmful cuts to coverage or introduce improvements. The current benchmarking process, finalized in 2017, established a new ceiling on the generosity of benefits provided under the base-benchmark plan (BBP), but also created new opportunities for states to expand the number of services covered under each category. This fact sheet examines the new benchmarking process and explains the opportunities available for states looking to make improvements to their EHB BBP. The paper also provides examples of procedural and substantive best practices from states that have introduced changes using the new standard.

II. Historical Regulatory Background

a. Benchmarking Process

Instead of establishing a federal definition of the items and services covered within each EHB category, HHS allowed states to come up with their own definitions. In 2013, the agency finalized the *Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Rule* ("2013 Rule"), which established a benchmarking process through which states define the services private plans must cover pursuant to the EHB requirement.

The 2013 Rule established ten plan options from which states could select a BBP to define EHBs.[2] States that failed to select a BBP were assigned the default benchmark, which is the largest small group plan, by enrollment, in the state.[3] The 2013 Rule established a federal minimum standard for prescription drug coverage – one drug per United Stated Pharmacopeia (USP) class and category, or the coverage provided in the state's BBP, whichever is greater. States had to define all other EHB categories using the benchmarking process.

2013 Rule and 2016 NBPP 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

The 2013 Rule also required states to supplement EHB categories not appropriately defined by the BBP. If an EHB BBP selected by a state did not include items or services in one of the ten EHB categories, the state had to add that particular category in its entirety from any other EHB BBP option.[4] The 2013 Rule established specific supplementing methodologies for the EHB category of pediatric oral and vision care that deviated from the general supplementing rule.[5] Similarly,

the 2013 Rule allowed plans to substitute benefits included in the BBP for other benefits that were actuarially equivalent and within the same EHB category.[6] While the 2013 Rule allowed substitution within EHB categories, it also allowed states to ban substitution of benefits by plans.[7]

In 2015, HHS finalized the *Notice of Benefit and Payment Parameters for 2016* ("2016 NBPP"). While the 2016 NBPP maintained the previous benchmarking standard and the ten plan options available, it introduced several important changes. First, the 2016 NBPP allowed states to re-select their BBP from the same ten BBP options, but based on the 2014 versions of the plans instead of the 2012 versions on which the original selections were made.[8] Second, the rule modified the EHB prescription drug standard by increasing formulary transparency, strengthening the exceptions process, prohibiting plans from offering covered prescription drugs only through mail-order, and requiring plans to establish Pharmacy and Therapeutics (P&T) Committees to periodically review and update formularies.[9] Third, the rule established a minimum uniform definition of habilitative services in order to minimize variability in how the benefit is covered and lack of coverage of habilitative services *vis-a-vis* rehabilitative services.[10] Finally, the 2016 NBPP clarified that pediatric services must be provided until at least the end of the month in which the enrollee turns 19 years of age.[11]

b. State Mandates

The ACA allows states to require plans in the private market to cover services in addition to EHBs. However, states are required to defray the cost of these additional services.[12] To avoid penalizing states with mandates preceding the enactment of the ACA, HHS' 2013 Rule exempts mandates enacted through state action prior to January 1, 2012 from the defrayal of cost requirement. In fact, for purpose of defrayal, pre-2012 state mandates are considered part of the state's EHB package.[13] Both the ACA and the 2013 Rule make states responsible for identifying which state-required benefits are in addition to EHBs and subject to defrayal. The Center for Consumer Information and Insurance Oversight (CCIIO) maintains lists of all state-required benefits by state, including information on whether the requirement was enacted before or after 2012.[14]

III. New EHB Benchmarking Standard for Plan Years 2020 and Beyond

In 2017, HHS finalized the *Notice of Benefit and Payment Parameters for 2019* ("2019 NBPP"), which introduced a major overhaul of the EHB base-benchmarking standard. In essence, the 2019 NBPP *further* reduced the standard and provided more leeway to states in selecting and designing their BBPs for plan years 2020 and beyond. In so doing, the rule expanded states' ability to cut back important services to the detriment of individuals and families. By the same

token, however, the 2019 NBPP opened the door to new opportunities for states seeking to improve coverage of EHBs for their residents.

a. Substantive Changes

The 2019 NBPP maintained states' authority to define the ten EHB categories through a benchmarking process, but introduced new options from which states select their BBP. Importantly, states are not required to make a new BBP selection and states not making a new selection default to their current BBP, selected for plan year 2017.[15]

2019 NBPP EHB Base-Benchmark Plan Options

- States may select the 2017 BBP of another state
- States may substitute one or more EHB categories in their BBP with the same categories from another state's 2017 BBP
- States may select new benefits for each EHB category that would provide the state's EHB BBP

States selecting a new BBP now have three options. First, states may select the BBP selected by another state in 2017.[16] Under this option, the selecting state's BBP would mirror, in all ten EHB categories, the BBP of the selected state. Second, states may replace one or more EHB categories under their 2017 BBP with the same categories from another state's 2017 BBP.[17] For example, a state may form a new BBP by selecting emergency services from the BBP of state A, maternity and newborn services from the BBP of state B, mental health and substance use disorder services from the BBP of state C, and so forth.

Finally, states may come up with a new combination of benefits for each EHB category that together would form the state's new EHB BBP.[18] This type of "do-it-yourself" approach allows states to create an entirely new BBP. A state may thus select certain EHB categories from other states' BBPs and define other categories by simply determining the services that will make up that category. States may also decide to define all ten EHB categories on their own without using another state's BBP as model.

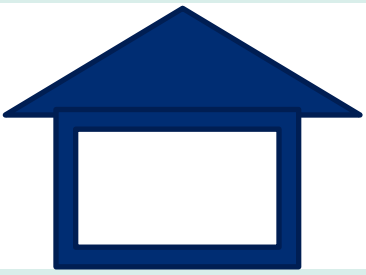
The 2019 NBPP established several limitations to this expanded state authority to define EHB categories. For example, under all of the three new benchmarking options, a state's BBP must provide a scope of benefits at least equal to the scope of benefits provided under a typical employer plan.[19] This limitation works as a floor and helps prevent a race to the bottom by ensuring that coverage would be at least comparable to the least comprehensive BBP option available to the state in 2017. On the other hand, under all of the three new benchmarking options, the selected BBP cannot exceed the generosity of the most generous plan available to the state in 2017.[20] This limitation, which effectively acts as a ceiling for states seeking to

change their BBP, imposes a maximum level of coverage, making it harder for states to expand the scope and number of services covered as EHBs.

The 2019 NBPP also introduced changes to the provision governing substitution of benefits. The rule now allows insurers to substitute services both within *and* between EHB categories unless prohibited by the state.[21] This means that plans can now substitute, for example, a service in the maternal and newborn care category for an actuarially equivalent service in the rehabilitative and habilitative services category.[22] As a result, this change creates the risk that a plan might skimp on coverage for an unpopular EHB category as long as it shifted coverage to more popular categories.

Limits to EHB BBP Selection under 2019 NBPP

BBP may not exceed the generosity of the most generous of the BBP options available to the state in 2017



BBP must provide a scope of benefits at least equal to the scope of benefits provided under a typical employer plan.

The 2019 NBPP also maintains or expands several protections to ensure that plans do not substitute away entire categories of EHBs or reduce coverage in a way that is detrimental to individuals' health. First, the rule requires states to ensure that the selected BBP provides an appropriate balance of coverage in all categories of EHBs.[23] Second, states must ensure that the selected BBP do not have benefits unduly weighted towards any of the categories of benefits.[24] Third, the selected BBP must provide benefits for diverse segments of the population, including women, children, and persons with disabilities.[25] Finally, the selected BBP must not include discriminatory benefit designs that contravene federal non-discrimination protections.[26]

b. Procedural Changes

States seeking to update their BBP under the 2019 NBPP must abide by certain procedural requirements to increase transparency and provide for public input in the benchmarking process. The rule requires states to post, on a relevant state website, reasonable public notice and an opportunity for public comment on the state's selection of a BBP.[27] In addition, states are required to accompany the notice with "associated information," although the rule does not define what constitutes associated information.[28] Similarly, while states are expected to provide reasonable time for stakeholders to comment, the rule does not specify what must be posted and how public input is provided, nor has CCIIO issued guidance for states in implementing this provision.

The 2019 NBPP also requires states changing their BBP to submit appropriate documentation to CCIIO in order to support the application. Required documentation includes a document specifying which of the three new benchmarking options the state is using to change its BBP and confirming that the proposed BBP complies with all the minimum requirements, including providing an appropriate balance of coverage in all categories, not having benefits unduly weighted towards any of the categories, providing benefits for diverse segments of the population, and not having a discriminatory benefit design.[29] Finally, the rule requires states changing their BBP to submit an actuarial report that certifies that the proposed BBP meets the generosity limit and the typical employer plan test.[30]

IV. New Opportunities to Expand Coverage of EHBs and Examples of States that Have Expanded EHBs under 2019 NBPP

The EHB benchmarking process, as modified by the 2019 NBPP, presents an opportunity for states to expand coverage of EHBs. Under the previous standards, most states did not select the most comprehensive of the BBP options available and instead either selected or were defaulted into the largest small group plan in the state.[31] This means that most states may now add certain services without exceeding the generosity of the most generous BBP option available to the state in 2017. As such, it is important for advocates and state leaders to evaluate the need for improvements and consider, using actuarial analyses, whether services may be added without running afoul of the generosity test.

Another key consideration for states looking to expand EHB coverage is that, as CCIIO has explained, the previous standard for determining whether a state mandate would be considered outside of EHBs and, thus, subject to defrayal of costs, remains the same under the new EHB benchmarking standard. This means that any additional service or expansion of existing services mandated through the EHB benchmarking process will not be treated as a state mandate for defrayal of cost purposes unless the benefit had also been mandated through *state action* after December 31, 2011.[32] While there is no official definition of what constitutes state action, HHS has clarified that it extends to legislative action, regulatory action, and administrative guidance, among other mandates that come from the state government and are outside of the EHB benchmarking process.[33] CCIIO's guidance exempting new BBP mandates from defrayal is important because it allows states to use any of the three new BBP options to require coverage of any service under the EHB benchmarking process as long as the state submits an actuarial analysis certifying that the BBP meets the generosity test.

Taking advantage of these opportunities, two states have received approval for new BBPs using the EHB standard under the 2019 NBPP, and both of these states used the process to effectively expand the number of services covered as EHBs. First, Illinois' new BBPP was

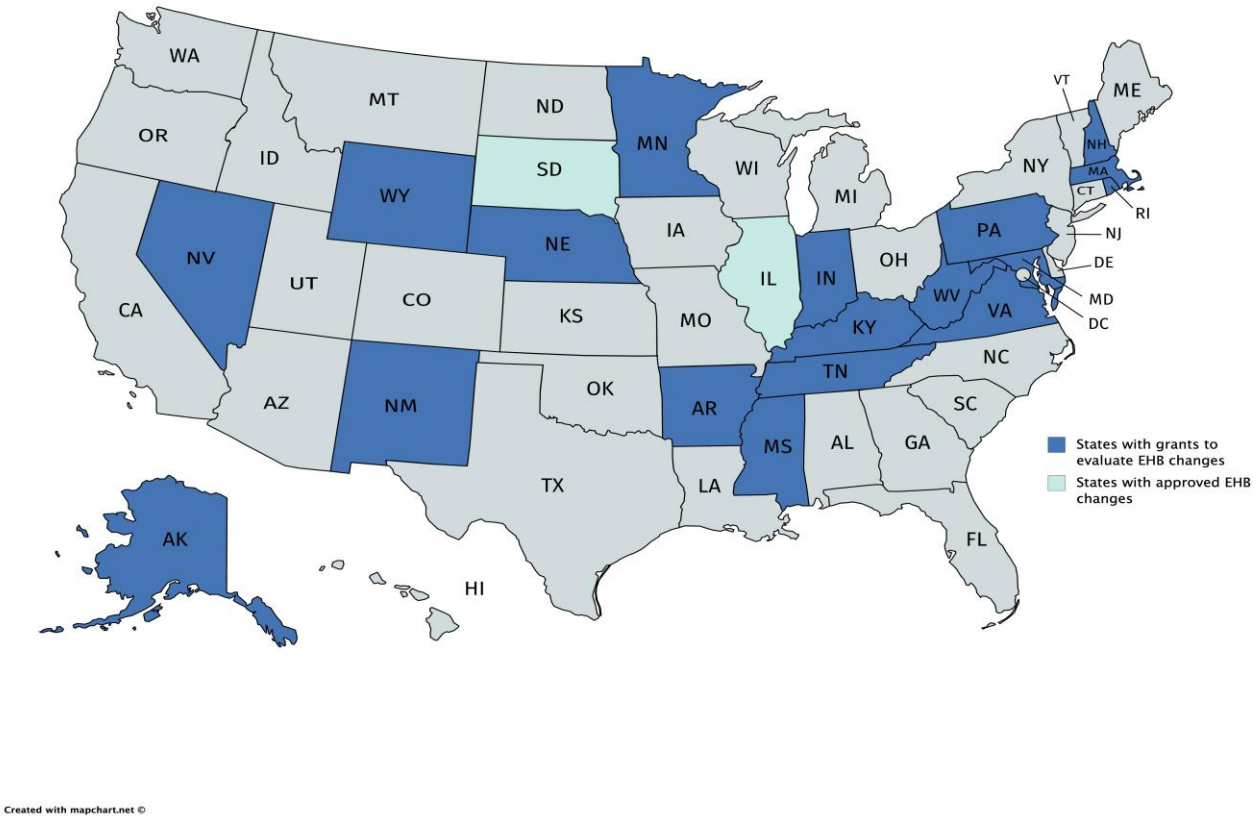
approved by CCIIO in August 2017 and applies to plan years 2020 and beyond.[34] Illinois used the EHB benchmarking process as a tool to combat the state's ongoing opioid overdose epidemic. The new BBP covers services such as non-opioid alternative therapies for pain, automatic prescriptions for the intranasal formulation of the overdose-reversal medication naloxone when initial dosages of opioids exceed 50MME, and tele-psychiatry care.

In addition, to reduce unnecessary opioid use and avoid development of opioid use disorders, Illinois' BBP now limits initial opioid prescriptions for acute pain. Lastly, the BBP requires plans to remove all barriers to accessing buprenorphine when prescribed as a medication for opioid use disorders. As required under the 2019 NBPP, Illinois informed CCIIO that it had used option three under the 2019 NBPP (allowing states to select a new set of benefits for each category) to define EHBs.[35] However, outside of the additional services and limitations already described, the state decided to use the same services in their previous BBP for all categories.

South Dakota is the second state to receive approval from CCIIO for a new BBP. The state received approval in July 2019, with the new BBP applying for plan years 2021 and beyond.[36] The new BBP covers applied behavioral analysis for Autism Spectrum Disorder for beneficiaries eighteen and under. As with Illinois, South Dakota informed CCIIO that it had used option three to create a new BBP.[37] This new BBP, however, retained the same level of benefits covered by the State's previous BBP, with the single exception that the new BBP requires coverage of applied behavioral analysis for autism.

Advocates should be aware that, in addition to Illinois and South Dakota, other states are in the process of evaluating their BBPs and consider changes. CCIIO has awarded thirty states and the District of Columbia grants through the *State Flexibility to Stabilize the Market Grant Program.* These grants are designed to "enhance the role of states in planning and implementing several of the federal market reforms and consumer protections."[38] While states are not required to use the grants to evaluate potential changes to their BBPs, twenty states have received approval from CCIIO to utilize the grants for implementation or planning of the EHB coverage provision and are likely to consider changes to their BBPs.[39] Advocates in these states should continue monitoring the use of these grants to make sure that states are seeking to expand, not cut, services and to advocate for implementation of the best practices discussed in the following section.

States receiving grants to evaluate EHB changes or with approved EHB changes



V. Best Practices for Updating EHB Benchmark Plans under 2019 NBPP

Given this opportunity to update and expand coverage of EHBs, states are likely to begin evaluating and proposing changes to their EHB BBPs in the upcoming years. Stakeholders and advocates should urge state leaders to consider the following best practices when evaluating and proposing changes.

a. State BBP planning and updating should track federal filing deadlines

Every year, HHS releases a new Notice of Benefit and Payment Parameters for the plan year beginning two years after the rule is finalized. That notice contains information about the deadlines that states seeking changes to their EHB BBPs should meet in order to be considered for approval by CCIIO. For example, the deadline to submit proposed BBPs for plan year 2022 is May 8, 2020.[40] Similarly, in the proposed *Notice of Benefit and Payment*

Parameters for 2021 ("2021 NBPP"), HHS proposed May 7, 2021 as the deadline for states seeking changes to their BBP for plan year 2023.[41]

Deadlines to Submit Changes to BBPs under New EHB Standard

- July 2, 2018 for Plan Year 2020
- May 6, 2019 for Plan Year 2021
- May 8, 2020 for Plan Year 2022
- May 7, 2021 (proposed) for Plan Year 2023

Because there are several steps that states must take before they submit a proposal, states should begin working on these steps with ample time to meet the corresponding deadlines and ensure that insurers have ample opportunity to adjust their plans as appropriate. Before the deadline, states should begin evaluating their current BBPs and hear from stakeholders about necessary changes; commission actuarial reports to understand how much they can improve coverage without exceeding the generosity limits; commission an actuarial report that certifies that the changes meet the generosity and typical employer plan requirements; and provide ample time for stakeholders to provide comments and/or participate in hearings and for the state to address those comments before submitting the proposal to CCIIO. Because of all these necessary steps and the need to ensure transparency and compliance with federal requirements, states should begin acting months ahead of the deadline.

b. States should evaluate their current BBP, with input from stakeholders, to determine whether changes are needed

In what is perhaps the most important step in the process, states will inevitably need to balance competing interests when deciding what services to add or expand using the new EHB benchmarking authority. The 2019 NBPP allows states to expand coverage, but this authority is not unlimited. As discussed previously, new BBPs may not exceed the generosity of the most generous BBP options the state had in 2017. States may thus be able to add certain services, but will not be able to expand benefits across the board without either cutting other benefits to balance out the actuarial value of the resulting BPP or risk running afoul of the generosity requirement.

States will need to conduct a thorough and transparent analysis of their current BBP in order to determine where improvements are needed. This analysis should include public engagement opportunities where stakeholders can formally recommend changes to the current BBP. Because such a process will result in competing interests advocating for the addition or expansion of different benefits, states must have a structured process to consider the proposals that relies on actual real-world data and sheds light on the most pressing health care

needs and coverage gaps in the state. State decision making should be solely guided by this data-driven process. State officials and advocates should commit to evidence-based coverage improvements that would have the most significant impact across the state, considering factors such as the prevalence and types of medical need, the intensity of that medical need (and consequences for not addressing it), and the disproportionate disease burden borne by different subpopulations

c. States should commission an actuarial analysis that follows CCIIO's rules to determine the extent to which services may be added without violating the generosity test

HHS did not specify a methodology for actuarial analyses used to determine whether adding services to a BPP exceeds the generosity of the most generous of the BPP options the state had in 2017. The only requirement added by the 2019 NBPP is that the analysis must comply with generally accepted actuarial principles and methodologies.[42] In 2018, CCIIO released guidance that provided states with an example of an accepted, albeit not required, methodology.[43] Pursuant to such guidance, states can commission reports that compare the *expected values* of the resulting BBP and the most generous plan.

To calculate the expected value of the plans, actuaries must use reasonable actuarial assumptions and methods and may use data acquired from insurers in the state for a recent plan year, and weigh the services and benefits provided in each EHB category. Under the sample methodology outlined by CCIIO, for example, the proposed BBP would fail to meet the generosity test "if the expected value for each applicable EHB category of benefits in the proposed State's EHB-benchmark plan exceeds 100 percent of expected value for those same EHB categories of benefits in the most generous [Comparison Plan]." Actuaries may also compare the overall benefit cost of the proposed BBP with the overall benefit cost of the most generous plan. Regardless of the selected methodology, it is essential that states demonstrate compliance with the requirements by comparing the proposed BBP to the most generous BBP option in 2017. It is not enough for the actuarial report to show the effect that the changes in the proposed BBP would have on the cost of the current BPP.

South Dakota is a good example of how actuaries should be conducting the generosity test analysis. Here are the steps taken by actuaries in that state:

1. **Step 1:** Actuaries in South Dakota first calculated the expected costs of benefits of the BBP selected by the State in 2017.[44] To determine the overall benefit cost of the plan, actuaries used utilization rates, claims, among other data from 2017.

2. **Step 2:** Actuaries then calculated the expected benefit cost of each of the other BBP options available to the State in 2017 using utilization rates, claims, among other data available from the plans in 2017.[45]
3. **Step 3:** Actuaries then calculated the relative benefit cost differences between the BBP selected by the State in 2017 and each of the other options available in order to determine which plan option was the most generous one.[46] From this analysis, actuaries in South Dakota were able to determine that the most generous options available in 2017 were the three largest state employee plans (each with a relative value of +0.3% compared to the BPP selected by South Dakota in 2017).[47]
4. **Step 4:** Actuaries then calculated the impact that adding applied behavioral analysis services would have on the expected cost of the BBP selected by the State in 2017. This analysis concluded that adding applied behavioral analysis to the 2017 BBP, with the corresponding limitations, resulted in an increase of 0.3% in value.[48]
5. **Step 5:** Actuaries compared the impact that adding applied behavioral analysis would have on the expected value of the BBP selected by the State in 2017 (+.03%) to the difference between the expected value of the three largest state employee plans and the expected value of the BBP selected by the State in 2017 (+.03%).[49] Using this analysis, actuaries concluded that the difference in expected value of adding applied behavior analysis was within the "allowable increase in generosity."[50]
6. **Step 6:** Finally, actuaries in South Dakota certified that the proposed BBP (with the addition of applied behavioral analysis) met both the generosity and typical employer plan requirements.[51]

Just like South Dakota, states proposing changes to their EHB BBPs should make sure that the actuarial analysis submitted to demonstrate compliance with the generosity requirement has been conducted using accepted methodology and having compared the values of the two comparison plans (most generous plan and proposed BBP) and not merely the overall increase in cost.

d. To avoid defrayal of cost, states should consider adding new coverage requirements through the EHB benchmarking process instead of enacting new mandates through state action

As explained above, CCIIO has stated that any additional service mandated through the EHB benchmarking process will not be treated as a state mandate for defrayal of cost purposes unless the benefit had also been mandated through state action after December 31, 2011. Currently, many states are evaluating requiring private plans (both in the Marketplace and outside the Marketplace) to cover certain benefits outside of the EHB benchmarking process. For example, legislation has been introduced in several states to require private plans to begin covering hearing aids for minors.[52] While the distinction between passing a new law and

modifying the EHB BBP may seem inconsequential, the implication of passing a statute mandating coverage of new services such as hearing aids is that the state will have to bear the costs incurred by plans to cover the new or added service(s). The reasoning behind this distinction is that, as opposed to modifying the BBP, enacting a new statute will be considered a state mandate passed after December 31, 2011. The same goes for mandates enacted through any other type of state action, such as regulations and administrative guidance.

While the distinction between passing a new law and modifying the EHB BBP may seem inconsequential, the implication of passing a statute mandating coverage of new services such as hearing aids is that the state will have to bear the costs incurred by plans to cover the new or added service(s).

Instead, states should take advantage of the opportunities afforded to them by the new EHB benchmarking standard and consider proposing new BBPs that include the additional services. First, as opposed to the previous BBP options, under any of the three new options, states have considerable leeway to expand services they believe necessary. For instance, a state that currently does not require coverage of hearing aids, may use option two and substitute the habilitative and rehabilitative services category of their BBP with the same category of the BBP selected by another state that does include coverage for hearing aids. Similarly, a state could use option three and simply re-define the rehabilitative and habilitative category of their BBP as extending to coverage of hearing aids.

Second, many of the services that states are seeking to add will not make the BPP exceed the generosity limit. Using the same example, many states have already commissioned actuarial analyses that show that the cost of adding hearing aids to the BBP is minimal. As such, it is likely that only adding coverage for hearing aids will not exceed the generosity of the most generous plan available to the state in 2017. As evidenced by the actuarial analyses of Illinois and South Dakota, the same is true for such services as non-opioid therapy alternatives and applied behavioral analysis.

e. States should ensure transparency throughout the process and provide stakeholders with meaningful opportunity to provide input

The 2019 NBPP requires states to comply with several procedural requirements that ensure stakeholder participation throughout the benchmarking process and guarantees transparency. As previously discussed, the rule requires states to provide reasonable public notice that contains associated information and an opportunity for stakeholders to comment before the state submits the proposal for approval by CCIIO. However, these requirements have not been uniformly enforced by CCIIO and the federal government has provided little guidance to states

that expand on the regulatory language. Nonetheless, there are several actions states could take to ensure that the public is kept informed at all times and that stakeholders have meaningful opportunity to provide input.

For instance, although the 2019 NBPP did not establish a minimum period of time for stakeholders to comment on the proposed BBP changes, this period should be ample enough to allow stakeholders to review the proposal, evaluate associated information in detail, write and submit comments, and, when available, participate in hearings where the agency proposing the changes is available to answer questions. In addition, to maintain transparency and guarantee that stakeholders are able to provide meaningful input, states should include all relevant information for commenters to evaluate the proposal.

The notice should be posted on the agency's public website and include information such as: which of the three options the state is using to select a new BBP; if using option one or two, the state or states the selecting state is using to model its BBP after; the specific service(s) the state is proposing to add, expand, limit, or eliminate; actuarial analysis(es) specifying how the changes affect the actuarial value of the BBP; and how the actuarial value of the resulting BPP compares to the value of the most generous BBP option available to the state in 2017 in the case of additions or expansion of benefits, and to the typical employer plan selected by the state in the case of limits to or elimination of benefits. States should also be able to respond to comments and, where necessary, address any significant discrepancies.

Advocates should urge states to adopt standards for public commenting that mirror those specified by HHS for states requesting waivers through Section 1115 of the Medicaid Act. Those standards require states to issue a public notice that contains a "comprehensive description" of the application and "a sufficient level of detail to ensure meaningful input from the public."[53] In addition, states seeking a section 1115 waiver are required to give stakeholders thirty days to submit comments.[54] Finally, at least twenty days before submitting the section 1115 waiver application, states must hold at least two public hearings, on separate dates and at separate locations, during which "members of the public throughout the state have an opportunity to provide comments" on the demonstration application.[55] While none of these steps are explicitly required by the 2019 NBPP, implementing such a robust commenting period would ensure that states seeking changes to their BBP comply with the requirement to provide reasonable public notice and a meaningful opportunity for comment.[56]

Implementing a robust notice and commenting period would ensure that states seeking changes to their BBP comply with the requirement to provide reasonable public notice and a meaningful opportunity for comment.

Illinois and South Dakota illustrate the difference between minimal and meaningful opportunity for comment. Illinois announced its proposal to select a new BBP via an email to stakeholders and gave stakeholders only twelve days to evaluate changes and provide input. Moreover, although the notice was posted on the Illinois Department of Insurance's website, the announcement merely included general information about the five items the state was proposing to add to its BBP. The notice did not include information about which of the three options the state was using to select a new BPP, actuarial information about the resulting BPP, or certification that the new BPP complied with the generosity and typical employer plan tests. South Dakota's State Division of Insurance, on the other hand, made available all of this information alongside the notice providing opportunity for comment. The state, in fact, made public an actuarial analysis, which contained detailed information about the actuarial effect of adding applied behavioral analysis services to the BPP and the methodology used to determine that such addition complied with the generosity requirements.

VI. Conclusion

The federal government has continuously deferred to states for the establishment of standards for coverage of EHBs. State authority to define EHB categories was expanded after adoption of the 2019 NBPP, which allowed states to significantly expand covered services as long as the value of the resulting BPP does not exceed the value (or generosity) of the most generous of the 2017 BPP options. Most, if not all, states have ample room for improvement regarding coverage of EHBs in the private market. Consequently, states should take advantage of the opportunities afforded to them by the new EHB standard and carefully consider where changes are needed and the extent to which such changes may be adopted without violating federal requirements. These changes should always be proposed and implemented keeping the best interest of enrollees in mind and maintaining transparency and open communication with stakeholders throughout the process.

ENDNOTES

[1] 42 U.S.C. § 18022(b)(1).
[2] 45 C.F.R. § 156.100(a).
[3] 45 C.F.R. § 156.100(c).
[4] 45 C.F.R. § 156.110(b)(1).

[5] 45 C.F.R. § 156.110(b)(2)–(3).
[6] 45 C.F.R. § 156.115(b)(1).
[7] 45 C.F.R. § 156.115(b)(2)(i).
[8] *See generally* 45 C.F.R. § 156.100(a); CCIIO, Information on Essential Health Benefits (EHB) Benchmark Plans, https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb (last visited March 17, 2020).
[9] 45 C.F.R. § 156.122. For more information on the EHB Prescription Drug standard and the changes introduced as part of the 2016 NBP, *see* NHeLP's 2015 EHB Prescription Drug Series beginning with Wayne Turner, Nat'l Health Law Prog., *EHB Prescription Drug Standard – Formulary Transparency* (2015), https://healthlaw.org/resource/ehb-prescription-drug-standard-formulary-transparency/.
[10] 45 C.F.R. § 156.115(a)(5).
[11] 45 C.F.R. § 156.115(a)(6).
[12] 42 U.S.C. § 18031(d)(3)(B).
[13] 45 C.F.R. § 155.170.
[14] In the *Notice of Benefit and Payment Parameters for 2021*, HHS has proposed to require states to submit an annual report to CCIIO detailing all the benefit mandates enacted by the state and whether the state is defraying the cost of covering such services. In the case of mandates for which the state is not defraying the cost, HHS has proposed to require states to submit their reasoning for not considering them state mandates for the purpose of defrayal. The proposed rule is pending approval. 85 Fed. Reg. 7128–7132.
[15] 45 C.F.R. § 156.111(d).
[16] 45 C.F.R. § 156.111(a)(1).
[17] 45 C.F.R. § 156.111(a)(2).
[18] 45 C.F.R. § 156.111(a)(3).
[19] 45 C.F.R. § 156.111(b)(2)(i). The rule defines "typical employer plan" as either one of the selecting State's 10 base-benchmark plan options available for the 2017 plan year, or the largest health insurance plan by enrollment within one of the five largest large group health insurance products by enrollment in the State. For more information about the typical employer plan requirement, which is particularly relevant in states that are seeking to cut benefits, *see* Hayley Penan, Nat'l Health Law Prog., *Step Guide to Updating Your State's Essential Health Benefits Benchmark Plan* (2018), https://healthlaw.org/resource/step-guide-to-updating-states-essential-health-benefits-benchmark-plans/.
[20] 45 C.F.R. § 156.111(b)(2)(ii).
[21] 45 C.F.R. § 156.115(b)(2)(ii).
[22] 45 C.F.R. § 156.115(b)(3)(i).
[23] 45 C.F.R. § 156.111(b)(1); 45 C.F.R. § 156.115(b)(3)(ii).
[24] 45 C.F.R. § 156.111(b)(2)(iii); 45 C.F.R. § 156.115(b)(3)(ii).
[25] 45 C.F.R. § 156.111(b)(2)(iv); 45 C.F.R. § 156.115(b)(3)(iii).
[26] 45 C.F.R. § 156.111(b)(2)(v).
[27] 45 C.F.R. § 156.111(c).
[28] *Id.*
[29] 45 C.F.R. § 156.111(e)(1).
[30] 45 C.F.R. § 156.111(e)(2).
[31] *See* CCIIO, Plan Year 2014-2016 Essential Health Benefits Benchmark Plans, https://www.cms.gov/CCIIO/Resources/Data-Resources/2014-2016-EHB-BenchmarkPlans (last visited March 17, 2020); CCIIO, *Essential Health Benefits: List of the Largest Three Small Group Products by State* (2015), https://ccf.georgetown.edu/wp-content/uploads/pdfs/largest-smgroup-products-4-8-15-508d-pdf-Adobe-Acrobat-Pro.pdf.

[32] CCIIO, *Frequently Asked Questions on Defrayal of State Additional Required Benefits* (2018), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-Defrayal-State-Benefits.pdf.
[33] *See* 81 Fed. Reg. 12242.
[34] Ill. Dep't of Ins., Illinois becomes first and only state to change Essential Health Benefit-benchmark plan (Aug. 27, 2018), https://www2.illinois.gov/IISNews/18098-DOI_Essential_Health_Benefit-benchmark_plan_Release.pdf.
[35] CCIIO, Illinois' 2020-2021 EHB Benchmark Plan Information, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2020-BPM-IL.zip (last visited March 17, 2020).
[36] S.D. Dep't of Labor & Regulation, Essential Health Benefits Benchmark Design Changes Approved for Plan Year 2021 (July 23, 2019), https://dlr.sd.gov/news/releases19/nr072319_ehb_benchmark_approved.pdf.
[37] CCIIO, South Dakota's 2021 EHB Benchmark Plan Information, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/SD-Plan-Documents.zip (last visited March 17, 2020)
[38] *See* CCIIO, State Flexibility to Stabilize the Market Grants, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/State-Flexibility (last visited March 17, 2020).
[39] CCIIO, *Fact Sheet: The State Flexibility to Stabilize the Market Grant Program* (2018), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/state-flexibility-grant-fact-sheet.PDF.
[40] 84 Fed. Reg. 17534.
[41] 85 Fed. Reg. 7132.
[42] 45 C.F.R. § 156.111(e)(2).
[43] CCIIO, *Example of an Acceptable Methodology for Comparing Benefits of a State's EHB benchmark Plan Selection in Accordance with 45 CFR 156.111(b)(2)(i) and (ii)* (2018), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Example-Acceptable-Methodology-for-Comparing-Benefits.pdf.
[44] Nicholas Ramey, Leif Associates, Inc., *State of South Dakota – Essential Health Benefits Analysis of 2021 Benchmark Plan Options* (2019).
[45] *Id.*
[46] *Id.* at 5.
[47] *Id.* at 7.
[48] *Id.*
[49] *Id.*
[50] *Id.*
[51] *Id.* at 11–13.
[52] *See*, for example, California AB 598 (2019–2020); *See also* Vermont S.320 (2020).
[53] 42 C.F.R. § 431.408(a)(1)(i).
[54] 42 C.F.R. § 431.408(a).
[55] 42 C.F.R. § 431.408(a)(3).
[56] For additional information about the notice and comment process for states submitting 1115 waiver applications, *see* Catherine McKee & Jane Perkins, Nat'l Health Law Prog., *Section 1115 Waiver Requirements: Transparency and Opportunity for Public Comment* (2017), https://healthlaw.org/resource/sec-1115-waiver-requests-transparency-opportunity-for-public-comment/.