



Essential Health Benefits: Proposed Policy Changes

Center for Consumer Information & Insurance Oversight (CCIIO)

Centers for Medicare & Medicaid Services (CMS)

Department of Health and Human Services (HHS)

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Agenda

- Background: Patient Protection and Affordable Care Act (PPACA) and Essential Health Benefits (EHB)
- Current EHB-Benchmark Plan Policy
- Proposed EHB-Benchmark Plan Policy
 - State options for changing its EHB-benchmark plan
 - Requirements for a State's EHB-benchmark plan
 - Requirements for a State that changes its EHB-benchmark plan
 - Additional EHB policy
- Proposed 2019 and 2020 Timelines
- State Consideration of the EHB-Benchmark Plan Selection
- Next Steps

Background: PPACA and EHB

Section 1302(b)(1): The Secretary shall define the EHB, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

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
10. Pediatric services, including oral and vision care

Background: PPACA and EHB

Section 1302(b)(2) and (3): The Secretary shall:

- Ensure that the scope of EHB is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary.
- Submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that EHB meet the limitation described above.
- Provide notice and an opportunity for public comment.

Background: PPACA and EHB

Section 1302(b)(4): The Secretary shall:

- Ensure that such EHB reflect an appropriate balance among the 10 categories, so that benefits are not unduly weighted toward any category.
- Not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life.
- Take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups.

Background: PPACA and EHB

Section 1302(b)(4): The Secretary shall:

- Ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life.
- Provide that a qualified health plan shall not be treated as providing coverage for the EHB described unless the plan provides that coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan.

Current EHB-Benchmark Plan Policy

Final EHB Rule (78 FR 12834): Defines EHB based on a base-benchmark plan selected by each State.

The base-benchmark plan serves as a reference plan for issuers designing their own plans that:

- Plan benefits must be “substantially equal” to the base-benchmark plan’s benefits; and
- Reflect both the covered benefits and limits on coverage of the base-benchmark plan.

States selected among:

- The largest plan by enrollment within one of the State’s three largest small group insurance products by enrollment;
- One of the State’s three largest State employee plans by enrollment;
- One of the three largest federal employee plans by enrollment; or
- The largest HMO plan by enrollment offered in the State’s non-Medicaid commercial market.

If a State did not select a base-benchmark plan, the default base-benchmark plan for that State was the largest small group market plan by enrollment in the largest product by enrollment in the State.

Current EHB-Benchmark Plan Policy

EHB-benchmark plans must cover all 10 statutory benefit categories:

- A base-benchmark plan that does not cover all statutory benefit categories must supplement a benefit category in its entirety, generally from another benchmark plan option in the State, to become the EHB-benchmark plan.

The State is responsible for identifying which additional State-required benefits are in excess of EHB.

Proposed EHB-Benchmark Plan Policy

- The Proposed EHB-Benchmark Plan Policy is incorporated into the 2019 Proposed Payment Notice
- Potential long term approach:
 - Create a default Federal benchmark plan
 - Example: National Formulary Drug List
 - Similar to the recommendations in the 2011 National Academy of Medicine* Report
- Will solicit additional comments in the future
- Short term approach: provide flexibility and stability

*previously known as the Institute of Medicine

Proposed EHB-Benchmark Plan Policy

Proposed EHB-Benchmark Plan Policy:

State options for changing its EHB-benchmark plan

Proposed EHB-Benchmark Plan Policy:

State options for changing its EHB-benchmark plan

We propose to provide a State with more flexibility to select its benchmark plan by providing the following new options, including:

Option 1 (45 CFR §156.111(a)(1)): Selecting the EHB-benchmark plan that another State used for the 2017 plan year under §156.100 and §156.110.

Option 2 (§156.111(a)(2)): Replacing one or more categories of EHB under §156.110(a) under its EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another State used for the 2017 plan year under §156.100 and §156.110.

Option 3 (§156.111(a)(3)): Otherwise selecting a set of benefits that would become the State's EHB-benchmark plan, provided that the new EHB-benchmark plan does not exceed the generosity of the most generous among a set of comparison plans, including:

- **§156.111(a)(3)(i)** The State's EHB-benchmark plan used for the 2017 plan year, and
- **§156.111(a)(3)(ii)** Any of the State's base-benchmark plan options used for the 2017 plan year described in §156.100(a)(1), supplemented as necessary under §156.110.

Proposed EHB-Benchmark Plan Policy:

State options for changing its EHB-benchmark plan

State Mandate Policy at §155.170

- Section 1311(d)(3)(B) of the PPACA permits a State to require QHPs to cover benefits in addition to the EHB.
- However, States are required to make payments, either to the individual enrollee or to the issuer on behalf of the enrollee, to defray the cost of these benefits.
- §155.170(a)(2):
 - A benefit required by State action taking place on or before December 31, 2011 is considered an EHB – **and doesn't need to be defrayed** by the State.
 - A benefit required by State action taking place on or after January 1, 2012, other than for purposes of compliance with Federal requirements, is considered in addition to the essential health benefits – **and needs to be defrayed** by the State.

Proposed EHB-Benchmark Plan Policy:

State options for changing its EHB-benchmark plan

How does the State mandate policy apply to the State options for changing its EHB-benchmark plan:

- Benefits mandated by State action prior to or on December 31, 2011, could continue to be considered EHB under §155.170, and would not require the State to defray the costs.
- However, if a State selects an EHB-benchmark plan from another State, the selecting State 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.

Proposed EHB-Benchmark Plan Policy:

State options for changing its EHB-benchmark plan

Example of Option 1: Select the EHB-benchmark plan that another State used for the 2017 plan year

- State A selects the State B's EHB-benchmark plan in whole.
 - State mandate policy: State A would be required to defray the cost of any benefits included in State B's EHB-benchmark plan that are required to be provided by State A's action after December 31, 2011, and that are subject to defrayal under current regulations.

Proposed EHB-Benchmark Plan Policy:

State options for changing its EHB-benchmark plan

Example of Option 2: Replace one or more categories of EHB under its EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another State used for the 2017 plan year

- State A selects the hospitalization category of benefits from State B's 2017 EHB-benchmark plan and replaces that category in its 2017 EHB-benchmark plan.
 - State mandate policy: If State A replaces a category of benefits in its EHB-benchmark plan with a category of benefits from State B's EHB-benchmark plan, State A must defray the cost of any benefits in that category mandated by State A after December 31, 2011 that are included in the replacement category of benefits and that are subject to defrayal under current regulations.

Proposed EHB-Benchmark Plan Policy:

State options for changing its EHB-benchmark plan

Example of Option 3: Select a set of benefits that would become the State's EHB-benchmark plan and does not exceed the generosity of the most generous among a set of comparison plans

- State selects a set of benefits as the State's EHB-benchmark plan.
 - State mandate policy: If the State selects a set of benefits to become its EHB-benchmark plan under paragraph (a)(3), any benefits mandated by that State after December 31, 2011 that are subject to defrayal under current regulations would not be considered EHB, and the State would be required to defray the cost of any such benefits included in the State's EHB-benchmark plan under this proposed option.

Proposed EHB-Benchmark Plan Policy

Proposed EHB-Benchmark Plan Policy:

Requirements related to a State's EHB-benchmark plan

Proposed EHB-Benchmark Plan Policy:

Requirements for a State's new EHB-benchmark plan

A State's EHB-benchmark plan would be required to:

- Provide an appropriate balance of coverage for the 10 EHB categories of benefits.
- Be equal in scope of benefits to what is provided under a typical employer plan as defined.
- Not have benefits unduly weighted towards any of the categories of benefits.
- Provide benefits for diverse segments of the population, including women, children, persons with disabilities, and other groups.

Proposed EHB-Benchmark Plan Policy:

Requirements for a State's EHB-benchmark plan

- We propose to define a typical employer plan as:
 - An employer plan within a product (as these terms are defined in §144.103 of this subchapter) with substantial enrollment in the product of at least 5,000 enrollees sold in the small group or large group market, in one or more States; or
 - A self-insured group health plan with substantial enrollment of at least 5,000 enrollees in one or more States.

Proposed EHB-Benchmark Plan Policy

Proposed EHB-Benchmark Plan Policy:

Requirements for a State that changes its EHB-benchmark plan

Proposed EHB-Benchmark Plan Policy:

Requirements for a State that change its EHB-benchmark plan

The State would be required to:

1. Provide reasonable public notice and an opportunity for public comment on the State's selection of an EHB-benchmark plan.
2. Notify HHS of the selection of a new EHB-benchmark plan by a date to be determined by HHS for each applicable plan year.
 - If the State does not make a selection by the annual selection date, the State's EHB-benchmark plan for the applicable plan year would be that State's EHB-benchmark plan applicable for the prior year.
3. Submit documents in a format and manner specified by HHS by a date determined by HHS.

Proposed EHB-Benchmark Plan Policy:

Requirements for a State that change its EHB-benchmark plan

Overview of State Documentation Requirements for EHB-benchmark Plans

State Documentation Requirements	Option 1: Select another State's EHB-benchmark Plan [in accordance with §156.111(a)(1)]	Option 2: Replace category or categories of benefits from another State's EHB-benchmark Plan [in accordance with § 156.111(a)(2)]	Option 3: Otherwise select a set of benefits for the State's EHB-benchmark Plan [in accordance with §156.111(a)(3)]
	Required?	Required?	Required?
Confirmations: Complies with §156.111(a), (b), and (c)	Yes	Yes	Yes
Actuarial certification and report: 1) Equal in scope of benefits provided under a typical employer plan 2) Does not exceed the generosity of the most generous among the plans listed at §156.111(a)(3)	No	Yes	Yes
	No	No	Yes
State's EHB-benchmark plan document: 1) Describes benefits and limits in accordance with §156.111(e)(3) 2) Provides formulary drug list for the State's EHB-benchmark Plan	Yes	Yes	Yes
	No	No	Yes
EHB Summary Chart: Provides a summary of the State's EHB-benchmark Plan	Yes	Yes	Yes

Proposed EHB-Benchmark Plan Policy:

Requirements for a State that change its EHB-benchmark plan

The proposed State documentation includes:

1. A document confirming that the State's EHB-benchmark plan selection complies with the requirements under §156.111(a), (b), and (c).
2. The State's EHB-benchmark plan document that reflects the benefits and limitations, including medical management requirements, a schedule of benefits and, if the State is selecting its EHB-benchmark plan using option 3, a formulary drug list in a format specified by HHS.
3. Other documentation specified by HHS, which is necessary to operationalize the State's EHB-benchmark plan.

Proposed EHB-Benchmark Plan Policy:

Requirements for a State that change its EHB-benchmark plan

4. For States using options 2 or 3 (the policy proposed at §156.111(a)(2) or §156.111(a)(3), an actuarial certification and an associated actuarial report from an actuary, who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies that affirms:

1. That the State's EHB-benchmark plan definition is equal in scope of benefits provided under a typical employer plan; and
2. For States using option 3, that the new EHB-benchmark plan does not exceed the generosity of the most generous among the following list of plans:
 - The State's EHB-benchmark plan used for the 2017 plan year, and
 - Any of the State's base-benchmark plan options used for 2017 plan year described in §156.100(a)(1), supplemented as necessary under §156.110.

Proposed EHB-Benchmark Plan Policy:

Requirements for a State that change its EHB-benchmark plan

States that select Options 2 and 3 would be required to submit an actuarial certification and an associated actuarial report:

- In accordance with generally accepted actuarial principles and methodologies:
 - This would include complying with all Actuarial Standards of Practice (ASOPs)
- From an actuary who is a member of the American Academy of Actuaries

To assist States, with the proposed rule we released a *Draft Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection* for comment.

Proposed EHB-Benchmark Plan Policy:

Requirements for a State that change its EHB-benchmark plan

Summary of key points from the draft example document:

- Step 1: Select the “Typical Employer Plan”
- Step 2: Calculate the expected value of covering all of the benefits at 100 percent value in the “Typical Employer Plan”
- Step 3: Compare the expected value of covering all of the benefits (at 100 percent value) in the “Typical Employer Plan” to the State’s proposed EHB-benchmark plan

Proposed EHB-Benchmark Plan Policy: Requirements for a State that change its EHB-benchmark plan

State Documentation Requirements	Does this document require use of a specific template?
	Required?
Confirmations: Complies with §156.111(a), (b), and (c)	Yes
Actuarial certification and report: 1) Equal in scope of benefits provided under a typical employer plan 2) Does not exceed the generosity of the most generous among the plans listed at §156.111(a)(3)	For the certification, yes; For the report, no
	For the certification, yes; For the report, no
State's EHB-benchmark plan document: 1) Describes benefits and limits in accordance with §156.111(e)(3) 2) Provides formulary drug list for the State's EHB-benchmark Plan	No
	Yes
EHB Summary Chart: Provides a summary of the State's EHB-benchmark Plan	Yes

Proposed EHB-Benchmark Plan Policy

Proposed EHB-Benchmark Plan Policy:

Additional EHB Policy

Proposed EHB-Benchmark Plan Policy: Additional EHB Policy

Other proposed changes:

Substitution: Allowing benefit substitution to occur *between* EHB categories (in addition to *within* the same EHB category, which is already permitted), as long as:

- the benefits are actuarially equivalent to the benefit that is being replaced and is not a prescription drug benefit, and
- the plan with substitutions still provides benefits that are substantially equal to the EHB-benchmark plan, provides an appropriate balance among the EHB categories such that benefits are not unduly weighted towards any category, and provides benefits for diverse segments of the population.

Proposed EHB-Benchmark Plan Policy: Additional EHB Policy

At this time, we are not proposing to make other EHB modifications. Thus, the following provisions would stay in place:

- 156.115: Issuer requirements to comply with EHB (with some modifications to reflect the proposal already discussed)
- 156.122: Prescription drug benefit
- 156.125: Prohibition on discrimination

Proposed 2019 Timeline

Proposed 2019 Timeline	Date
States' deadline for 2019 EHB-Benchmark Plan selection required document submissions	March 16, 2018
HHS publishes final 2019 EHB-benchmark plan documents on CCIIO's website.	April 2018

- HHS would not update the Plans and Benefits Template Add-in file used for 2019 QHP certification.
 - Each State would need to instruct its issuers on how to manually change its current Add-in file to align with its new EHB-benchmark plan.
- HHS would not be able to allow States to submit additional documentation or changes to submitted documents after the deadline.
- Any questions or issues that a State has about the EHB-benchmark plan documents would need to be asked and resolved prior to the State's submission deadline.

Proposed 2020 Timeline

Proposed 2020 Timeline	Date
States' deadline for 2020 EHB-Benchmark Plan selection required document submissions	July 1, 2018
HHS publishes final 2020 EHB-benchmark plan documents on CCIIO's website.	To be determined

- HHS *would* update the Plans and Benefits Template Add-in file used for 2020 QHP certification.
- HHS would not be able to allow States to submit additional documentation or changes to submitted documents after the deadline.
- Any questions or issues that a State has about the EHB benchmark plan documents would need to be asked and resolved prior to the State's submission deadline.

State Consideration of the EHB-Benchmark Plan Selection

- HHS recognizes most States as the primary enforcers of EHB policy. Thus, when a State would select a benchmark plan from another State, we would defer to the selecting State's interpretation of the benefits and limits, even when such interpretation differs from the originating State's interpretation.
- In selecting a new EHB-benchmark plan, States may want to consider a variety of factors, including:
 - Impact on premium tax credits and subsidies

Next Steps

Comments on the
Proposed 2019 Payment Notice are due:
November 27, 2017