Essential Health Benefits: A Background Paper

I. Introduction

The Affordable Care Act (ACA) established a requirement that plans sold in the individual and small group markets provide a comprehensive set of services known as essential health benefits (EHBs). This requirement does not apply to self-insured group plans, large group plans, or grandfathered plans.[1] The statute specifies that the following ten categories of items and services must be included:[2]

1. Ambulatory 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
10. Pediatric services, including oral and vision care

In 2011, the U.S. Department of Health and Human Services (HHS) outlined a process for states to select a benchmark plan, which would be used to set a standard that plans would be required to meet regarding scope of benefits. A state's choice of benchmark plan does not create any standards around cost-sharing levels.[3] States could choose one of the following options as their benchmark:[4]

1. One of the three largest small group plans in the state by enrollment
2. One of the three largest state employee health plans by enrollment
3. One of the three largest federal employee health plan options by enrollment
4. The largest health maintenance organization (HMO) offered in the state's commercial market by enrollment

[1] Available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf
[2] 42 USC § 18022(b)(1); 45 CFR **§** 156.110(a).
[3] Available at https://www.kff.org/health-reform/fact-sheet/quick-take-essential-health-benefits-what-have-states-decided-for-their-benchmark/
[4] 45 CFR **§** 156.100(a).

For states that did not choose a benchmark plan, the default plan would be the small group plan with the largest enrollment in the state.[5]

II. Maryland's Current EHB

For plan years 2017 through 2020, Maryland selected the largest small group plan, the CareFirst BlueChoice HMO HRA/HSA $1500 plan, as the benchmark plan. Since this plan included all of the required EHBs, it did not need to be supplemented.[6] The benchmark plan contains benefits in all of the ten categories described above.[7]

III. New Flexibility for States

A. New HHS Guidance

In April 2018, HHS issued the *Final Notice of Benefit and Payment Parameters for 2019*,[8] which gives states greater flexibility in updating their essential health benefit (EHB) benchmark plans. HHS added a new regulatory section (45 CFR § 156.111) that provides states with the ability to update their EHB-benchmark plans more frequently and to choose from among more options. Starting in 2020, states will have three new options for selecting an EHB-benchmark plan:

Option 1: A state may select the EHB-benchmark plan that another state used for the 2017 plan year. Benefits mandated by the selecting state prior to December 31, 2011, could continue to be considered EHB and would not require the state to defray the costs. A state selecting another state's EHB-benchmark plan under this option would still be required to defray the cost of any benefits included in that state's EHB-benchmark plan that are benefits mandated by the selecting state after December 31, 2011, and that are subject to defrayal under the current regulations.

Option 2: A state may replace one or more categories of EHBs under its EHB-benchmark plan used for the 2017 plan year with the same category or categories of benefits from another state's EHB-benchmark plan used for the 2017 plan year. For example, a state may select the prescription drug coverage from another state's EHB-benchmark plan (which might include a different formulary drug count) and a third state's EHB-benchmark plan hospitalization category. Similar to the first option, benefits mandated by the selecting state prior to December 31, 2011, will continue to be considered EHB and would not require the state to defray the costs. However, the state would be required to defray the cost of any benefits included in the categories of benefits from the other state's

[5] 45 CFR **§** 156.100(c).
[6] Maryland Insurance Administration. *Selection of the 2017 Benchmark Plan*. (June 11, 2015). Available at https://insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/2017-benchmark-plan-w-appendices.pdf.
[7] For a full list of EHBs in individual and small group plans see https://insurance.maryland.gov/Consumer/Documents/publicnew/essentialbenefitschart.pdf. Also see the summary of Maryland's benchmark plan at https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/MD-BMP.zip.
[8] Available at https://www.govinfo.gov/content/pkg/FR-2018-04-17/pdf/2018-07355.pdf.

EHB- benchmark plan that are mandated by the selecting state's after December 31, 2011.

Option 3: A state may select a set of benefits that would become its EHB-benchmark plan using a different process. The same defrayal requirements of the other two options would apply.

Under all three options, a state's new benchmark plan may not exceed the generosity of the most generous among a set of comparison plans. Comparison plans include the state's EHB-benchmark plan used for the 2017 plan year, as well as other plans available as base-benchmark plan options for the 2017 plan year. The state would determine whether its proposed EHB-benchmark plan exceeds the generosity of the most generous of a set of comparison plans using an actuarial certification. The plan must also be equal in scope to a typical employer plan.

Under any of the available three options, a state can change their EHB-benchmark plan in any given year, not only in the years specified by HHS. States that prefer to maintain their current EHB-benchmark plan can do so without action. States are also required to provide reasonable notice and public comment when selecting an EHB-benchmark plan.

Finally, the rule includes new data collection requirements

1. A document that identifies and describes the benchmark plan and affirms compliance with federal requirements
2. An actuarial certification report
3. A summary of the selected plan that includes benefits and limitations
4. Any other documentation that night be required

The deadline for the 2020 plan year was July 2, 2018.

HHS also released accompanying guidance in April 2018 on the approaches to actuarial certification that provided an example of an acceptable methodology for comparing benefits.

1. Pick an appropriate comparison plan by selecting either a benchmark plan option from plan year 2017 or the largest plan by enrollment—determined as one of the five largest group products.
2. Calculate the expected value of fully covering (100 percent actuarial value) all of the benefits in each EHB category in both the appropriate comparison plan and the state's proposed benchmark plan.
3. Compare the expected value of fully covering all of the benefits in each EHB category of the appropriate comparison plan to that of the state's proposed benchmark plan.

See Attachment A for more details.

B. Illinois's EHB-Benchmark Plan

Illinois used option 3 described above to select a set of benefits for its EHB-benchmark plan for 2020, called the Access to Care and Treatment Plan.[9] This flexibility allowed Illinois to update its EHB benchmark plan to help address the opioid crisis and improve access to mental health and substance use disorder resources. Illinois used its 2019 EHB-benchmark plan as a base and made the following five benefit changes:

1. Topical anti-inflammatory medication, including but not limited to Ketoprofen, Diclofenac, or another brand equivalent approved by the FDA for acute and chronic pain
2. Limiting opioid prescriptions for acute pain to no more than seven days
3. Removal of barriers to prescribing Buprenorphine or brand equivalent products for medication assisted treatment of opioid use disorder
4. At least one intranasal spray opioid reversal agent when initial prescriptions of opioids are dosages of 50MME or higher
5. Tele psychiatry

Illinois submitted an actuarial report and certification to demonstrate that the proposed 2020 EHB benchmark plan met the following two actuarial requirements under the law:

- The EHB benchmark plan must be equal to, or greater than the scope of benefits provided under a typical employer plan
- The EHB benchmark plan does not exceed the generosity of the most generous among a set of comparison plans

[9] Please see the Illinois's EHB benchmark plan information and application documents at https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2020-BPM-IL.zip.