Essential Health Benefits - An Overview

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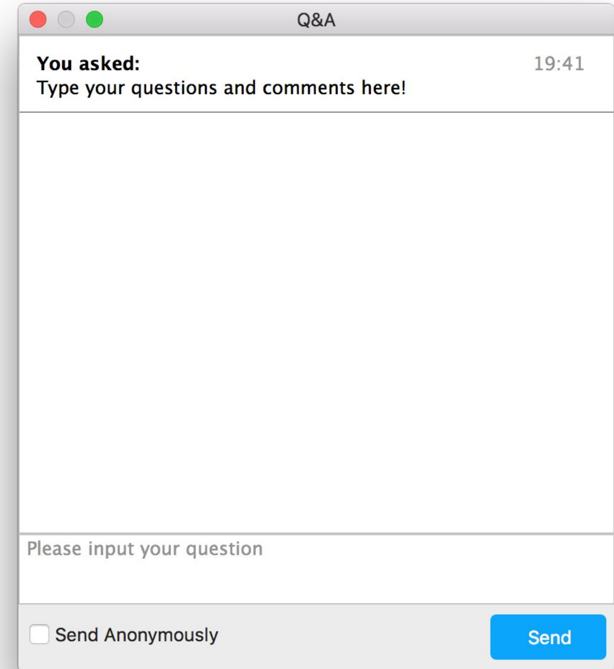
Housekeeping – Q&A and Chat

- Please use the Q&A box for all **questions** to the panelists
  - Click on the Q&A icon at the bottom of the screen
- We will answers questions at each section break and at the end
- Webinar is being recorded. Everyone who registered will receive a link to the recording
- If you have a **technical issue**, please use the chat function



Audio Settings

What we will talk about today

- About the National Health Law Program
- Background on EHB
- Minimum national coverage standards
- EHB benchmarking and state flexibility
- Defrayal
- Using EHB to advance health equity
- Upcoming trainings

About the National Health Law Program

- National non-profit committed to improving health care access, equity, and quality for underserved individuals and families
- State & Local Partners:
  - Disability rights advocates – 50 states + DC
  - Poverty & legal aid advocates – 50 states + DC
- National Partners
- Offices: CA, DC, NC

NHeLP’s Equity Stance

Health equity is achieved when a person’s characteristics and circumstances — including race and ethnicity, sex, gender identity, sexual orientation, age, income, class, disability, health, immigration status, nationality, religious beliefs, language proficiency, or geographic location — do not predict their health outcomes.

https://healthlaw.org/equity-stance/

NHeLP's Mission

The National Health Law Program (NHeLP) protects and advances the health rights of low-income and underserved individuals to access high quality health care. NHeLP advocates, educates, and litigates at the federal and state levels.

We stand up for the rights of the millions of people who struggle to access affordable, quality health care.

Background on EHB

Background on EHBs

- Pre-ACA - many plans had significant coverage gaps
  - 40% of plans did not cover maternity care
  - No coverage requirements for Rx, behavioral health, etc.

- EHBs = Set of benefits that non-grandfathered individual and small group insurance plans and Medicaid Alternative Benefit Plans must cover.
  - Most other plans (e.g., large employer) cannot impose annual or lifetime caps on EHB

Background on EHBs

Sec. 1302 of the ACA: "the Secretary **shall define** the essential health benefits, except that such benefits shall include **at least**…"

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services (incl. family planning) and chronic disease management;
- Pediatric services, including oral and vision care.

Defining EHB

- Per the ACA, EHB:
  - Must be equal to the scope of benefits provided under a typical employer plan
  - HHS Secretary must ensure that EHBs:
    - Reflect balance among categories;
    - Account for diverse health needs across populations; and
    - Do not discriminate against individuals based on age, disability, of expected length of life

EHB Review and Update

The ACA requires HHS to periodically review and update EHB to assess:

- difficulty in accessing services
- identify coverage gaps
- account for new medical/scientific developments

Report to Congress and public

(42 U.S.C. § 18022(b)(4)(G), (H))

See NHeLP's Principles to Guide HHS Review Process for Essential Health Benefits

National Standards

- **Habilitative Services:** Coverage cannot be less favorable than coverage of rehabilitative services
- **MH/SUD:** Must meet mental health and substance use disorder parity requirements
- **Rx:** at least the greater of
  - one drug in every United States Pharmacopeia (USP) category and class, or
  - the same number of drugs in each USP category/class as the state’s benchmark plan

EHB benchmarking and state flexibility

Key considerations for EHB benchmarking

- States have considerable EHB flexibility under federal rules
- Many states have no formal process for EHB benchmark selection
- Forty-two states plus the District of Columbia currently use a small group plan as the state's EHB benchmark (based on previous benchmark options)
- Most states can add or improve benefits without exceeding the EHB generosity test and without triggering defrayal
- Nine states have added/improved benefits with minimal actuarial impact and minimal effect on premiums

Who selects EHB benchmark plans?

Inconsistency across states

- Lack of legal (or any formal) process in many states
- General lack of public information

- Broadly, we found states have:
  - A legislative selection process
    - CA, MD, NH, WA, CO, and NV
    - Degree of legislative involvement varies
  - A regulatory/delegated selection process
    - Express delegation through statute, e.g., NY, UT, NM
  - An unclear and/or undefined selection process
    - Many states w/ federal default plan (largest small group product in state), e.g., ND, IN, IA, AK, FL, MN, PA, WY, WV
    - Many states w/ virtually no authority found, e.g., IA, PA, WY, WV

Procedural requirements for benchmark selection

- **Public Process:** Requires states to provide *"reasonable notice and an opportunity for public comment on the state's selection of an EHB benchmark plan that includes posting a notice on its opportunity for public comment with associated information on a relevant state web site."*

  45 C.F.R. § 156.111(c)

- Vague and ill-defined, but CMS has discretion to reject benchmark plan selections if state fails to comply with procedural requirements
- Best practices include forming a stakeholder group, prioritizing health equity, full transparency

Benchmarking Process

- Benchmark plan option:
  - States create benchmark plan from scratch or based on other plans in the state our outside
  - States can select from other states, but not necessary
  - Deadline for new EHB benchmark selection: First Wednesday in May

Typicality Test

States MUST submit actuarial report confirming that:

- Benchmark plan is not less generous than the least generous typical employer plan, and
- Benchmark plan is not more generous than the most generous typical employer plan

Typicality Test

Comparison Plans:

- One of the selecting State's 10 base-benchmark plan options established at 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, provided that:
  - The product has at least 10 percent of the total enrollment of the five largest large group health insurance products in the State;
  - The plan provides minimum value;
  - The benefits are not excepted benefits, and
  - The benefits in the plan are from a plan year beginning after December 31, 2013.

Problems with EHB benchmarking

- Leads to vast inconsistencies and coverage gaps
- ACA consumer protections should not be based on commercial health plans
- Most states use small group plan as EHB benchmark
  - Least generous of the benchmark options
  - Embeds discriminatory benefit design
  - Perpetuates disparities
- Out2Enroll – 41 EHB benchmark plans exclude gender affirming care
- See also NHeLP letter to HHS Sec. Becerra – *Re: Advancing Health Equity Through Essential Health Benefits*

Defrayal

About Defrayal

- States are required to defray the cost for Qualified Health Plans of benefit mandates enacted 2012+
- CCIIO clarified that states seeking new benefits/mandates through benchmarking will not be subject to defrayal
- Benefit mandates not subject to defrayal when enacted to comply with federal requirements – see 45 CFR §155.170(a)(2)
  - e.g., Nondiscrimination requirements, Mental Health Parity and Addiction Equity Act
- Changes in cost-sharing NOT subject to defrayal
- States report mandates

Defrayal

- NBPP/2025 clarifies that states with post-2011 legislative or regulatory benefit mandates may now add the benefit to the benchmark and cease to defray the cost
  - Not allowed under previous rule (states had to repeal mandate altogether)
  - Would still have to meet actuarial requirements (typicality) and receive approval from CCIIO
- No clarification regarding defrayal exception for mandates needed for compliance with federal law

Example #1: Benefit Mandate

- In 2014, Utah passed legislation requiring plans to provide Applied Behavioral Analysis (ABA) therapy for children with Autism Spectrum Disorder and expanded the requirement in 2019 (S.B. 57, 60th Leg., Gen. Sess. (Utah 2014); S.B. 95, 63rd Leg., Gen. Sess. (Utah 2019).
- Utah Insurance Department set up defrayal
  - Calculated cost of benefit and established a process to reimburse QHPs for the cost (U.A.C. R590-283)
- **Defrayal costs to state:**
  - **FY 2020 - $1.8 million**
  - **FY 2021 - $1.9 million**
  - **FY 2022 - $2 million**

  (Regulatory Impact Summary Table, Appendix 1, 22 Utah Bull. DAR File No. 44181)

Example #2: Updating EHB Benchmark Plan

South Dakota updated its EHB benchmark to require ABA therapy

1. Commissioned an actuarial analysis comparing current benchmark to 2017 benchmark options
2. States can add or improve benefits up to the most generous option available in 2017
3. Adding or improving benefits through benchmarking **does not trigger defrayal** – see CCIIO Frequently Asked Questions on Defrayal of State Additional Required Benefits

Category	Plan	Relative Benefit Value
Small Group	Wellmark Blue Select PPO Primary (Default)	0.0%
	Sanford Signature Series	-1.0%
	DAKOTACARE Choice Group	0.1%
State Employee	$500 Deductible	0.3%
	$1,000 Deductible	0.3%
	$1,800 Deductible HSA	0.3%
FEHBP	BCBS Standard	9.1%
	BCBS Basic	8.6%
	GEHA Standard	10.1%
HMO	Sanford Signature Series	-1.0%

State of South Dakota Analysis of 2021 State Benchmark Options - https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/actuarial%20report%20and%20certificate_sd.pdf.

Using EHB to advance health equity

Important Considerations for Advocates

Evaluate state current benchmark plan and consider how EHB benchmarking can advance health equity

- Many states can improve their base benchmark plans w/more generous benefits
- Engage your EHB decision makers (exchange authority, DOI)
- Ensure robust public process
  - Stakeholder engagement
  - Adequate notice and comment period
- Data-driven process identifying health gaps and unmet needs

Routine Adult Dental Care

- Through regulation, HHS had banned states from including non-pediatric routine oral health services as EHB
- Ban not supported by ACA's intent
- Lack of dental care in adults is a significant contributor of health disparities
- **NEW RULE: States *may* add routine adult dental care to their benchmark plan, as long as the proposed plan meets actuarial requirements (typicality) and CCIIO approves** (effective 2027 PY)

Adult dental opportunities and challenges

- Scope of benefit
  - No comparison plan required
    - ADA recommends comprehensive evaluation, periodontal maintenance, diagnostic radiographs, etc.
    - Visit limits ok, monetary caps not ok
  - Other EHB requirements apply
- Networks
- Cost sharing protections

Pharmacy & Therapeutic (P&T) Committees

- Currently meet at least quarterly
- Physicians, pharmacists, prescribers
- 20% of member have no conflict of interest w/issuers or manufacturers
- Rule now requires **a consumer or patient representative** to serve on the P&T (Beginning Jan. 1, 2026)
  - Relevant experience in patient/community organizations
  - Broad understanding of one or more conditions
  - No fiduciary obligation or interest in health facility
  - Disclose financial interests

Key considerations for state regulators

- Center health equity using a data-driven process to identify unmet health needs
- Industry groups have more resources and power than consumers
- Educate consumers about the process and what is at stake
- Accountability to ensure that people informing the process are diverse with regards to race, ethnicity, disability, income, LGBTQ+ etc.
  - Full disclosure of participants, consultants, conflict of interest
  - Post all comments, testimony, etc. received
- Provide light-lift ways for consumer groups to inform the process **early** (surveys, etc.)

Best Practices for EHB Benchmark Updates

- **Engage** diverse stakeholders early on (including legislators in states that require legislation for benchmarking changes)
- **Ensure** consumer participation through open meetings, trainings, and a robust public comment period
- **Identify** unmet health needs and prioritize closing disparities through a data-driven approach
- **Recognize** that data gaps can perpetuate health disparities
- **Maximize** transparency
- **Establish** a formal regulatory framework for reviewing and updating the state's benchmark
- **Center** health equity when identifying and prioritizing the greatest unmet health needs

State Changes to EHB Benchmark Plans as of June 2024

State	Changes	Year
Virginia	• Medical formula • Medically necessary myoelectric, biomechanical, or microprocessor-controlled prosthetic devices	2025 +
North Dakota	• Hearing aids – one per 36 months • Nutritional benefits (screening and counseling) • Weight loss drug • Periodontal disease – acute or chronic • PET scans • Opioids – limits opioid prescriptions to 7 days, ends prior auth for OUD treatment • Insulin/Insulin supplies – limits cost sharing	2025 +
Vermont	• Annual hearing exam and one set of hearing aids per year each 3 years	2024 +
Colorado	• Adds annual mental health wellness visit • Adds alternatives for pain management including chiropractic, physical therapy, cognitive therapy • Adds acupuncture • Requires gender affirming care	2023 +
Oregon	• Mandatory coverage of buprenorphine • Automatic coverage of naloxone when opioids are prescribed at 50 MME or higher • Adds coverage of non-opioid alternatives to treat pain	2022 +
Michigan	• Mandatory coverage of buprenorphine • Automatic coverage of naloxone when opioids are prescribed at 50 MME or higher	2022 +
Illinois	• Cover alternative therapies for pain, such as topical anti-inflammatories • Remove barriers to obtaining buprenorphine products for opioid use disorder treatment • Cover at least one intranasal spray opioid reversal agent when initial prescriptions of opioids exceed certain limit • Cover tele-psychiatry care	2022 +
New Mexico	• Removes benefit limits for prosthetics • Expands eligibility for weight loss drugs and programs • Adds coverage of 3 naloxone formulations • Adds benefits for artery calcification testing and hepatitis C	2022 +

Upcoming webinars

- **Introduction to Medicaid Managed Care** - June 11, 2024, 2:00 PM (EDT)
  Register here

- **Medicaid Eligibility & Enrollment and the Unwinding** - June 12, 2024, Noon (EDT)
  Register here

All webinars will be recorded. Slide decks and recordings will be sent to everyone who registers.

Additional trainings

In addition, please visit NHeLP's website for webinar recordings on the following topics:

- Medicaid 101
- ACA 101
- Medicaid and Health Law Research
- Administrative Advocacy and the APA
- Reproductive and Sexual Health Rights and Justice
- Health Equity