State-mandated benefits and ACA defrayal obligations

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States have historically addressed gaps in health care coverage by requiring insurers to cover specific benefits. However, under the Affordable Care Act (ACA), states must defray the cost of newly enacted state benefit mandates that apply to Qualified Health Plans (QHPs), the subsidized health coverage sold through the ACA's Marketplaces. State mandated benefits established since December 31, 2011, are considered in addition to the ACA's ten essential health benefits (EHB) and may be subject to defrayal.

Although defrayal requirements have been in effect for well-over a decade, states continue to seek greater clarity from the Centers for Medicare & Medicaid Services (CMS) regarding what constitutes a new benefit mandate and when defrayal might be triggered. Recent CMS changes to defrayal regulations have only added to the confusion.[1]

This brief describes the regulatory framework governing the ACA's defrayal requirements, identifies key issues for state policymakers and advocates, and recommends ways to protect access to needed health care benefits and services that meet the needs of state residents.

1. The ACA, defrayal, and essential health benefits (EHB)

The ACA has made comprehensive health care coverage more affordable to millions. The ACA's Marketplaces allow individuals and families to purchase QHPs that meet federal standards for coverage and value. Low- and middle-income people may qualify for premium tax credits (PTCs) to lower monthly premiums, and cost sharing reductions (CSRs) to lower out-of-pocket costs. At the same time, the QHPs sold on the ACA Marketplaces must provide a

[1] Dept. of Health & Human Srvs., *Notice of Benefit and Payment Parameters for 2027; and Basic Health Program Final Rule*, 91 Fed. Reg. 29526 – 29877, 29864 (May 20, 2026), https://www.govinfo.gov/content/pkg/FR-2026-05-20/pdf/2026-10050.pdf (hereinafter "NBPP/2027 Final Rule").

comprehensive set of services in at least ten essential health benefit (EHB) categories.[2] Insurers may not impose annual or lifetime limits on services considered EHB, which are also subject to cost sharing caps.[3]

States may require QHPs to offer benefits in addition to EHB.[4] However, these additional required benefits may be subject to defrayal.[5] Specifically, the ACA states "A State shall make payments – (I) to an individual enrolled in a QHP offered in such State; or (II) on behalf of an individual described in subclause (I) directly to the QHP in which such individual is enrolled; to defray the cost of any additional benefits…"[6] Moreover, benefits provided by QHPs in addition to EHB, as well as additional benefits required by a state, must not be taken into account when determining PTCs or CSRs.[7]

CMS first established regulations implementing the ACA's defrayal requirement in 2013.[8] CMS has made several changes to defrayal rules, most significantly in the 2027 Notice of Benefit and Payment Parameters Final Rule (discussed in Section 3 below). However, the basic defrayal framework has remained largely consistent.

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[2] 42 U.S.C. § 300gg-6(a); 42 U.S.C. § 18022(a)(2). The ten EHB categories are: (1) Ambulatory patient services; (2) Emergency services; (3) Hospitalization; (4) Maternity and newborn care; (5) Mental health and substance use disorder services, including behavioral health treatment; (6) Prescription drugs; (7) Rehabilitative and habilitative services and devices; (8) Laboratory services; (9) Preventive and wellness services and chronic disease management; and (10) Pediatric services, including oral and vision care. In addition to QHPs, EHB coverage standards also apply to non-grandfathered individual and small group plans.
[3] 42 U.S.C §§ 300gg-6(b); *id*. § 18022(c). Note, EHB cost sharing protections apply to large employer plans not subject to EHB coverage standards.
[4] 42 U.S.C. § 18031(d)(3)(A); 45 C.F.R. § 155.170(a)(1).
[5] 42 U.S.C. § 18031(d)(3)(B); 45 C.F.R. § 155.170(a)(2).
[6] 42 U.S.C. § 18031(d)(3)(B)(ii).
[7] 26 U.S.C. § 36B(b)(3)(D); 42 U.S.C § 18071(c)(4). The premium that QHP issuers report as attributable to EHB is commonly referred to as the ''EHB percent of premium." Dept. of Health & Human Srvs., *Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans Final Rule*, 85 Fed. Reg. 29164 - 29261, 29219 (May 14, 2020, https://www.govinfo.gov/content/pkg/FR-2020-05-14/pdf/2020-10045.pdf (hereinafter NBPP/2021).
[8] Dept. of Health & Human Srvs., *Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule*, 78 Fed. Reg. 12834 – 12872 (Feb. 25, 2013), https://www.govinfo.gov/content/pkg/FR-2013-02-25/pdf/2013-04084.pdf (hereinafter "EHB Standards Final Rule")(*codified at* 45 C.F.R. § 155.170).

a. Defrayal required for newly enacted state-mandated benefits

Benefits required by state action after December 31, 2011, are considered in addition to EHB and may be subject to defrayal.[9] States must calculate the cost of additional required benefits according to accepted actuarial principles and methodologies, conducted by a member of the American Academy of Actuaries.[10] The calculation of the additional benefits' costs must be done prospectively, to "allow for the offset of an enrollee's share of premium and for purposes of calculating the premium tax credit and reduced cost sharing."[11] Federal regulations are silent as to whether defrayal payments may be made concurrently with premiums (*e.g.*, monthly), or retrospectively, based on actual claims data. States may opt to pay plan enrollees directly or the QHP issuer.[12] Finally, states, not CMS, are responsible for determining which state-required benefits are in addition to EHB and subject to defrayal.[13]

b. Certain benefit changes are not subject to defrayal

States may make certain benefit changes that are not subject to defrayal. For example, CMS regulations specify that benefits required for the purposes of compliance with federal requirements are considered EHB and not subject to defrayal.[14] These may include requirements to cover preventive services; requirements to comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA); and the removal of discriminatory age limits from existing benefits.[15]

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[9] 45 C.F.R. § 155.170(a)(1).
[10] 45 C.F.R. § 155.170(c)(2).
[11] EHB Standards Final Rule, 78 Fed. Reg 12838.
[12] 42 U.S.C. § 18031(d)(3)(B)(ii); 45 C.F.R. § 155.170(b).
[13] 45 C.F.R. § 155.170(a)(4). In 2020, HHS instituted an annual reporting requirement for state-mandated benefits requiring defrayal. NBPP/2021, 85 Fed Reg. 29164, 29261 (May 14, 2020), (added subsection (f) to § 156.111), https://www.govinfo.gov/content/pkg/FR-2020-05-14/pdf/2020-10045.pdf. CMS removed annual reporting in 2022, Dept. of Health & Human Srvs., *Notice of Benefit and Payment Parameters for 2023 Final Rule*, 87 Fed. Reg. 27208 , 27390 (May 6, 2022), https://www.govinfo.gov/content/pkg/FR-2022-05-06/pdf/2022-09438.pdf.
[14] 45 C.F.R. § 155.170(a)(1).
[15] NBPP/2021, 85 Fed Reg 29218. Note that QHPs and other plans offered by issuers receiving federal financial assistance are subject to the ACA's nondiscrimination protections under Section 1557 (42 U.S.C. § 18116; 45 C.F.R. § 92.207 (prohibiting "marketing practices or benefit designs that discriminate on the basis of race, color, national origin, sex, age, disability, or any combination thereof, in health insurance coverage or other health-related coverage")). EHB prescription drugs and other benefits must also comply with EHB

Changes to cost-sharing or benefit delivery do not trigger defrayal. CMS defines "state-required benefits'' to include the care, treatment and services that an issuer must provide to its enrollees.[16] Other state requirements addressing benefit delivery method, including "state rules related to provider types, cost-sharing, or reimbursement methods would not fall under [CMS's] interpretation of state-required benefits" subject to defrayal.[17] For example, more that two dozen states have capped co-pays for insulin in state regulated plans, including QHPs.[18] These state requirements do not trigger defrayal.

c. Prescription drugs covered beyond benchmark minimums are considered EHB

Federal rules set minimum EHB coverage standards for prescription drugs. QHPs and other EHB plans must cover - one drug per US Pharmacopeia class and category, or the same number of drugs in each class and category as the state's EHB benchmark plan, whichever is

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nondiscrimination requirements (42 U.S.C. § 18022(b); 45 C.F.R. § 156.125 ("a non-discriminatory benefit design that provides EHB is one that is clinically-based")). *See also* Center for Consumer Information and Insurance Oversight (CCIIO), CMS, *2027 Final Letter to Issuers in the Federally-facilitated Exchanges* (May 2026), https://www.cms.gov/files/document/2027-final-letter-issuers.pdf (incorporating *2017 Letter to Issuers in the Federally-facilitated Marketplaces* (Feb. 29, 2016) at 45, https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/final-2017-letter-to-issuers-2-29-16.pdf ("if an issuer does not cover a single-tablet drug regimen or extended-release product that is customarily prescribed for HIV patients and is just as effective as a multi-tablet regimen, absent an appropriate reason for the exclusion (such as a substantial difference in the cost of the two regimens), such a plan design might effectively discriminate against, or discourage enrollment by, such HIV patients would benefit from such innovative therapeutic options. As another example, if an issuer places most or all drugs that treat a specific condition on the highest cost formulary tiers, that plan design might effectively discriminate against, or discourage enrollment by, individuals who have those conditions"); Dept. of Health & Human Srvs., Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg.10,822, 10,823 (Feb. 2027), https://www.govinfo.gov/content/pkg/FR-2015-02-27/pdf/2015-03751.pdf.

[16] EHB Standards Final Rule, 78 Fed Reg 12838. See also NBPP/2027, 91 Fed. Reg. 29587

[17] Dept. of Health & Human Srvs., *Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Proposed Rule*, 77 Fed. Reg. 70647 (Nov. 26, 2012), https://www.govinfo.gov/content/pkg/FR-2012-11-26/pdf/2012-28362.pdf.

[18] Rebecca Smith, et al., *Impact of state and federal insulin out-of-pocket cost caps on the type 1 diabetes population*, Milliman White Paper (Feb. 2026), https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2026-Articles/3-16-26_Milliman_Breakthrough-T1D_Insulin-OOP-Cost-Paper.pdf.

greater.[19] CMS clarified that drugs covered in excess of the regulatory minimum are considered EHB, subject to ACA cost sharing and other protections.[20] These drugs would also not be subject to defrayal, unless states require coverage since December 31, 2011.[21]

d. What is a state action?

One area of significant confusion is what constitutes a state action for the purposes of defrayal. While CMS has provided some clarification in guidance and discussion in rulemaking, questions remain. For example, CMS clarified that state action can include legislation, regulations, guidance, or other actions.[22] CMS has further stated that "a law requiring coverage of a benefit passed by a state after December 31, 2011, is still a state-required benefit requiring defrayal even if the text of the law says otherwise."[23]

States have relied on assurances from CMS that benefits which have been added or improved through the EHB benchmarking process would not trigger defrayal. In a 2018 guidance, CMS expressly provided that benefits included in a new EHB benchmark plan would not be treated as state mandates and therefore would not be subject to defrayal under 45 C.F.R. § 155.170

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[19] 45 C.F.R § 156.122(a). In 2018, then CMS Administrator Seema Verma recommended imposing mandatory, nationwide caps on EHB prescription drug coverage. *See* Seema Verma, Administrator, Ctrs. for Medicare & Medicaid Services, Memorandum to Sec, Azar, Dept. of Health and Human Servs., *Re: Key 2020 Payment Notice Issues, Policy #4 – Establishing a National Drug Count for the Essential Health Benefits Prescription Drug Benefit,* 14-18 (Aug. 29, 2018) (on file with NHeLP). Administrator Verma acknowledged that such cuts would result in significant harm to consumers where "[i]nsufficient coverage could cause conditions to worsen, which could cause public health problems (e.g., preventable spread of contagious diseases) and greater costs to the health care system." *Id*. at 16. Verma conceded that the proposal would make it harder for consumers to access the prescription drugs they need and would lead to adverse selection by insurers. *Id.* 16-18. Secretary Azar did not advance Verma's proposal.

[20] 45 C.F.R § 156.122(f).

[21] Dept. of Health & Human Srvs., *Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO–OP) Program; and Basic Health Program Final Rule,* , 89 Fed. Reg. 26218, 26410 (Apr. 15, 2024), https://www.govinfo.gov/content/pkg/FR-2024-04-15/pdf/2024-07274.pdf (hereinafter NBPP/2025).

[22] Dept. of Health & Human Srvs., *Notice of Benefit and Payment Parameters for 2017 Final Rule*, 81 Fed. Reg. 12242 (Mar. 8, 2016), https://www.govinfo.gov/content/pkg/FR-2016-03-08/pdf/2016-04439.pdf.

[23] NBPP/2021, 85 Fed. Reg. 29219.

unless they were mandated after December 31, 2011 "through legislative or regulatory action separate from an EHB-benchmark plan selection process."[24]

However, CMS declined to codify this clarifying language in its most recent revision to regulations implementing defrayal (discussed further in Section 3 below).

e. CMS enforcement authority

Under federal rules, states have authority to determine what benefits, if any, are state-mandated benefits subject to ACA defrayal obligations.[25] However, CMS has previously noted that some states may not be complying with defrayal obligations.[26]

According to CMS:

> [I]f the Secretary determines that a state or Exchange has engaged in serious misconduct with respect to compliance with requirements under Title I of the PPACA, which includes the requirement that states defray the cost state benefit requirements in addition to EHB, HHS is authorized to rescind up to 1 percent of payments otherwise due to a state per year until corrective actions are taken by the state that are determined to be adequate by the Secretary.[27]

In response to the 2024 Government Accountability Office (GAO) review of CMS oversight of defrayal obligations, "HHS concluded that [it] would take a more targeted approach where HHS provides written guidance on how to assess State-required benefits paired with continued individualized technical assistance and outreach to States."[28]

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[24] Ctrs. for Medicare & Medicaid Servs, *Frequently Asked Questions on Defrayal of State Additional Required Benefits* (Oct. 23, 2018), https://www.cms.gov/cciio/resources/fact-sheets-andfaqs/downloads/faq-defrayal-state-benefits.pdf (hereinafter "CMS FAQ").
[25] 45 C.F.R. § 155.170(a)(4).
[26] *See, e.g.*, NBPP/2021, 85 Fed Reg 29219 ("Due to state noncompliance with defrayal of state required benefits, issuers may be covering benefits as EHB that were required by state action after December 31, 2011, that actually require defrayal under federal requirements, but for which the state is not actively defraying costs.").
[27] NBPP/2021 85 Fed Reg 29223 (citing to 42 U.S.C. § 18033(a)(4)).
[28] GAO, *Health Insurance Marketplaces: CMS Has Limited Assurance That Premium Tax Credits Exclude Certain State Benefit Costs* (Dec. 4, 2024) at 12, https://www.gao.gov/products/gao-25-107220 (hereinafter "GAO Defrayal Report").

In the most recent rulemaking, CMS stated it is "continuing to evaluate our oversight of defrayal requirements."[29]

2. State operationalization of defrayal

CMS does not publish a list of states with defrayal obligations.[30] In its 2024 review, the GAO identified a handful of states, including Maine, Massachusetts, Minnesota, Montana, Utah, and Virginia with state-mandated benefits subject to defrayal.[31] For example, Minnesota defrays the cost of certain pediatric neuropsychiatric disorders.[32] Virginia requires coverage of pediatric hearing aids of up to $1,500 per hearing aid, per ear, every 24 months.[33] However, few states provide detail on how they implement defrayal.[34]

a. Utah's implementation of defrayal

Utah provides detailed information on its defrayal processes, established through the state rulemaking process. Utah has been defraying the cost of ABA therapy provided to children diagnosed with Autism Spectrum Disorder (ASD) since 2020. In March 2019, Utah passed S.B. 95, which expanded the coverage for the treatment of autism spectrum disorder that was provided in a 2014 bill.[35] The 2019 bill removed the age requirements and 600-hour service cap from Utah's mandated coverage for treatment of autism spectrum disorder and eliminated a provision that previously allowed the Insurance Commissioner to waive the additional

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[29] NBPP/2027 Final Rule, 91 Fed. Reg 29587.
[30] CMS acknowledged the "State Required Benefits" list appearing on its website with state EHB benchmark selections is not actively updated and reflects reports from 2015. NBPP/2021, 85 Fed. Reg. 29220.
[31] GAO Report at 5, note 28 *supra*. *See also* Maine Bureau of Insurance, *A Report to the Committee on Health Coverage, Insurance, and Financial Services 131st Maine Legislature Concerning LD 1539: An Act To Provide Access to Fertility Care* (Jan. 2023), https://legislature.maine.gov/doc/9670.
[32] MINN. LAWS 62A.3097 (2025). *See also* Ashley Setala, Health Policy Director, Minnesota Commerce Depart., Health Benefit Mandates, slide 20 (Feb. 26, 2025) (estimating $139,323 in defrayal costs since 2020), https://assets.senate.mn/committees/2025-2026/3118_Committee_on_Commerce_and_Consumer_Protection/2.27%20Commerce%20Benefit%20Mandate%20Presentation.pdf.
[33] VA CODE ANN. § 38.2-3418.21 (2026).
[34] See, *e.g.*,California Health Benefits Review Program, *Essential Health Benefits: Exceeding EHBs and the Defrayal Requirement*, at 3 (2023) (noting that information about defrayal and cost in Massachusetts is not publicly available), https://www.chbrp.org/sites/default/files/2023-08/EHB_Defrayal_FINAL.pdf.
[35] *See* S.B. 95, 63rd Leg., Gen. Sess. (Utah 2019).

coverage requirement for certain health benefit plans.[36] This bill applied only to those health benefit plans offered in the individual market or large group market that were entered into or renewed on or after January 1, 2020.[37]

A fiscal note filed with S.B. 95 projected that the bill could cost the state approximately $1.7 million annually.[38] The Utah Insurance Department estimated in 2019 the defrayal obligation could cost approximately from $1.8 to $2 million between 2020 and 2022.[39]

After S.B. 95 became law in May 2019, the Utah Insurance Department requested an opinion from the Utah Attorney General to determine if the ABA therapy coverage included in the bill was a State-Required Benefit that triggered the ACA defrayal requirement.[40] The opinion confirmed that the coverage did constitute a state-required benefit triggering ACA defrayal.[41]

In response, the Utah Office of Administrative Rules published a Notice of Proposed Rule on November 1, 2019, which created a defrayal process for Utah State-Required Benefits, particularly targeting the ABA therapy benefit.[42] The proposed rules took effect January 1, 2020.[43]

The Utah State-Required Benefits defrayal system relies on carriers identifying and reporting those claims that will be subject to defrayal, such that the Insurance Commissioner can accurately project defrayal costs.[44] The Utah Health Information Network (UHIN) Standards Committee published an updated ABA therapy billing standard for carriers to uniformly identify those claims subject to defrayal.[45] The Utah Insurance Department developed a standardized

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[36] *Id*.
[37] *Id.*
[38] *See* S.B. 95, 63rd Leg., Gen. Sess. (Utah 2019) (referencing attached Fiscal Note).
[39] Utah Insurance Department, Rule R590-283 Defrayal of State-Required Benefits, *Notice of Proposed Rule, Rule Analysis, Rule R590-283* (Nov. 1, 2019), https://rules.utah.gov/publicat/bulletin/2019/20191115/44181.htm.
[40] *See Utah 2020 Rates Individual and Small Group*, UTAH STATE LEG. (2019), slide 35, https://le.utah.gov/interim/2019/pdf/00004798.pdf (estimating annual defrayal cost of $1 to $2 million). Note the GAO reported that Utah's defrayal payments totaled $4.6 million annually in 2021 and 2022. See GAO Report at 11, note 28 *supra*.
[41] *See* Rule Analysis, note 39 *supra*.
[42] *See* 22 Utah Bull. DAR File No. 44181 (Nov. 15, 2019), UTAH ADMIN. CODE r. 590-283 *et seq.*
[43] UTAH ADMIN. CODE r. 590-283-9.
[44] *See id* at r. 590-283-6.
[45] *See* Utah Health Information Network Standards Committee, *Adaptive Behavior Services/Applied Behavior Analysis (ABA) Billing Standard V.3.1*, UTAH INSURANCE DEPT., https://insurance.utah.gov/wp-content/uploads/R590-283UHIN-ABABillingStandard-v3.1.pdf.

template for insurers to facilitate the reporting of state-required benefit claims subject to defrayal.[46]

Utah's regulatory framework allows for the Insurance Commissioner to audit both carrier's claims that are subject to defrayal and carrier's processes for determining which claims are subject to defrayal.[47] Those found to be in violation of the regulatory requirements laid out in U.A.C. R590-283 *et seq*. will be subject to penalties.[48]

b. Updating EHB benchmark plans and defrayal

To our knowledge, at least three states submitted EHB benchmark proposals by the May 7, 2025, submission deadline for changes to take effect by January 2027:

- Utah – behavioral health treatment for autism spectrum disorder;[49]
- California – fertility services, improved coverage of hearing aids and durable medical equipment including hearing aids;[50]
- Nevada – expanded coverage of HIV and hepatitis C treatments, as well as drugs approved for the treatment of, and withdrawal from, opioid use disorder.[51]

However, HHS confirmed that it is pausing review of states' applications to update their EHB benchmark plans.[52] State insurance regulators from California, Utah, and Nevada with pending

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[46] Defrayal of State Mandated Benefits Data Reporting Template, https://insurance.utah.gov/wp-content/uploads/283MandateDefrayalDataTemplate.xlsx (last visited Aug. 2, 2026).
[47] Utah Admin. Code. at r. 590-283-7, note 42 *supra*.
[48] *Id.* at r. 590-283-8.
[49] Utah Insurance Department, Proposed 2027 Utah Essential Health Benefit Plan (May 5, 2025), https://insurance.utah.gov/proposed-2027-utah-ehb-plan/
[50] California Dept. of Managed Health Care, *DMHC Applies to Update California's Benchmark Plan, Expand Essential Health Benefits to Include Fertility Services, Hearing Aids & Wheelchairs* (May 5, 2025), https://dmhc.ca.gov/Resources/Newsroom/PressReleases/May5,2025.aspx.
[51] Nevada Div. of Insurance, *Plan Year 2027 Benchmark Plan Change Actuarial Report* (Feb. 11, 2025), https://doi.nv.gov/uploadedFiles/doi.nv.gov/Content/Healthcare_Reform/Individuals_and_Families/Essential_Health_Benefits/NV457-2302%20DRAFT%20Nevada%20EHB%20actuarial%20report(1).pdf
[52] Dept. of Health & Human Srvs., *Notice of Benefit and Payment Parameters for 2027; and Basic Health Program Proposed Rule*, 91 Fed. Reg. 6292, 6302 (Feb. 11, 2026), https://www.govinfo.gov/content/pkg/FR-2026-02-11/pdf/2026-02769.pdf: NBPP/2027 Final Rule, 91 Fed Reg 29584.

applications, as well as consumer advocacy organizations, harshly criticized HHS for its lack of action.[53] Each of these states invested considerable time and resources developing their EHB benchmark proposals. They solicited public input, conducted hearings, commissioned actuarial analyses, engaged in deliberative processes, and in some cases enacted enabling legislation, all while relying on the EHB benchmarking framework proposed by HHS nearly 15 years ago.[54]

More states were pursuing EHB benchmark updates, but HHS quashed those efforts by rescinding, without explanation, the EHB-Benchmark Plan Modernization Grant for States with a Federally-Facilitated Exchange, and the Expanding Access to Women's Health Grant last year.[55]

Utah and other states simply followed defrayal regulations and CMS' assurances that "starting in PY 2025, a State that is defraying the costs of a benefit required by a mandate that is in addition to EHB under § 155.170 will be permitted to cease defraying the costs of that benefit if the benefit is included in its EHB-benchmark plan or upon updating its EHB-benchmark plan in the future to include such benefit coverage."[56]

3. Changes to defrayal under the NBPP for 2027

The 2027/NBPP Final Rule included changes to federal regulations governing defrayal for state required benefits. However, the regulatory changes will likely prove burdensome and fail to clarify state defrayal obligations.

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[53] *See* Amy Lovten, *Stakeholders Push Admin to Restart Review of EHB Benchmark Plans*, Inside Health Policy (Apr. 22, 2026); Letter from NAIC Consumer Representatives to NAIC President Scott A. White, et al., *Re: Protecting state flexibility in Essential Health Benefits* (Apr. 2, 2026), https://docs.google.com/document/d/1LblVVLDMhDPut90af1XH5WJgbNr2aaJoQEY0mdLFeWM/edit?tab=t.0.

[54] Dept. of Health and Human Srvs., Ctr. for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin* (Dec. 16, 2011), https://www.cms.gov/cciio/resources/files/downloads/essential_health_benefits_bulletin.pdf.

[55] U.S. Dept. of Health and Human Srvs., Ctr for Medicare & Medicaid Srvs., *EHB-Benchmark Plan Modernization Grant for States with a Federally-Facilitated Exchange*, CMS-2U2-25-001 (Feb. 14, 2025), https://www.grants.gov/search-results-detail/356740; U.S. Dept. of Health and Human Srvs., Ctr for Medicare & Medicaid Srvs., *Expanding Access to Women's Health Grant*, CMS-2R2-24-001 (Sep. 6, 2024), https://www.grants.gov/search-results-detail/354660.

[56] See NBPP/2025, 89 Fed Reg 26269 (codified at 45 C.F.R. § 155.170(a)(1)).

The NBPP/2027 Final Rule amends 45 C.F.R. § 155.170(a) to provide that any state-required benefit will be considered "in addition to EHB" and subject to defrayal if, beginning in Plan Year 2028, the benefit is:

1) required by state action taking place after December 31, 2011,
2) applicable to small group and/or individual markets,
3) specific to required care, treatment, or services, and
4) not required by state action to comply with federal requirements.[57]

Some of the benefits in a state's EHB benchmark plan, including benefits that have been added or improved via the EHB benchmarking process, could be subject to defrayal in 2028 if CMS later identifies the benefit is as a state-mandate.

In the preamble to the NBPP/2027 Final Rule, CMS suggests that states may repeal required benefits to avoid defrayal obligations: "if a State repeals the underlying State action that requires a benefit, that benefit would no longer be considered a State-required benefit for purposes of § 155.170, and the State would not be required to defray its cost even if that benefit remains in the State's EHB benchmark plan."[58] Conceivably, a benefit could still be covered through the state's EHB benchmark plan even if a state repealed the benefit mandate. However, this assurance does little to help Utah and other states with pending EHB benchmark updates.

However, the NBPP/2027 Final Rule is less clear regarding what exactly constitutes a state mandate subject to defrayal. According to CMS, "[a]s finalized, any State required benefit that fulfills the four conjunctive elements at § 155.170(a)(2)(i) through (iv) would require defrayal, regardless of whether the benefit is included in the State's EHB-benchmark plan."[59]

CMS has previously said that state actions could include legislation, regulations, or some other sort of action.[60] Some states have issued bulletins or promulgated regulations requiring coverage of certain benefits pursuant to the state's EHB benchmark plan.[61] State regulations and other administrative actions implementing EHB, including legislation requiring updates to benchmark plans, could conceivably fall within CMS' definition of a state required mandate under revised § 155.170(a)(2)(i) through (iv), potentially subjecting the state to defrayal under the plain meaning of the regulatory text. Some states have enacted legislation requiring

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[57] NBPP/2027 Final Rule, 91 Fed. Reg. 29864 (codified at 45 C.F.R. § 155.170(a)(2).
[58] NBPP/2027 Final Rule, 91 Fed. Reg. 29586 ("States with benefit mandates that duplicate benefits included in the State's EHB-benchmark plan and that seek to avoid a defrayal obligation may repeal the applicable State requirement.").
[59] NBPP/2027 Final Rule, 91 Fed. Reg. 29583.
[60] NBPP/2017, 81 Fed. Reg. 12242.
[61] *See, e.g.*, 3 CCR 702-4-2-42-5.

agencies to add certain benefits through benchmarking. It is unclear if those states would need to repeal such statutes to avoid defrayal.

In its 2018 FAQ on defrayal, CMS made clear that benefits provided as part of the EHB benchmarking process would not be treated as state mandates and therefore would not be subject to defrayal, unless they were mandated after December 31, 2011 "*through legislative or regulatory action separate from an EHB-benchmark plan selection process*."[62] Commenters urged CMS to include such language in the NBPP/2027 Final Rule, including the National Association of Insurance Commissioners, which stated that "HHS should explicitly clarify that state selection of an EHB benchmark plan does not constitute 'state action' to mandate benefits."[63] However, CMS declined to include such language in the regulatory text.[64]

CMS suggests that states need not repeal a state mandate *in toto*, but could repeal a mandate as it applies to QHPs: "States with benefit mandates that duplicate benefits included in the State's EHB-benchmark plan and that seek to avoid a defrayal obligation may repeal the applicable State requirement, such that the benefit continues to be covered as EHB under the EHB benchmark plan or otherwise limit the applicability of the requirement for QHPs."[65]

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[62] CMS FAQ, at 1 (emphasis added), note 24 *supra*.
[63] National Association of Insurance Commissioners, Comments on Notice of Benefit and Payment Parameters for 2027 Proposed Rule, at 3 (March 13, 2026), https://www.regulations.gov/comment/CMS-2026-0496-0812. *See also* Attorneys General from California, et al., Comments on Proposed Rule: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program, at 18 (March 13, 2026), https://www.regulations.gov/comment/CMS-2026-0496-0797; Nat'l. Health Law Prog., Comments, Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program Proposed Rule Proposed Rule, at 5 *March 12, 2026), https://www.regulations.gov/comment/CMS-2026-0496-0615.
[64] CMS noted concerns raised by commenters, stating "a State's selection or update of an EHB benchmark plan under § 156.111 does not constitute a ''State action'' for purposes of defrayal and, by itself, cannot trigger a defrayal obligation. Instead, for purposes of § 155.170, ''State action'' refers to a State statute, regulation, guidance, or other requirement, separate from the State's selection or update of its EHB benchmark plan, that requires QHPs to cover a benefit that is in addition to EHB." NBPP/2027 Final Rule, 91 Fed. Reg. 29586.
[65] NBPP/2027 Final Rule, 91 Fed. Reg. 29586-29587. In footnote 120, CMS notes that imposing benefit mandates depending on a plan's status as a QHP or whether it is sold through the Exchange may violate ACA section 1252 (42 U.S.C. § 18012). The statutory text suggests that states could not impose requirements on QHPs that do not otherwise apply in the individual (or small group) market; but could remove coverage requirements from QHPs (which are subject to defrayal) while retaining them for other plans sold in the individual and small group markets.

CMS delayed the effective date for this new defrayal rule from 2027, as proposed, to 2028. CMS acknowledged "that providing States enough time to plan for and effectuate the new defrayal requirements is necessary."[66]

CMS also said that it "intends to continue to engage with States and provide technical assistance as needed to ensure States understand when a State-benefit requirement is in addition to EHB and requires defrayal.[67]

Recommendations for states

States should work to protect access to needed health care services and refrain from prematurely repealing current laws and regulations. Instead, states may seek clarifying guidance from CMS on the meaning of "state action" that would trigger defrayal obligations. State insurance commissioners and other officials should also press CMS to move forward with pending EHB benchmark update proposals.

States may not need to repeal mandates outright. Some states are considering legislative proposals granting regulator authority to temporarily suspend, rather than repeal, laws or regulations requiring benefits. Such proposals should be narrowly tailored to benefits that could be subject to defrayal and limited in applicability to QHPs, and not the broader individual and small group market (to which defrayal requirements do not apply). States should also include checks on administrative authority to suspend legislative requirements, such as a sunset provision, or otherwise tie benefit suspension federal defrayal requirements currently in effect (*e.g.*, the federal rule's effective date, a court injunction, etc.).

State mandated benefits remain an important tool to address urgent health care needs, particularly since HHS has declined to move forward with EHB benchmark updates. State officials should work with consumer groups and members of the state's congressional delegation to ensure access to medically necessary care and preserve hard fought-for consumer protections and affordability measures.

[66] NBPP/2027 Final Rule, 91 Fed. Reg. 29583.
[67] NBPP/2027 Final Rule, 91 Fed. Reg. 29587.