Explainer: Proposed Changes to the Essential Health Benefits Standard in the 2025 Notice of Benefits and Payment Parameters

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The U.S. Department of Health and Human Services (HHS) recently released the Notice of Benefit & Payment Parameters for plan year 2025 (2025 NBPP), which introduces several updates on coverage standards that apply to a vast array of health plans across the country. Among those are policies related to Essential Health Benefits (EHB), the Affordable Care Act's (ACA) solution to ensuring that expanded eligibility for health insurance (through Medicaid expansion or Marketplace options) was accompanied by comprehensive coverage of a basic set of health services. In this explainer, we discuss the changes being proposed by HHS, the importance of EHBs and the proposed NBPP changes for purposes of advancing health equity, and areas for improvement that remain moving forward.

Background

Before the ACA's enactment, most health plans offered lackluster coverage or excluded categories of benefits we now consider essential, such as mental health and substance use disorder (MH/SUD) treatment, maternity and newborn care, and rehabilitative and habilitative services and devices. As a result, the ACA required all non-grandfathered individual and small group market plans, as well as Medicaid's Alternative Benefit Plans (ABP) provided to the Medicaid expansion population, to cover a minimum level of health benefits considered essential. While the ACA did not extend the EHB coverage mandate to large group and self-insured plans, it provided cost-sharing protections, barring annual or lifetime caps for EHBs.

The law also gave HHS the authority to define EHBs within certain parameters including:

- EHBs must include, at least, services in ten categories of benefits;
- the scope of EHB must be equal to the scope of benefits under a "typical employer plan" (hereinafter typicality requirement);

- EHBs must reflect an appropriate balance among the different categories of benefits; and
- the resulting benefit designs must not discriminate against individuals based on age, disability, or expected length of life.

HHS is also required to periodically review the EHBs and update the definition of EHBs "to address any gaps in access to coverage or changes in the evidence base."

Since 2011, HHS delegated the responsibility to define EHBs to the states through a benchmarking process, whereby states select a model plan that all other non-grandfathered plans in the state must follow in terms of benefits covered. The benchmarking process has undergone several changes throughout the years, but HHS has not wavered in its intention to continue to allow states to define EHBs rather than set a national standard. HHS did introduce minimum standards for some EHB categories where gaps remained years after the ACA went into effect, including prescription drugs, MH/SUD, and habilitative services and devices. Unfortunately, those actions have not sufficiently addressed persisting variation in coverage across the states that is significantly contributing to health disparities.

For example, despite the fact that rates of maternal death are on the rise particularly among women of color, the benchmarking process has allowed wide variation among states' EHB benchmark plans' coverage of maternity care and inconsistent coverage of fundamental services, such as prenatal and labor services, postpartum and lactation services, breastfeeding support and supplies, and midwives and doula support. Similarly, benchmark plans inconsistently cover medications for SUDs despite the fact that such services are considered the gold standard of care for this condition. With regards to rehabilitative and habilitative services, many benchmark plans exclude medically necessary hearing aids from coverage and some limit mobility devices, including wheelchairs, to use inside the home.

Given this reality, HHS issued a Request for Information (RFI) in December 2022 soliciting formal input regarding coverage of benefits in plans subject to the EHB requirement. The EHB changes contained in the 2025 NBPP are the result of HHS' analysis of the hundreds of comments state policymakers, advocates, and other stakeholders submitted in response to the RFI. NHeLP has persisted in raising the alarm on the barriers that Black, Indigenous, and Other People of Color (BIPOC), LGBTQIA+ individuals, individuals with disabilities, and other marginalized communities still face in accessing essential services.

2025 NBPP Changes to EHB Requirements

Streamlining the Benchmarking Process

The current EHB rules allow states to update their benchmark plans in three alternative ways:

(1) by selecting the benchmark plan from another state;
(2) by selecting one or more categories of EHBs from another state's benchmark plan; or
(3) by otherwise selecting a set of benefits that would become the state's EHB benchmark plan.

The rule also establishes that states that do not elect to change their benchmark using one of these three options would default to their previously selected benchmark plan.

For states that elect to update their benchmark plan, the rule establishes two parameters. First, the proposed benchmark plan must be *equal to, or greater than, to the extent that supplementation is required to provide coverage within each EHB category,* the scope of benefits provided under a typical employer plan. The rule also defines typical employer plan as any of the following:

- One of the selecting State's 10 base-benchmark plan options available for the selecting state's selection 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.

Second, the proposed benchmark plan cannot exceed, in actuarial terms, the generosity of the most generous among a set of comparison plans, including: the State's EHB–benchmark plan used for the 2017 plan year and any of the State's base-benchmark plan options for the 2017 plan year. States are required to submit various documentation to HHS when seeking changes to their benchmark plan, including an actuarial report and certification and a formulary drug list in the format and manner specified by HHS.

While the current benchmarking rule has afforded states additional flexibilities to expand access to key services and address persisting gaps in coverage, states report the process is burdensome and time-consuming. To date, nine states have taken advantage of the flexibilities; however, as HHS explains in the preamble to the 2025 NBPP, many more states could benefit from seeking changes and HHS is intent on making it as easy as possible for states to use benchmarking as a tool for improving access to health care services.

With that in mind, HHS proposes three new policies to simplify the EHB benchmarking process and encourage more states to take advantage of the flexibilities. First, the proposed rule

would consolidate the three current benchmark options and would only maintain option three, which already encompasses the first two options. Second, the proposed rule would eliminate the requirement for states to submit a drug formulary in situations when the state is not requesting changes to their prescription drug EHB. These two proposals would save states time and money, increasing the likelihood that they will look to EHB benchmarking to address unmet health needs.

The third proposal seeks to provide more room for states to adopt new benchmark plans (and add new coverage requirements) in order to address unmet health needs without losing sight of the ACA's typicality requirement. The proposal would fundamentally change the two parameters that, as explained above, states have to comply with when seeking benchmark changes. With regards to "typicality," which many stakeholders (including our organization), states, and actuaries have interpreted to establish a "floor" that prevents states from using the benchmarking flexibilities to cut or eliminate currently covered/mandated services, HHS clarifies that the rule was never intended to serve as a floor. Rather, HHS emphasizes that states have to make sure that the proposed benchmark plan is *exactly equal* (in actuarial terms) to any of the plans that could be considered typical employer plans described above. At the same time, HHS argues that such rule has been burdensome on states because actuaries have to first determine the actuarial scope of all typical employer plan options and then determine whether the actuarial scope of the proposed benchmark plan is equal to the actuarial scope of any of the typical employer plan options.

To ease this burden on states, HHS now proposes to actually establish a floor that would be represented by the typical employer plan (of those options outlined above) with the less generous actuarial value. The proposed rule also imposes a maximum level of actuarial scope for the proposed benchmark plans represented by the typical employer plan (of those options outlined above) with the most generous actuarial scope of benefits. Because the most generous typical employer plan option would serve as a ceiling, the generosity limit described above would be duplicative and would therefore be eliminated under the proposed rule. As with the current generosity limit, the purpose of the "ceiling" is to avoid a situation in which states add services excessively leading to uncontrolled increases in costs that would then be passed on to consumers.

The proposed rule, effectively introducing a range of options to meet typicality rather than full equivalency, is in line with what we believe is a more appropriate reading of the ACA. One of the fundamental underlying principles in the ACA is that by investing in critical services we will transform health care coverage and reduce long-term spending. It would make little sense for the ACA to list these critical services and then suggest they be covered only to the minimal extent already covered. The shortcomings in many employer plans are one of the reasons that

prompted Congress to include EHB as a key component of the ACA, intending to invest in these services beyond pre-ACA minimum norms. Therefore, a section requiring EHB benefits to be "equal to" a typical employer plan arguably should be construed as "no less than" or "within the general range of," rather than "strictly no more than," given the ACA as a whole.

The ultimate effect of the proposed rule would be to permit states to consider the largest health insurance plan by enrollment within one of the five largest large group health insurance products by enrollment in the State as one of the typical employer plan options used to calculate the actuarial limit/maximum that a proposed benchmark plan can achieve. Because large group plans tend to be more generous than individual and small group market plans, it is conceivable than many states will now have more actuarial room to expand coverage requirements under the benchmarking process. This will allow states to significantly expand access to key services where gaps remain, particularly those where gaps are contributing to health disparities.

Expanding Coverage of Routine Adult Dental Care

When HHS first established the benchmarking process in federal regulations, the agency included a provision that prohibited health plan issuers from offering routine non-pediatric dental care, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as EHB. In the 2025 NBPP, HHS proposes to delete the reference to routine non-pediatric dental care from this provision. This would also enable states to include coverage of adult dental care through the benchmarking process, although, as the preamble to the proposed rule explains, the rule does not require states to make such changes.

HHS justified the current exclusionary rule by finding that adult dental and vision care, long-term home care, and non-medically necessary orthodontia services were traditionally not included in employer plans. As HHS notes in the 2025 NBPP, however, employer plans have increasingly expanded coverage of adult dental care to the point that it is now reasonable to conclude that such services are part of typical employer plans. Regardless, as we explained above, a more appropriate reading of the ACA that treats typicality as a minimum requirement or as a range would call into question the need to categorically exclude specific services from coverage.

Additionally, HHS observed that adult dental and vision care, long-term home care, and non-medically necessary orthodontia services can be offered under separate plans as "excepted benefits." The concept of excepted benefits was introduced in the Health Insurance Portability and Accountability Act (HIPAA) to exempt certain plans from the statute's obligations. In its

definition of excepted benefits, the HIPAA statute and implementing regulations include limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits. The ACA, however, did not change the definition of excepted benefits, nor did it explicitly state that already defined excepted benefits were to be excluded from the definition of EHBs. As a result, a plain reading of the EHB statute and other provisions related to Qualified Health Plans (QHPs) lends no support to the notion that under no circumstance could vision, dental, and long-term care benefits be considered EHBs.

The proposal to remove the regulatory prohibition on adult dental care may have far-reaching implications for health equity. For example, BIPOC consumers are less likely than white consumers to receive dental care, in part because of lack of coverage (while the Medicaid expansion reduced such disparities, they persist particularly in states that have not expanded Medicaid and states with less generous dental benefits). Moreover, lack of access to dental services also leads to other serious conditions, including cardiovascular disease and low birthweights, which are more prevalent in underserved communities. By allowing states to require dental care coverage (coupled with the proposal to expand the actuarial room that states have to expand benefits), the 2025 NBPP opens the door to the possibility that states will use the benchmarking process to require dental care as a way to address the aforementioned health disparities regarding dental care and related conditions.

HHS also seeks comments as to whether the agency should repeal the whole provision so that states are also allowed to require coverage of adult vision and long-term home care as EHBs. Because the legal reasoning outlined above and the equity considerations also apply to these services, we will be urging HHS to extend the scope of the proposed rule and expect many stakeholders to do so as well.

Improving Access and Strengthening Cost-Sharing Protections for Prescription Drugs

Under the current federal EHB rules, plans must cover the greater of: one drug per class or category of the U.S. Pharmacopeia (U.S.P.) or the number of drugs covered by the state's benchmark plan in each U.S.P. class and category. Federal regulations also require plans to establish Pharmacy & Therapeutics (P&T) committees to evaluate new approved drugs or new indications in a timely manner.

In the 2025 NBPP, HHS proposes or asks about various potential amendments to the prescription drug standard. First, HHS proposes to require plans to include a consumer representative as part of P&T committees so that the consumer perspective would be considered when evaluating extending coverage to new drugs in the market or new indications

without having to wait for updates to the U.S.P. Second, while HHS does not propose moving away from the U.S.P. as a model for prescription drug coverage, the proposed rule asks stakeholders for feedback regarding the risks and benefits of replacing the U.S.P. with a different drug classification system.

Perhaps the most significant prescription drug proposal in the 2025 NBPP is HHS' intention to codify a current policy that establishes that, when plans cover prescription drugs beyond the bare minimum, those additional medications are still considered EHBs. This ensures that cost-sharing protections apply to the whole spectrum of a plan's drug formulary, rather than being limited to those medications the plan is required to provide. Many issuers across the country have tried to exclude some drugs from the EHB cost-sharing protections, imposing exorbitant financial burdens on consumers. As expected, the heaviest burden falls on individuals with complex health needs who use costly prescription drugs. Codifying HHS' policy would protect these patients and strengthen health equity regarding access to prescription drugs.

Introducing Additional Flexibility on Defrayal of Non-EHB State Mandates

The ACA establishes that while states are permitted to require coverage of benefits in addition to those considered EHBs, they must defray the cost of providing those state-mandated benefits. Through rulemaking, HHS defined state mandates in addition to EHBs as those mandates enacted via state action (legislative, administrative, or otherwise) at any time after December 31, 2011. In 2018, after HHS adopted the current benchmark options, the agency subsequently determined that state coverage mandates adopted through the EHB benchmarking process would be considered EHBs and would therefore not be subject to defrayal unless the state also enacted the mandate via state action outside of the benchmarking process after 2011.

This policy has allowed states to take advantage of the current expansive benchmarking options to effectively adopt new coverage mandates (and in so doing address unmet health needs and health disparities) without having to cover the cost of providing such benefits. It has enabled states to require coverage of gender-affirming care services, expanded SUD treatment and non-opioid treatment alternative for pain, hearing aids, and weight loss medications, among other services that particularly benefit underserved communities, by adding such benefits to their benchmark plans and without having to bear the cost of paying for those services.

However, several aspects of defrayal requirements have remained unclear. For example, as originally written, the HHS policy requires states to defray the cost of mandates that are adopted simultaneously via a post-2011 state action and through benchmarking. It also

seemingly prohibits states from adopting a mandate via state action and subsequently switching to the benchmarking process without being subject to defrayal. This likely unintended result has the effect of deterring states from seeking new coverage mandates altogether. To avoid this situation, HHS proposes to codify that all benefits covered in a state's EHB benchmark plan would not be considered in addition to EHB and therefore not subject to defrayal. As HHS explains, this rule would enable states to switch from state mandate to benchmarking without defraying and would allow states that are currently defraying the cost of state-enacted mandates to cease defraying such costs if and when the state updates its benchmark plan to reflect the new benefit.

What's Missing?

Undoubtedly, the 2025 NBPP includes important changes to the EHB standard that will enable states to use the benchmarking process to address persisting coverage gaps. However, there are various changes we hoped to see that were unfortunately not included. First, the proposal is silent as to whether HHS intends to establish a process to periodically review and update EHBs as required by the ACA. To date, HHS has yet to conduct such a review. Given the gaps that remain in individual and small group market plans, it is likely that such a review will shed light on the need to update EHB standards at the federal level to address ongoing needs. Advocates have pushed HHS to establish a transparent process to conduct periodic EHB reviews and updates; and to engage health care consumers and other key stakeholders.

Second, the proposed rule does not offer changes or clarifications to the provision of the defrayal rule that exempts state mandates enacted for the purpose of complying with federal requirements from defrayal. To our knowledge, only a couple of states have passed mandates outside of the benchmarking process and have justified not applying defrayal by reasoning that the mandates are necessary to ensure compliance with a federal requirement, such as non-discrimination rules or mental health and SUD parity. We also know of various states that have been reluctant to adopt state mandates for fear of defrayal, despite stakeholders' position that defrayal would not apply because the mandate in question is necessary to ensure compliance with federal non-discrimination or parity rules. While HHS has offered states assistance in interpreting this provision, clarification through rulemaking would help enable states to take advantage of the exemption. For example, HHS could have provided examples of these scenarios in the preamble to the rule. HHS could also have outlined a process for states to take advantage of the exemption.

In addition, the 2025 NBPP is silent as to the effect of coverage mandates passed for purposes of compliance with federal requirements on the benchmarking actuarial ceiling (which the proposed rule establishes as the most generous of the typical employer plan options). When a

mandate is passed for purposes of complying with a federal requirement, such coverage should not be considered for purposes of calculating the actuarial limit of the benchmark plan. Plans are required to comply with such a mandate regardless of the resulting costs and states should not be penalized for seeking to enforce federal requirements through the benchmarking process. Rather, states should be allowed to use their actuarial room to address other gaps that are contributing to health disparities.

We hope that HHS will address these concerns in future iterations of the EHB rules.

Conclusion

EHBs are a fundamental and underutilized tool to advance health equity. In the 2025 NBPP, HHS seeks to use its authority to define EHBs to allow states to strengthen coverage in a way that addresses unmet health needs, particularly among underserved communities. We welcome these changes, while at the same time we urge HHS to continue to maximize the agency's authority to advance the goals of the ACA and the Biden-Harris administration regarding health equity through improvements in access to health care services across all states.