Addressing Health Disparities Through the Essential Health Benefits

Héctor Hernández-Delgado, Senior Attorney
Wayne Turner, Senior Attorney
NAIC Special Committee on Race and Insurance
September 19, 2023
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
Our Equity Stance

Vision:

The National Health Law Program (NHeLP) believes that 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. We also believe that these characteristics and circumstances should not limit people’s experience in the world or in our organization. Our equity vision is one of collective liberation, where

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

• EHB authorities and compliance
  • HHS review and updating process
• The defrayal problem
• The generosity limit
• Best practices in EHB benchmark updating
  • State selection processes
  • Identifying unmet health needs
  • Engaging consumers and other stakeholders
Background on EHBs

- Pre-ACA - many plans had coverage gaps
  - 40% of plans did not cover maternity care

- 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.

- At a minimum, they must include:
  - 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.
Essential Health Benefits (EHB)

- Sec. 1302 of the ACA: “the Secretary shall define the essential health benefits, except that such benefits shall include at least…”
  - Reflect balance among categories;
  - Account for diverse health needs across populations; and
  - Do not discriminate against individuals based on age, disability, or expected length of life
EHB compliance and enforcement

- HHS leaves it largely to states to define and enforce EHB
  - Before 2019: states select a benchmark plan from 10 commercial plans
  - After 2019: states keep their selected benchmark plan, select the benchmark plan from another state in its entirety, select categories of EHB from benchmark in another state, or create a new benchmark altogether
- HHS RFI on EHB: “a lack of consumer complaints about exclusions or claims denials.” 87 Fed. Reg. 74098
- Clarification: “a non-discriminatory benefit design that provides EHB is one that is clinically-based.” 45 CFR §156.125(a)
About Defrayal

- ACA requires states to defray the cost of new benefit mandates (post-2011)
- CCIIO clarified that states seeking new benefits/mandates through benchmarking will not be subject to defrayal
  - However, switching from state mandate to benchmarking mandate is not permitted (state will have to defray in that case)
- Benefit mandates not subject to defrayal when enacted to comply with federal requirements – see 45 CFR §155.170(a)(2)
- Changes in cost-sharing NOT subject to defrayal
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
• Only 2 states selected benchmarks that explicitly cover methadone for OUD
• See also NHeLP letter to HHS Sec. Becerra – Re: Advancing Health Equity Through Essential Health Benefits
Substantive changes to EHB benchmarking options for 2019+

EHB benchmark plan options:
  - Selecting EHB benchmark plan used by another state in 2017
  - Replacing one or more categories from the state’s 2017 benchmark plan with the same category from another state’s 2017 benchmark plan
  - Selecting new benefits to create a whole new benchmark plan

  - New default: previous year’s benchmark

  - State flexibility grants - September 15, 2021 to September 14, 2023

  - Deadline for new EHB benchmark selection: First Wednesday in May
Benchmarking Process: Limits on Benchmark Options

**Generosity Test (Ceiling):**
Benchmark plan may not include more generous benefits than the most generous of the ten benchmark options the state had available in 2017.

**Typical Employer Plan (Floor):**
Benchmark plan may not be less comprehensive than any one of the 2017 benchmark options or largest employer plan in the state.
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
- 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

• Vague and ill-defined, but CMS has discretion to reject benchmark plan selections if state fails to comply with procedural requirements

• Public Process:
  • Notice
  • Public comment period
  • Posting “associated information” on the relevant state website

  45 C.F.R. § 156.111(c)

• Best practices include:
  • forming a stakeholder group
  • engaging consumers
  • full transparency
  • prioritizing health equity
EHB benchmark selection processes can perpetuate health disparities

- Generosity cap plus potential impact on premiums limit what benefits states can add or improve through EHB
- Many states have no process for EHB benchmark selection
- Who wins?
  - Well-resourced conditions/constituencies
  - Politically connected interests/lobbyists
  - Insurers, provider groups, drug companies
- Who loses?
  - Underserved and marginalized populations
  - BIPOC, persons with disabilities, chronic conditions, LGBTQI+

➢ An open, more equitable process that prioritizes the greatest health needs
Advancing health equity through EHB

- 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 ensuring 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.)
Adding/improving benefits to comply with federal requirements does not depend on EHB benchmarking

- Mental Health Parity and Addiction Equity Act
  - *Virginia Bulletin* requiring plans to cover Autism Spectrum Disorder treatment
  - *Washington Memo* on covering behavioral health emergency services
- Section 1557
- Pre-existing conditions exclusions/discrimination (42 U.S.C. §§ 300gg-3; 300gg-4)
- EHB nondiscrimination provision (42 U.S.C. § 18022(b)(4) - 45 C.F.R. §156.125(a) “a non-discriminatory benefit design that provides EHB is one that is clinically-based.”)
  - *Colorado Letter* on state law requiring plans to cover infertility treatment
- We have been asking CCIIO to clarify that these mandates are also exempt from the generosity limit
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
<table>
<thead>
<tr>
<th>State</th>
<th>Changes</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Virginia</strong></td>
<td>• Medical formula&lt;br&gt;• Medically necessary myoelectric, biomechanical, or microprocessor-controlled prosthetic devices</td>
<td>2025+</td>
</tr>
<tr>
<td><strong>North Dakota</strong></td>
<td>• Hearing aids – one per 36 months&lt;br&gt;• Nutritional benefits (screening and counseling)&lt;br&gt;• Weight loss drug&lt;br&gt;• Periodontal disease – acute or chronic&lt;br&gt;• PET scans&lt;br&gt;• Opioids – limits opioid prescriptions to 7 days, ends prior auth for OUD treatment&lt;br&gt;• Insulin/Insulin supplies – limits cost sharing</td>
<td>2025+</td>
</tr>
<tr>
<td><strong>Vermont</strong></td>
<td>• Annual hearing exam and one set of hearing aids per year each 3 years</td>
<td>2024+</td>
</tr>
<tr>
<td><strong>Colorado</strong></td>
<td>• Adds annual mental health wellness visit&lt;br&gt;• Adds alternatives for pain management including chiropractic, physical therapy, cognitive therapy&lt;br&gt;• Adds acupuncture&lt;br&gt;• Requires gender affirming care</td>
<td>2023+</td>
</tr>
<tr>
<td><strong>Oregon</strong></td>
<td>• Mandatory coverage of buprenorphine&lt;br&gt;• Automatic coverage of naloxone when opioids are prescribed at 50 MME or higher&lt;br&gt;• Adds coverage of non-opioid alternatives to treat pain</td>
<td>2022+</td>
</tr>
<tr>
<td><strong>Michigan</strong></td>
<td>• Mandatory coverage of buprenorphine&lt;br&gt;• Automatic coverage of naloxone when opioids are prescribed at 50 MME or higher</td>
<td>2022+</td>
</tr>
<tr>
<td><strong>Illinois</strong></td>
<td>• Cover alternative therapies for pain, such as topical anti-inflammatories&lt;br&gt;• Remove barriers to obtaining buprenorphine products for opioid use disorder treatment&lt;br&gt;• Cover at least one intranasal spray opioid reversal agent when initial prescriptions of opioids exceed certain limit&lt;br&gt;• Cover tele-psychiatry care</td>
<td>2022+</td>
</tr>
<tr>
<td><strong>New Mexico</strong></td>
<td>• Removes benefit limits for prosthetics&lt;br&gt;• Expands eligibility for weight loss drugs and programs&lt;br&gt;• Adds coverage of 3 naloxone formulations&lt;br&gt;• Adds benefits for artery calcification testing and hepatitis C</td>
<td>2022+</td>
</tr>
<tr>
<td><strong>South Dakota</strong></td>
<td>• Adds applied behavior analysis for Autism Spectrum Disorder</td>
<td>2021+</td>
</tr>
</tbody>
</table>
Resources

National Health Law Program

• Essential Health Benefits: Best Practices in EHB Benchmark Selection

• Essential Health Benefits (EHB) benchmarking process

• NHeLP Letter to CCIIO Director, Ellen Montz, Re: Request for Modifications to the Federal Prescription Drug and Maternity Care Essential Health Benefit Standards

• NHeLP letter to HHS Sec. Becerra – Re: Advancing Health Equity Through Essential Health Benefits