Essential Health Benefits: Best Practices in State Benchmark Selection

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To address long standing coverage gaps and help ensure that people can obtain the health services they need, the Affordable Care Act (ACA) established a comprehensive set of benefits that most health plans must provide - the ten Essential Health Benefits (EHBs).[1] Under regulations from the U.S. Department of Health and Human Services (HHS), states define EHBs through a benchmarking process, where states select a base benchmark plan which serves as a reference for defining EHBs in the state.[2] However, the benchmarking approach has led to wide variation in how states define EHBs resulting in significant deficiencies in coverage of key benefits.[3]

While federal rules specify EHB benchmark options and other requirements applicable to EHBs, states have significant flexibility in their EHB benchmark selections.[4] If a state does not select a plan, the default is its previous year's benchmark plan.[5] Forty-two states, plus the District of Columbia, currently use a small group plan as the state's EHB benchmark.[6] These commercial

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[1] 42 U.S.C. § 300gg–6; 42 U.S.C. § 18022; 42 U.S.C. § 1396u-7(b)(5). EHB requirements apply to non-grandfathered individual and small group plans, as well as Medicaid Alternative Benefits Plans (ABPs).
[2] 45 C.F.R. § 156.111.
[3] Nat'l Health Law Program, Letter to Sec. Becerra, *Re: Advancing Health Equity Through Essential Health Benefits* (Dec. 6, 2021), https://healthlaw.org/resource/nhelp-letter-to-hhs-sec-becerra-re-advancing-health-equity-through-essential-health-benefits/.
[4] 45 C.F.R. §§ 156.110, 156.111. In 2019, HHS expanded the benchmark options available to states. See HHS 2019 Notice of Benefit and Payment Parameters Final Rule, 83 Fed. Reg. 16930 (Apr. 17, 2018), https://www.federalregister.gov/documents/2018/04/17/2018-07355/patientprotection-and-affordable-care-act-benefit-and-payment-parameters-for-2019. See also Héctor Hernández-Delgado & Wayne Turner, Natl. Health Law Program, *Essential Health Benefits (EHB) benchmarking process* (April 14, 2020), https://healthlaw.org/resource/essential-health-benefits-ehb-benchmarking-process/.
[5] 45 C.F.R. § 156.111(d)(1). Prior to 2020, the default for states not selecting an EHB benchmark plan was the largest small group plan, by enrollment. 45 C.F.R. § 156.100(c).
[6] Center for Consumer Information and Insurance Oversight (CCIIO) https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Final-List-of-BMPs_4816.pdf.

plans sold to small businesses and nonprofits are usually the least generous of the base benchmark options. Therefore, most states could expand or improve benefits by selecting a more generous option.

In addition, the most recent update to the federal rules allows states to put together an entirely new plan that would make up the state's benchmark, as long as such plan does not exceed, in actuarial terms, the generosity of the most generous plan the state had available when the last selection was made.[7] Despite these opportunities, as of 2022, only a handful of states have updated their EHB benchmark plans.[8] By implementing processes that engage stakeholders in the selection process, states can continue to increase benefits and close coverage gaps. The deadline for submitting a proposed modified EHB benchmark is the first Wednesday in May of the year that is two years before the effective date of the new EHB benchmark plan.[9]

The new deadline for submitting a new EHB benchmark plan is the first Wednesday in May of the year that is two years before the effective date of the new EHB benchmark plan.

Federal rules provide few details on the process states should use for selecting and updating their EHB benchmark plans. Minimally, states must provide public notice and the opportunity to comment on the state's benchmark selection.[10] This issue brief examines best practices for selecting EHB benchmark plans, including strategies to engage consumers and other stakeholders. By adopting an open, transparent, and data-driven public process, states can address unmet health care needs by expanding benefits through the EHB benchmarking process.

I. Expanding and improving benefits through EHB benchmarking

To help address coverage gaps, states may seek to require plans to cover specific benefits. However, under the ACA, states must defray the costs in Qualified Health Plans (QHPs) of new benefit mandates.[11] A benefit required by state action, taking place after December 31, 2011,

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[7] 45 C.F.R. § 156.111(a)(3).
[8] Illinois, South Dakota, Michigan, New Mexico, Oregon, and Colorado, https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb#overview. See also Appendix A for further details.
[9] 45 C.F.R. § 156.111(d).
[10] 45 C.F.R. § 156.111(c).
[11] 42 U.S.C. § 18031(d)(3)(B). States must either 1) make payments directly to the individual enrollee or 2) to the QHP issuer on behalf of the enrollee to defray the costs of the additional State-Required Benefit. 42 U.S.C. § 18031(d)(3)(B)(ii); 45. C.F.R. § 155.170.

other than for the purposes of compliance with federal regulation, is considered a state-required benefit subject to defrayal.[12]

Utah must pay $2,000,000 in 2022 alone to defray the cost of its ABA therapy mandate. If Utah had updated its EHB benchmark to include ABA therapy instead of enacting a new mandate, it could have avoided triggering the ACA's defrayal requirement.

The defrayal requirement has deterred most states from enacting new benefit mandates. For example, Utah enacted a new state mandate requiring plans to cover Applied Behavioral Analysis (ABA) therapy for persons diagnosed with autism spectrum disorder, thereby triggering the ACA's defrayal requirement.[13] Utah must pay a projected $2,000,000 in 2022 alone to defray the cost of its ABA therapy mandate.[14] If Utah had updated its EHB benchmark to include ABA therapy instead of enacting a new mandate, it could have avoided triggering the ACA's defrayal requirement.[15]

The distinction between passing a new law and updating a state's EHB benchmark plan is significant. States that update their EHB benchmark may incur some costs, for example, in conducting an actuarial analysis and meeting other administrative requirements. However, these costs are minimal, especially when compared to the annual appropriation of state funding to defray the costs of new benefit mandates.

Making changes through the EHB benchmarking process is also now considerably easier following the changes adopted by HHS through the Notice of Benefit and Payment Parameters (NBPP) Rule for 2019.[16] Under the current benchmarking rules, states can select a new EHB

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[12] *Id.* at § 155.170(a)(2).
[13] In 2014, Utah required plans regulated by the state to provide Applied Behavioral Analysis (ABA) therapy for children diagnosed with Autism Spectrum Disorder, and expanded the requirement in 2019. *See* S.B. 57, 60th Leg., Gen. Sess. (Utah 2014) and S.B. 95, 63rd Leg., Gen. Sess. (Utah 2019). The state established a defrayal process in 2019. 22 Utah Bull. DAR File No. 44181 (Nov. 15, 2019), UTAH ADMIN. CODE r. 590-283 et seq. *See also* 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.
[14] *See* 22 Utah Bull. DAR File No. 44181 (Nov. 15, 2019) (referencing Appendix 2: Regulatory Impact on Non-Small Businesses). Note: this amount does not include the state's costs in establishing and administering defrayal.
[15] Center for Consumer Information and Insurance Oversight, *Frequently Asked Questions on Defrayal of State Additional Required Benefits,* Q1 (Oct. 23, 2018), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-Defrayal-State-Benefits.pdf.
[16] Final Rule, HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16930 - 17071 (Apr. 17, 2018).

benchmark plan from three options: selecting the benchmark plan from another state; selecting individual EHB categories from benchmark plans in other states; and, most importantly, creating an entirely new benchmark for all EHB categories.[17] These new benchmarking options give states significantly more leeway in expanding coverage of EHB categories because they are not dependent on an actual health plan. Having this expansive new authority should, at a minimum, encourage states to evaluate whether improvements in EHB coverage are needed.

Since most states are using the least generous plan for their EHB benchmark, they can add or expand benefits by updating their EHB benchmark plans.

States' ability to add or enhance benefits through benchmarking is limited, however. A state's new benchmark plan cannot "exceed the generosity" of either the benchmark plan for plan year 2017 or any of the 10 benchmark plan options the state had available for 2017.[18] Nonetheless, since, as noted above, most states are using the least generous plan for their EHB benchmark, they can substantially expand benefits without exceeding the generosity limit. In other words, most states are leaving money on the table, and can add benefits without triggering defrayal by updating their EHB benchmark plans.

II. Best practices for EHB benchmark selection

Most states have not adopted a formal process for selecting and updating the state's EHB benchmark plan. Federal rules require states to post a notice on a relevant state website regarding the opportunity for public comment with associated information.[19] However, HHS declined to set minimum requirements for the public comment process, such as holding public hearings or specifying the length of the public comment period.[20] Instead, HHS prioritized retaining state flexibility, looking to states to "reasonably interpret" the public comment requirement.[21]

[17] 45 C.F.R. § 156.111(a).
[18] 45 C.F.R. § 156.111(b)(2)(ii).
[19] 45 C.F.R. § 156.111(c).
[20] Final Rule, HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16930, 17017 (Apr. 17, 2018).
[21] *Id*.

A. Selecting entity

Federal regulations recognize that the "State" is responsible for selecting its EHB benchmark plan, subject to federal oversight.[22] However, the regulations do not designate a specific state entity or individual responsible for EHB benchmark selection. In 2011 guidance, HHS noted that in most states, the executive branch would select the state's benchmark plan, acknowledging that in some states the legislature may be involved.[23] However, there is wide variation among states on which entity is responsible for selecting the EHB benchmark plan.

In many states, the state department of insurance selects the EHB benchmark (*e.g.*, New Mexico, Michigan, South Dakota).[24] In Vermont, the health care regulatory board, Green Mountain Care Board, makes the selection.[25] In some states, multiple entities collaborate to choose the EHB benchmark plan. In Arkansas, the state-based marketplace provides a recommendation to the state insurance commissioner, who then issues a decision on the state's benchmark plan.[26] In New York, the state-based marketplace works with the state Department of Health to select the benchmark plan.[27] A few states including California and

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[22] 45 C.F.R. § 156.100(a); 45 C.F.R. § 156.111(a).
[23] Ctrs. For Medicare & Medicaid Srvs., Frequently Asked Questions on Essential Health Benefits Bulletin, Q19 (Dec. 16, 2011), https://www.cms.gov/cciio/resources/files/downloads/ehb-faq-508.pdf.
[24] *See* State of New Mexico: Office of the Superintendent of Insurance, Benchmark Valuation Report, Wakely Consulting Group (July 9, 2020), https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb; State of New Mexico: Office of the Superintendent of Insurance, Benchmark Valuation Report, Wakely Consulting Group (July 9, 2020), https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb; Michigan's 2022 Essential Health Benefits Benchmark Plan: Executive Report (July 1, 2020), https://www.michigan.gov/documents/difs/2022_EHB_Benchmark_Report_700759_7.pdf; South Dakota Department of Labor & Regulation, Essential Health Benefits Benchmark Design Changes Approved for Plan Year 2021 (July 23, 2019), https://dlr.sd.gov/news/releases19/nr072319_ehb_benchmark_approved.pdf.
[25] *See* Vermont Health Connect, *Vermont's Benchmark Plan*, https://info.healthconnect.vermont.gov/essentials (noting that In August 2012, the Department of Vermont Health Access recommended a benchmark plan to the Green Mountain Care Board for their review and approval. The Green Mountain Care Board approved that plan in October 2012).
[26] *See* Ark. Dep't of Insurance, R. 103, Essential Health Benefits Benchmark Plan (Aug. 22, 2012), https://insurance.arkansas.gov/uploads/finalrules/Rule103.pdf,
[27] *See* Letter from Donna Frescatore to Lisa M. Cuozzo (July 1, 2015), https://info.nystateofhealth.ny.gov/sites/default/files/Benchmark%20Plan%20for%202017%20Letter.pdf; *See also* Millman, *New York's Essential Health Benefit Base Benchmark Options* (July 13, 2015), https://info.nystateofhealth.ny.gov/sites/default/files/New%20York%E2%80%99s%20Essential%20Health%20Benefit%20Base%20Benchmark%20Options_0.pdf ("The New York State Department of Health asked Milliman to analyze and compare the health services covered by the ten plans that are options for New York's Essential Health Benefit (EHB) benchmark effective January 1, 2017").

Washington selected their benchmark plan by passing legislation.[28] Utah also relied on the legislative process to codify a procedure by which state regulators would select a benchmark.[29] In multiple states, however, it is unclear who is responsible for the state's EHB benchmark selection (*e.g.*, Connecticut, Indiana, Iowa, North Dakota, and Wyoming).

For more information, see Appendix B, SELECT STATE EHB BENCHMARK AND SELECTION PROCESSES, a survey of select states conducted by the law firm Hooper, Lundy & Bookman in conjunction with the National Health Law Program.

Best practice: States should clarify, if necessary, which entity has authority to select and update the state's EHB benchmark plan (*e.g.*, state insurance commissioner, exchange authority, legislature). The EHB selecting entity should establish clear procedures and timeline for reviewing and updating the EHB benchmark, maximizing transparency and public participation.

B. Public notice

Federal rules require states to provide a "reasonable public notice" of the state's proposed update to the state's EHB benchmark plan by posting the notice on a "relevant" state website.[30] However, federal rules provide no specifics beyond this general requirement. Notice should be posted on a website that is easily accessible to the general public, such as the state department of insurance or state-based Marketplace website. It is more likely that a wider range of stakeholders will view the notice if it is on a high-traffic website rather than one that is limited to administrative or policy-change information, such as the state equivalent of the Federal Register.

States should also consider other ways to publicize notice of a proposal to update the state's EHB benchmark plan. For example, states can cross-post the notice on multiple websites to get additional reach. States can also issue press releases and post notice on social media to solicit comments. For example, when Michigan proposed updates to its EHB benchmark in March 2020, the Department of Insurance and Financial Services issued a press release and posted on Twitter several times to drive public comments.[31] Additionally, some states regularly

[28] Cal. Health & Safety Code § 1367.005; 2012 WA H.B. 2319.
[29] 2012 Utah H.B. 144.
[30] 45 C.F.R. § 156.111(c).
[31] Press Release, *DIFS Seeks Public Comment on Michigan Essential Health Benefits Benchmark Plan Update to Enhance Benefits for Opioid Addiction Prevention and Treatment*, Mich. Dep't of Insurance &

send out emails to interested stakeholders announcing the proposal and public comment period.

Best practice: Departments of insurance and other agencies should coordinate public posting and prominently feature announcements of EHB benchmark updates on their websites. Agencies should issue press releases and share links to the EHB benchmarking information via social media.

C. Public comment periods

Federal rules also require a "reasonable" public comment period, but do not say how long a state's public comment period must be. It is important for states to give the public sufficient time to study the proposal, formulate opinions, and communicate those ideas back to the state. For example, in 2018, Alabama proposed significant changes to its EHB benchmark, but provided only a two-week public comment period.[32] Advocates objected, arguing that two weeks is not a reasonable length of time to allow for meaningful public review and comment.[33] The state ultimately withdrew its proposal in part because of the lack of opportunity for stakeholder input.[34]

States should adopt standards for EHB public commenting that mirror those specified by HHS for states requesting waivers through § 1115 of the Medicaid Act. Those standards require states to issue a public notice that contains a "comprehensive description" of the application and "a sufficient level of detail to ensure meaningful input from the public."[35] In addition, states seeking a § 1115 waiver are required to give stakeholders at least thirty days to submit comments.[36] While none of these steps are expressly required, implementing such a robust commenting period would ensure that states seeking changes to their EHB benchmark comply

Financial Serv's (Mar. 31, 2020), https://www.michigan.gov/difs/News-and-Outreach/press-releases/2020/03/31/difs-seeks-public-comment-on-michigan-essential-health-benefits-benchmark-plan-update-to-enhance-be. *See also* Mich. Dep't of Insurance & Financial Serv's (@MIDFS), Twitter (Apr. 12, 2020 1:10 PM), https://twitter.com/MIDIFS/status/1249382030317674496.

[32] Alabama Dept. of Insurance, EHB Benchmark Plan Revisions (July 19, 2018), https://www.aldoi.gov/currentnewsitem.aspx?ID=1008.

[33] Hayley Penan, Nat'l. Health Law Program, Letter to Yada Horace, Insurance Rate Analyst, Alabama Department of Insurance, RE: Alabama PY 2020 EHB Benchmark Plan (Aug, 2, 2020), https://healthlaw.org/resource/nhelp-comments-re-alabama-py-2020-ehb-benchmark-plan/.

[34] Alabama DoI, note 32 *supra*.

[35] 42 C.F.R. § 431.408(a)(1)(i).

[36] 42 C.F.R. § 431.408(a).

with the requirement to provide reasonable public notice and a meaningful opportunity for comment.[37]

Best practice: Comment periods for EHB benchmark selection should be a minimum of thirty days. States should publicly post all comments received, and explain how the comments influenced its decision-making. States should also consider soliciting public comments at the onset of its EHB benchmark selection process, providing consumers and other stakeholders the opportunity to identify health care coverage gaps to help prioritize benefits and services that the state should add.

D. Actuarial analysis

Under federal rules, states cannot exceed the generosity of the most generous plan available to the state in 2017.[38] This limitation, which effectively acts as a ceiling for states seeking to change their EHB benchmark, imposes a maximum level of coverage. States must commission an actuarial analysis to demonstrate compliance with the generosity test.

HHS did not specify a methodology for actuarial analyses used to determine whether adding services exceeds the generosity of the most generous of the EHB benchmark options the state had in 2017. The analysis must comply with generally accepted actuarial principles and methodologies.[39] In 2018, the Center for Consumer Information and Insurance Oversight (CCIIO) released guidance that provided states with an example of an accepted, albeit not required, methodology.[40] Pursuant to such guidance, states can commission reports that compare the *expected values* of the resulting EHB benchmark and the most generous plan.

To calculate the expected value of the plans, actuaries must use reasonable actuarial assumptions and methods and may use data acquired from insurers in the state for a recent plan year, and weigh the services and benefits provided in each EHB category. Under the sample methodology outlined by CCIIO, for example, the proposed EHB benchmark plan

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[37] For additional information about the notice and comment process for states submitting § 1115 waiver applications, *see* Catherine McKee & Jane Perkins, Nat'l Health Law Prog., *Section 1115 Waiver Requirements: Transparency and Opportunity for Public Comment* (2017), https://healthlaw.org/resource/sec-1115-waiver-requests-transparency-opportunity-for-public-comment/.
[38] 45 C.F.R. § 156.111(b)(2)(ii).
[39] 45 C.F.R. § 156.111(e)(2).
[40] CCIIO, Example of an Acceptable Methodology for Comparing Benefits of a State's EHB benchmark Plan Selection in Accordance with 45 C.F.R. §§ 156.111(b)(2)(i) and (ii) (2018), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Example-Acceptable-Methodology-for-Comparing-Benefits.pdf.

would fail to meet the generosity test "if the expected value for each applicable EHB category of benefits in the proposed state's EHB-benchmark plan exceeds 100 percent of expected value for those same EHB categories of benefits in the most generous [Comparison Plan]."[41]

Actuaries may also compare the overall benefit cost of the proposed EHB benchmark plan with the overall benefit cost of the most generous plan. Regardless of the selected methodology, it is essential that states demonstrate compliance with the requirements by comparing the proposed EHB benchmark plan to the most generous option in 2017. Here is an example of the process from Colorado:[42]

- Step 1: Actuaries determine the most generous plan from the 2017 options. Generosity in this case was determined by richer coverage of acupuncture, PT/OT/ST, and pediatric dental benefits. The values ascribed to the different plans are based on claims data in the State.
- Step 2: Actuaries compare the expected value at 100% actuarial value of the most generous plan to the expected value at 100% actuarial value of the current benchmark plan. Based on this calculation, they determine that, because of richer acupuncture, PT/OT/ST, and pediatric dental benefits, the most generous 2017 plan option had a total value of 100.26% compared to the current benchmark (or .26% over the total value of the current benchmark).
- Step 3: Actuaries compare the expected value at 100% actuarial value of the proposed benchmark plan to the expected value at 100% actuarial value of the current benchmark. Based on this calculation, they determine that, because of the new proposed benefits (acupuncture, gender-affirming care, mental health wellness exams, and increased prescription drug coverage), the proposed benchmark had a total value of 100.16% compared to the current benchmark (or .16% over the total value of the current benchmark).
- Step 4: Actuaries compare the expected values at 100% actuarial value of the proposed benchmark and the most generous 2017 plan option. Because 100.16% is less than 100.26%, they determine the proposed benchmark plan is within the limit and meets the generosity test.

As noted above, states are required to submit an actuarial certification and associated actuarial report affirming that the state's EHB benchmark plan complies with the requirements of the law.[43] Typically, states contract with at least one private company to conduct these

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[41] *Id*. at 4.
[42] State of Colorado Division of Insurance, *Benchmark Plan Benefit Valuation Report* (May 2021), https://drive.google.com/file/d/1rTeY63imbtlmFIzFHerSeyfHKE6hZSN8/view?usp=sharing.
[43] 45 C.F.R. § 156.111(e)(2)(i) and (ii).

analyses and compile reports. States can maximize stakeholder engagement in EHB benchmark selection by making the process of soliciting consultants and actuaries as transparent as possible. For example, New Mexico made its Request for Proposal (RFP) publicly available, along with an associated FAQ document.[44] States should additionally engage stakeholders in the process of developing the RFP and ultimately selecting consultants and actuaries to perform these services

Best practice: States should commission an actuarial analysis early on, to compare its current EHB benchmark with the most generous plan available. The net difference will dictate how much in benefits the state can add to the EHB benchmark without exceeding the generosity test. States should publicly share the analysis, as well as an explanation of its findings.

E. Transparency

When updating their EHB benchmark plans, states must post "associated information" on the relevant state website, along with public notice and the opportunity to comment.[45] However, federal rules do not specify what information states must post during the benchmark selection process. When a state submits its benchmark selection to CCIIO, it must include an actuarial certification and associated actuarial report affirming that the state's EHB benchmark plan complies with the requirements of the law.[46] Once CCIIO approves a state's EHB-benchmark plan, the required documents are posted on the CCIIO website.[47]

The public should have access to these reports and documents so that they can see and study the comparison of benefits and assessment of a proposed plan's generosity. Such documents should also be easy to find. Some states, like Colorado, Florida, and Oregon, post the analysis on the insurance department's website.[48] Oregon's Division of Financial Regulation established

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[44] New Mexico State Purchasing Division of the Gov't Serv's Dep't & Office of Superintendent of Insurance, *Request For Proposals (RFP): Health Insurance Essential Health Benefits Plan Evaluation Actuarial Services* (May 4, 2019), https://www.osi.state.nm.us/wp-content/uploads/2019/07/Actuarial-Services-RFP.pdf; New Mexico Office of Superintendent of Insurance, *Essential Health Benefits Benchmark Plan Questions and Responses* (July 2019), https://www.osi.state.nm.us/wp-content/uploads/2019/07/Essential-Health-Benefits-Benchmark-Plan-Questions-Responses.pdf.
[45] 45 C.F.R. § 156.111(c).
[46] 45 C.F.R. § 156.111(e)(2)(i) and (ii).
[47] *See* Center for Medicaid & Medicare Services, Information on Essential Health Benefits (EHB) Benchmark Plans, https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.
[48] [48] Colorado Division of Insurance, ACA - Benchmark Health Insurance Plan Selection (last accessed Nov. 13, 2020), https://doi.colorado.gov/aca-benchmark-health-insurance-plan-selection; Florida Office of Insurance Regulation, Evaluation of Florida's Essential Health Benefits Benchmark Plan (Oct. 13,

an EHB advisory committee with a dedicated page on its website focusing on EHB, where the Division posts relevant documents, public comments submitted, and links to the state-level EHB regulations.[49]

Best practice: States should post all documents, presentations, and other relevant information including all comments received during the public comment period. Additionally, states should publicly address how they are responding to comments. States should also continue posting information from previous years' benchmark selection so advocates can track changes over time.

F. Stakeholder coalitions

Before a state proposes an update to its EHB benchmark plan, it should first engage with a diverse coalition of stakeholders. Engaging with stakeholders in the pre-planning stage can strengthen the proposal by helping to identify coverage gaps. For example, Oregon established a standing stakeholder advisory committee that holds public hearings, solicits comments, and then recommends changes.[50] Colorado convened an *ad hoc* workgroup of stakeholders to advise in the evaluation of the State's EHB benchmark plan.[51]

States should engage a diverse array of stakeholders, not only for this pre-planning process, but to advise the state throughout the EHB benchmarking process. Stakeholder advisory groups should include consumers, caregivers, patient advocates, physicians, nurses, community health providers, public health officials, and researchers. Stakeholder advisory groups should conduct open, public meetings and ensure accessibility for persons with disabilities. For instance, Oregon's EHB Rulemaking Advisory Committee livestreams its

2019), https://www.floir.com/siteDocuments/2019LegislativeBenchmarkReport.pdf; Oregon Division of Financial Regulation, Essential Health Benefits (EHB) Rulemaking Advisory Committee (last visited June 21, 2022), https://dfr.oregon.gov/help/committees-workgroups/Pages/EHB-rulemaking-committee.aspx.

[49] *See* Oregon Division of Financial Regulation, Essential Health Benefits (EHB) Rulemaking Advisory Committee, https://dfr.oregon.gov/help/committees-workgroups/Pages/EHB-rulemaking-committee.aspx (last visited June 21, 2022).

[50] Oregon Division of Financial Regulation, Department of Consumer and Business Services, 2022 ESSENTIAL HEALTH BENEFITS RULEMAKING ADVISORY COMMITTEE CALL FOR APPLICATIONS (Feb. 6, 2020), https://dfr.oregon.gov/Documents/EHB-Announcement.pdf. See also Essential Health Benefits (EHB) Rulemaking Advisory Committee, note 49 *supra*.

[51] Colorado Division of Insurance, Division of Insurance Seeks Stakeholders for Workgroup to Review State Benchmark Health Insurance Plan (Dec. 16, 2020), https://doi.colorado.gov/announcements/division-of-insurance-seeks-stakeholders-for-workgroup-to-review-state-benchmark.

meetings, and posts meeting materials on its website.[52] States should also post membership, governance documents including by-laws, conflict-of-interest disclosures, meeting minutes, and other relevant documents. States should provide child-care and other supports to allow participation from a diverse array of stakeholders.

States will not be able to add or expand all the benefits that people need. Therefore, stakeholder advisory groups should center health equity when prioritizing which benefits the state should add or expand.

EHB stakeholder groups should foster collaboration, not conflict. Given the generosity test and other limitations, states will not be able to add or expand all the benefits that people need. Therefore, stakeholder advisory groups should center health equity when prioritizing which benefits the state should add or expand. The EHB benchmarking update should address the greatest unmet health needs, not the demands of the best-resourced advocates.

Best practice: States should establish standing EHB stakeholder groups to periodically review and recommend changes to the state's EHB benchmark plan. Advisory groups should be transparent, represent a broad and diverse array of stakeholders, and center health equity in its processes and recommendations. EHB advisory groups should not replace seeking broader public input in the EHB benchmark updating process.

G. Public hearings

Although not required under federal rules, states should convene public hearings to solicit feedback from consumers and other interested parties as they are required to do in other contexts. For example, at least twenty days before submitting a § 1115 waiver application, states must hold at least two public hearings, on separate dates and at separate locations, during which "members of the public throughout the state have an opportunity to provide comments" on the demonstration application.[53] States should adopt a similar practice for EHBs and benchmark plans.

Some states have already adopted the practice of holding public hearings in the context of EHBs. When Delaware initially selected its EHB benchmark plan in 2012, the state Department of Health and Human Services held a public forum during the open comment period to review

[52] Essential Health Benefits (EHB) Rulemaking Advisory Committee, note 49 *supra*.
[53] 42 C.F.R. § 431.408(a)(3).

the EHB materials and solicit comments.[54] New York and Alabama have also conducted webinars to explain the EHB benchmark selection process and answer questions.[55]

To ensure these public meetings are accessible to as many people as possible, states should provide multiple ways of participating, including in-person access, a livestream, a toll-free phone dial-in, and an option to request translation or ASL services. States should also provide child care on site and post a transcript or recording of the meeting online afterwards. Comments provided through public hearings should be part of the administrative record and publicly available.

Best practice: States should hold public hearings explaining the EHB benchmarking process and the potential proposed EHB benchmark changes, with an opportunity for consumers and other interested parties to provide feedback. Hearings should be open and accessible for persons with disabilities, with multiple ways of participating. Comments provided at public hearings should be part of the administrative record.

H. Use of data

States that have updated their EHB benchmark plans did so to add specific benefits. For example, Illinois, Michigan, and Oregon added treatments for substance use disorder (SUD) to address the growing and deadly opioid crisis in those states.[56] While evidently behavioral health is a priority in all states, going forward, states should use a more comprehensive approach to examine health disparities and unmet health needs. States can efficiently and effectively address these needs by using evidence-based research and data to identify coverage gaps. By using a data-driven approach, state regulators can prioritize which benefits should be added or improved in EHB benchmark plans.

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[54] Delaware Dep't of Health & Human Serv's, *Defining Delaware's Essential Health Benefits in a Benchmark Health Insurance Plan* (last accessed Nov. 13, 2020), https://dhss.delaware.gov/dhcc/healthbenefitspr.html.

[55] NY State of Health, *Essential Health Benefits Decision for 2017 Webinar* (Jun. 24, 2015), https://info.nystateofhealth.ny.gov/EssentialHealthBenefits2017; Alabama Dep't of Insurance, *Alabama Essential Health Benefits* (Jun. 20, 2012), https://www.aldoi.gov/PDF/Consumers/Webinar%20PP%20slides%20%206-20-12.pdf.

[56] Illinois Department of Insurance, Illinois becomes first and only state to change Essential Health Benefit-benchmark plan (Aug. 27, 2018), https://www2.illinois.gov/IISNews/18098-DOI_Essential_Health_Benefit-benchmark_plan_Release.pdf; CMS, The Centers for Medicare & Medicaid Services (CMS) Approves New Essential Health Benefit Benchmarks for Michigan (Aug. 28, 2020), https://www.cms.gov/files/document/82820-mi-ehb.pdf; CMS, The Centers for Medicare & Medicaid Services (CMS) Approves New Essential Health Benefit Benchmarks for Oregon (Aug, 28, 2020), https://www.cms.gov/files/document/82820-or-ehb.pdf.

To obtain the data needed to identify health needs and coverage gaps, states need not start from scratch; they can engage with other state agencies, such as the state's public health department, and academic and research institutions.[57]

Federal data sources can also provide state-level information on health and health care. These include national surveys, such as:

- Behavioral Risk Factor Surveillance System (BRFSS), which collects data on health-related risk behaviors, chronic health conditions, and use of preventive services; [58]
- Youth Risk Behavior Surveillance System (YRBS), which monitors six categories of health-related behaviors that contribute to the leading causes of death and disability among youth and adults; and [59]
- National Survey on Drug Use and Health (NSDUH), which provides data with respect to drug use patterns and development of SUDs across states and disaggregated by age and other risk factors.[60]
- National Health Interview Survey (NHIS), which collects data on a broad range of health topics and health care access.[61]

These and other sources of data provide a glimpse of various health status issues in people of different races, ethnicities, sexes, gender identities, ages, and sexual orientations, and intersections thereof. Using multiple data sources allows for cross-referencing and provides better quality, and therefore more useful, information.

Best practice: A data-driven review process should identify unmet health needs and help prioritize what benefits and services states should add when updating their EHB benchmark plans. States should be mindful that some data resources may not provide a detailed breakdown of key factors such as race, disability, sexual orientation, gender identity, and sex

[57] See *e.g.*, Oregon Health Authority, *Oregon's State Health Assessment* (2018), https://www.oregon.gov/oha/PH/ABOUT/Documents/sha/state-health-assessment-full-report.pdf; Colorado Health Institute, *Racial and Ethnic Health Disparities Lead to Worse Health Outcomes Among Colorado's Aging Population* (May, 2021), https://www.coloradohealthinstitute.org/research/racial-and-ethnic-health-disparities-lead-worse-health-outcomes-among-colorados-aging.
[58] U.S. Ctrs. for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, https://www.cdc.gov/brfss/index.html.
[59] U.S. Ctrs. for Disease Control and Prevention, Youth Risk Behavior Surveillance System, https://www.cdc.gov/healthyyouth/data/yrbs/index.htm.
[60] Substance Abuse and Mental Health Serv. Admin. (SAMHSA), National Survey on Drug Use and Health, https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health.
[61] U.S. Ctrs. for Disease Control and Prevention, National Health Interview Survey, https://www.cdc.gov/nchs/nhis/index.htm.

characteristics. States should align their EHB benchmarking process with other state-wide efforts to address health disparities and advance health equity.

Conclusion

Most, if not all, states have ample room for improvement regarding coverage of EHBs in the private market. Consequently, states should take advantage of the opportunities afforded to them by the most recent federal changes to the EHB standard and carefully consider where modifications are needed and the extent to which such changes may be adopted within the scope of current federal requirements. These changes should always be considered and implemented keeping the best interest of enrollees in mind and maintaining transparency and open communication with stakeholders throughout the process.

Appendix A

State Changes to EHB Benchmark Plans as of June 2022		
State	Changes	Plan year
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 • Limit opioid prescriptions for acute pain to 7 days • 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
South Dakota	• Adds applied behavior analysis for Autism Spectrum Disorder	2021

Appendix B

(see attached)

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"SELECT STATE EHB BENCHMARK AND SELECTION PROCESSES"

HLB OVERVIEW

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SELECT STATE EHB BENCHMARK AND SELECTION PROCESSES

October 20, 2021

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Previously Reviewed: Connecticut, Kentucky, North Dakota, Virginia, Hawaii, Indiana & Iowa
Newly Reviewed: Arkansas, Florida, Massachusetts, Minnesota, Pennsylvania, Wyoming & West Virginia

Notes: We have endeavored to categorize states based on publicly available information, but states may be miscategorized due to insufficient information, conflicting, and/or vague authorities.

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Select State EHB Benchmark and Selection Processes

(1) LEGISLATIVE EHB BENCHMARK / EHB SELECTION PROCESS

State	Legislative Approval Required to change EHBS?	Which state office, agency or governmental body selects the EHB benchmark plan?	Is the benchmark plan analysis available to the public?	What are the current state-required benefits in the 2017-2022 EHB benchmark plan?	How are (can) changes to the benchmark plan and/or EHBs be made?	What is the state's public process?[1]	Other Notes
CA	*Yes*	*Legislature**	*Yes. See the 2012 Benchmark Plan Comparison for EHBs, here.*	*Subject to additional requirements, in CA, EHBs are broadly defined as health benefits defined under § 1302(b) of the Patient Protection and Affordable Care Act [42 U.S.C. § 18022] (referred to hereinafter as "Section 1302(b) of the ACA"), the health benefits covered in CA's benchmark plan (the Kaiser Foundation Health Plan, Inc. Northern Region Small Group HMO $30 Copayment Plan), and pediatric dental and vision coverage. Cal. Ins. Code § 10112.27 (insurance products regulated by the Cal. Dept. of Ins. ["CDI"]); Cal. Health & Safety Code § 1367.005 (insurance products regulated by the Dept. of Managed Health Care ["DMHC"]).* *The current State-required benefits reported to CMS are available here.*	*Because of CA's unusual bifurcated health regulatory scheme, there are two underlying authorities governing the selection of the State's EHBs. First, Cal. Code. Ins. § 10112.27 governs health insurance products regulated by the CDI. Second, Health & Safety Code § 1367.005 governs health insurance products regulated by the DMHC. The two statutes are substantively the same. They establish the EHBs for the individual and small group market effective on or after January 1, 2017. Both CDI and DMHC are delegated rulemaking authority to implement the respective EHB statutes, however neither department would have the authority to adopt regulations contrary to the underlying legislation. Thus, any changes to the State's EHBs for 2017-2022 would likely require an act by the legislature.*	*In 2012, there was a public hearing regarding CA's EHB benchmark selection. While our understanding is that CA has taken public comment, had legislative hearings, and held stakeholder meetings regarding the EHB selection process in the past, we have not found authority outlining formal requirements for the CA's public process. See, e.g., Cal. Code Regs. tit. 28, § 1300.67.005 (establishing EHB requirements, but not outlining a public process for the contemplation thereof).*	**While the Legislature selected the benchmark plan in statute, both DMHC and CDI were authorized to make recommendations regarding the establishment of EHBs in 2012 based on public comment and stakeholders.*
MD	*Yes**	*Maryland Insurance Commissioner*	*Yes. See the Maryland Insurance Administration, "Selection of the 2017 Benchmark Plan", here.*	*EHBs are defined in Md. Code Ann., Ins. § 31-116 as the benefits set forth in the State benchmark plan notwithstanding other benefits mandate by State law.* *The EHB benchmark plan is defined as the health benefit plan designated by the State to serve as the EHB standard for exchange, individual and small employer market products. Id. § 31-101(bb).* *The current State-required benefits reported to CMS are available, here, and also available on the MD Department of Insurance website.*	*Under § 31-116, the MD Insurance Commissioner is delegated authority to determine the EHB benchmark plan, and corresponding EHBs, subject to numerous requirements set forth in the statute. The statute contemplates the process for the selection of the 2017-2022 benchmark plan, which is to be in place "until [HHS] requires that a new benchmark plan be selected shall be selected by the Commissioner." Id. Thus, it appears that a change to the benchmark plan for 2017-2022 would require either: (a) a revision to the statutory language in § 31-116, or (b) subsequent federal guidance.* *The Commissioner is delegated the authority to establish EHB regulations, which are currently set forth in Md. Code Regs. 31.11.06.01 et seq. Given the authority delegated to the*	*Under Section 31-116, the EHB selection process requires for there to be: (1) analysis of the State's enrollment; (2) an open and transparent process to select the EHB benchmark plan available to stakeholders; and (3) at least one public hearing, and the opportunity for public comment. The statute does not establish a formal public comment period.*	**Section 31-116 would likely need to be amended to make changes to the EHB benchmark, however the Commissioner may also have authority to make certain changes through regulation.*

[1] States are required to provide "reasonable public notice" and an "opportunity for public comment" on the State's selection of an EHB-benchmark Plan, which is to be available online. 45 C.F.R. § 156.111.

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					Commissioner, it is conceivable that changes to EHBs could be made through regulation, however we did not find any such regulations currently in place.		
NH	*Yes*	*The NH Joint Health Care Reform Oversight Committee.* See NH Rev Stat § 420-N:3.*	*The NH Joint Health Care Reform Oversight Committee's website has analysis for the 2012 selection process on its website. While we have not found similar analysis for subsequent years, the NH Insurance Department has had stakeholder meetings discussing the benchmark plan for subsequent years.*	*In NH, the EHB benchmark plan is selected by the NH Joint Health Care Reform Oversight Committee. N.H. Rev. Stat. Ann. § 420-G:4-d(I). Individual and small group market products are required to include coverage of EHBs in a plan substantially equivalent to the NH EHB benchmark plan in effect for the plan year 2019. N.H. Rev. Stat. Ann. § 420-G:4-d(I).* *The current State-required benefits reported to CMS are available, here.*	*NH's EHB statute provides that to the extent the federal government ceases to define EHBs, the Commissioner of Insurance shall define EHBs through public rulemaking. Because federal regulation defines EHBs based on State-specified EHB benchmark plans (45 C.F.R. § 156.100 et seq.), the requirement for the Commissioner to establish EHB definitions would appear to be operative. N.H. Rev. Stat. Ann. § 420-G:4-d. However, while not exhaustive, our research did not find corresponding EHB regulations promulgated by the Commissioner. Because the statute provides that EHBs are to be "substantially equivalent" (but not identical) to the benchmark plan, and given the authority delegated to the Commissioner, it appears that changes to EHBs could be made via regulation.* *Changes to the Benchmark Plan would require a decision by the NH Joint Health Care Reform Oversight Committee.*	*There were legislative hearings and related reports for the selection of the benchmark plan in 2012 through NH Joint Health Care Reform Oversight Committee. More recently, it appears to that the public was provided the opportunity to participate in discussions regarding the States EHB-Benchmark plan through the NH Insurance Department stakeholder working group. The last workgroup meeting we have found information for was in January 14, 2019. See AHP Working Group Meeting Notes (Jan 14, 2019).*	**The Health Care Reform Oversight Committee is a standing joint committee of the NH General Court. Per NH Rev Stat § 420-N:3, the Speaker of the House appoints the joint committee's three House members and the President of the Senate appoints its three Senate members.*
WA	*Yes*	*Insurance Commissioner**	*None found.*	*WA statute broadly defines EHBs as the same categories provided in Section 1302 of the ACA, plus "[o]ther services as supplemented by the [Insurance Commissioner]," and the benefits and services provided in the State's "benchmark reference" plan. Wash. Admin. Code § 284-43-5602; see also Wash. Admin. Code §§ 284-43-5702 (establishing the pediatric oral and vision benchmark plan).* *The current State-required benefits reported to CMS are available here.*	*State regulation provides that the Commissioner is responsible for selecting the benchmark plan in consultation with the Board of the Washington health benefit exchange (the "Board") and the Health Care Authority. Wash. Rev. Code Ann. § 48.43.715. The Commissioner is to select the "largest small group plan in the state by enrollment as the benchmark plan." Wash. Rev. Code Ann. § 48.43.715. If necessary, to supplement the benchmark plan's benefits in order to include "all of the ten essential health benefits categories," the Commissioner shall do so "by*	*In 2015, the Office of the Insurance Commissioner engaged stakeholders for feedback on the benchmark selection process. Stakeholders were invited to submit written comments and to participate in a town hall meeting. For subsequent years, we did not identify any established processes for the public to engage in the EHB selection process.*	**While regulation provides that the Insurance Commissioner is to select the benchmark plan, the plan and definition for EHBs are provided for in WA legislation. Thus, the legislation would appear to be*

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					rule" in consultation with the Board and the Health Care Authority. Id. *Because the benchmark plan and EHBs are also provided in statute, it appears that legislation would be required to make significant benchmark/EHB changes in the state. The Commissioner does not appear to have broad flexibility to supplement the benchmark plan.*		*needed to make changes.*
CO	Yes*	Division of Insurance (DOI)	Yes. *See* Colorado 2017 Benchmark Plan Selection Chart and FAQs: 2017 Benchmark Plan Selection. *See also* comments regarding the 2023 Benchmark Documents and Analysis.	C.R.S. 10-16-102(22) provides that EHBs have the same meaning as set forth in section 1302 of the ACA. *See also* C.R.S. 10-16-104 (mandatory coverage provisions). CO regulations also provide further guidance on the categories of EHBs. 3 CCR 702-4:4-2-42 (Section 5). The state-required benefits reported to CMS for 2017-2022 are found here. On May 7, 2021, DOI submitted all required materials to CMS to update the CO EHB benchmark plan for the 2023 plan year. The new plan includes enhanced coverage for gender-affirming care that meets individual needs and discourages the use of a "one-size-fits-all" framework for transgender persons seeking medical care, in addition to other benefits. *See* CMS approves Colorado's new EHB-benchmark plan Oct. 12, 2021. The 2023 EHB Benchmark Plan information is available here.	We did not find much authority related to CO's benchmark/EHB selection. However, it appears that the DOI has been tasked with selection of the EHB benchmark plan (see public process). Regarding changes to EHBs, the state appears to legislate around changes to any mandated benefits, including consideration of whether new mandated benefits are subject to defrayal. *See, e.g.*, DOI Letter to CMS re: Analysis of EHBs and Infertility Coverage (July 30, 2020); *see also* Proposed Additional Benefits Derived from Legislation (MH Wellness Exam Benefit and SUD Benefit). Further, in FAQs, DOI indicated that "Colorado is not able to design a new benefit to include in the benchmark, nor is it able to put additional restrictions, limits, or conditions on existing benefits." As such, at appears legislative approval may be required in certain instances. Notwithstanding, statute provides for the Commissioner of DOI to promulgate rules or revisions to certain benefits. *See, e.g.*, C.R.S. 10-16-148.	For the 2023 plan year, DOI invited stakeholders to advise in the evaluation of the EHB benchmark plan and any potential changes. Once all comments had been received, the DOI indicated that it would be discussed with the Governor's Office, and a plan would be selected.	*As noted, it appears that the legislature generally governs changes to EHBs, however, in certain instances, the DOI can make changes to EHBs.
NV	Likely, yes	Division of Insurance (DOI)	Yes. It appears that during the public comment period, DOI provides plan documents and	There is essentially no allusion to the benchmark plan and/or EHBs in NV State law or regulation. The DOI website alludes to the EHB benchmarking process, but does not cite to state authority.	As noted, we did not find much in the way of authority related to NV's EHB benchmark/EHB selection. However, it appears that the DOI has been tasked with selection of the benchmark plan (see public process).	Nevada appears to seek public input at public meetings held across the state before deciding on the benchmark plan. After the public comment period, DOI makes a recommendation to the Governor as	

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(1) LEGISLATIVE EHB BENCHMARK / EHB SELECTION PROCESS

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			other support materials such as comparison tools. *See* DOI, Essential Health Benefit Presentation.	For plan years 2017-2022, the benchmark plan is the HPN Solutions HMO Platinum 15/0/90% product. The current state required benefits reported to CMS are found here. Nevada also has a list of its mandated benefits for health benefit plans available here.	Regarding changes to EHBs, the state appears to legislate mandated benefits, but it is not entirely clear how they approach EHBs specifically. It seems likely that they would require a similar process. *See* Nevada Mandated Benefits.	to which EHBs should be required for the state. *See* Request for Public Input on 2017 Plan.	

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(2) REGULATORY/DELEGATED EHB BENCHMARK / EHB SELECTION PROCESS

State	Legislative Approval Required to change EHBS?	Which state office, agency or governmental body selects the EHB benchmark plan?	Is the benchmark plan analysis available to the public?	What are the current state-required benefits in the 2017-2022 EHB benchmark plan?	How are (can) changes to the benchmark plan and/or EHBs be made?	What is the state's public process?[2]	Other Notes
NY	*No*	*New York Superintendent of Financial Services, in consultation with the Commissioner of Health. N.Y. Comp. Codes R. & Regs. tit. 11, § 52.7. 1.*	*Yes. For 2017, see Milliman 2017 EHB Report and NY State of Health EHB Webinar.* *For 2012, see Milliman 2012 EHB Report.*	*EHBs are broadly defined under NY statute as the same categories of benefits listed in Section 1302 of the ACA. N.Y. Ins. Law §§ 3217-I; 4306-h. The statute also provides actuarial requirements for levels of coverage for exchange products and cost-sharing restrictions. Id., § 4306-h(b) and (c).* *More detailed definitions for minimum EHBs required to be in the NY Benchmark Plan are provided in State regulation. Comp. Codes R. & Regs. tit. 11, § 52.71. Thereunder, the Superintendent is given the authority to select the "New York Benchmark Plan", subject to certain guardrails. Id.* *The current State-required benefits reported to CMS are available here.*	*New regulations would be required to change the list of minimum State EHBs. See N.Y. Comp. Codes R. & Regs. tit. 11, § 52.71(b). However, the Superintendent appears to have broad authority to make changes to the benchmark plan. Not only does State regulation give the Superintendent the authority to select a benchmark plan from selected plans (e.g., the State's largest small-group plan), but the EHB Benchmark plan may include "[a]ny other set of benefits that the superintendent selects." N.Y. Comp. Codes R. & Regs. tit. 11, § 52.71(c).*	*While we have not found information related to a public process for the selection of the 2022 EHB benchmark plan in NY, for the 2017 EHB selection process, NY State of Health (NY's Exchange) held a webinar presentation, opened the floor to discussion, and took public comments. See NY Essential Health Benefits Decision for 2017 Webinar.*	
UT	*No*	*Insurance Commissioner*	*No, there does not appear to be analysis regarding the States benchmark plan/EHBs. However, there are various rate summaries and bulletins related to healthcare reform in Utah, available on the Utah Insurance Department website.*	*Utah statute grants the Commissioner the authority to determine the State's EHBs and promulgate related regulations, subject the following requirements: (1) EHBs cannot require the State to contribute to premium subsidies; and (2) the Commissioner may add benefits in addition to benefits included in the benchmark plan selected by the Commissioner. Utah Code Ann. § 31A-45-403. Under regulation, the commissioner designated the "the PEHP Utah Basic Plus plan as the Utah Essential Health Benefits Package for purposes of the PPACA in Utah." Utah Admin. Code r. R590-266-4.* *The current State-required benefits reported to CMS are available here.*	*The Commissioner is delegated authority to promulgate benchmark plan/EHB regulations, and appears to have the authority to make changes to the benchmark plan/EHBs. See Utah Code Ann. § 31A-45-403.*	*Utah's Administrative Procedures Act (Utah Admin Code r. R590-266 et seq.) requires a public hearing if required by State or federal law, or if requested by 10 interested persons/associations. Utah Code Ann. § 63G-3-302. Public hearings are required to be held before a rule becomes effective and "no less than seven days nor more than 30 days after receipt of the request for hearing." Here, federal law requires a public process. It's unclear whether the State will interpret this as requiring a public hearing.*	
VT	*No*	*Vermont Department of*	*A guidance document from*	*VT regulation provides that a qualified health plan must offer the EHBs required in Section 1302 of the*	*As noted, AHS's guidance document suggests that there is a formal review of the EHB*	*AHS's guidance provides that the State's 5-year EHB selection*	

[2] States are required to provide "reasonable public notice" and an "opportunity for public comment" on the State's selection of an EHB-benchmark Plan, which is to be available online. 45 C.F.R. § 156.111.

Select State EHB Benchmark and Selection Processes

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State	Legislative Approval Required to change EHBS?	Which state office, agency or governmental body selects the EHB benchmark plan?	Is the benchmark plan analysis available to the public?	What are the current state-required benefits in the 2017-2022 EHB benchmark plan?	How are (can) changes to the benchmark plan and/or EHBs be made?	What is the state's public process?[2]	Other Notes
		Health Access recommends plan. Green Mountain Care Board (independent health care regulatory commission) selects plan.	*VT's Agency of Human Services ("AHS"), titled "EHB Benchmark Plan Process" indicates that VT intends to engage in a periodic review of the benchmark plan, including a market study to analyze benefit gaps and project the impact of benefit changes. While not exhaustive, we did not find this or related reports.*	*ACA "and any additional benefits required by the Secretary of Human Services by rule after consultation with the Advisory Committee" after approval from the Green Mountain Care Board. Vt. Stat. Ann. tit. 33, § 1806. The current benchmark plan is Blue Cross Blue Shield CDPH-HMO.* *The current State-required benefits reported to CMS are available here.*	*benchmark plan. The guidance also provides a five-year process for selecting a new benchmark plan, inclusive of analysis and stakeholder engagement. It is unclear whether the State would contemplate changes to the benchmark plan/EHBs prior to the State's selection of a 2022 Benchmark plan.*	*process includes public engagement. AHS will conduct stakeholder meetings in the second year of a five-year process to identify and implement a new benchmark plan, and the Green Mountain Care Board will carry out a public comment period in March of the third year of the five-year process.*	
DE	*No*	*DE Health Care Commission (DHCC) and the Delaware Department of Health and Social Services (DHSS).*	*Yes. See, e.g., 2012 Benchmark Comparison; ChooseHealth Delaware, Defining Delaware's EHBs for Plan Year 2017.*	*For individual, group and blanket health plans, DE statute defines EHBs by reference to Section 1302 of the ACA. Del. Ins. Code §§ 3610, 3571M. State statute further provides that the Insurance Commissioner shall issue regulations setting forth what constitutes "essential health benefits." Id. However, the only regulation regarding EHBs that we found relates specifically to fully insured multiple employer welfare arrangements and association health plans. This regulation ties EHBs to the federal definition. 18 Del. Admin. Code 1405-8.0.* *For plan years 2017-2022, the benchmark plan is the Small Group Shared Cost EPI $2000/100 Plan by Highmark BCBSD Inc.* *The current State-required benefits reported to CMS are available here.*	*In 2012, the DHCC and DHSS selected the benchmark plan after public comment. See, e.g., Public Meeting Reminder, July 2012. For EHBs, it appears that the Insurance Commissioner has the power to issue regulations setting forth EHBs, but has not done so to date. Ostensibly, the Commissioner could make changes to EHBs in the future without legislative changes.*	*Originally, in 2012, DHSS and DHCC prepared detailed materials for the public to review, as well as a process for submitting feedback to the State concerning DE's essential health benefits. They also held a public forum, inviting the public to attend and submit comments. See https://dhss.delaware.gov/dhcc/healthbenefitspr.html.* *Similarly, for the 2017 plan year, DHCC and DHSS also conducted a public comment period on selection of the benchmark plan.*	

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(2) REGULATORY/DELEGATED EHB BENCHMARK / EHB SELECTION PROCESS

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ME	*No**	*Bureau of Insurance*	*We did not find analysis for the 2012 and 2017 benchmark selection.* *Maine does have analysis related to the 2022 EHB benchmark selection process that is available to the public.*	*State statute defines EHBs as the "essential health benefits that are substantially similar to that of the essential health benefits required in this State for a health plan subject to the federal Affordable Care Act as of January 1, 2019." Me. Rev. Stat. tit. 24-A, § 4320-D. There's essentially no other (past) allusion to the benchmark plan and/or EHBs.* *In 2012 and 2017, Maine did not select an EHB benchmark plan through state statute or regulation. Because Maine did not selected an EHB benchmark plan, the benchmark plan in Maine is the Federal default Plan from largest small group product in the state. For plan years 2017-2022, this is the Blue Choice, $30,00, $2,500 Deductible plan.* *The current state-required benefits reported to CMS are found here.* *As discussed in the next column, Maine will be selecting an EHB benchmark plan in 2022.*	*ME's former Governor, Paul LePage (R), was generally unsupportive of the ACA. Since current Governor Janet Mills (D) was elected in 2019, the State has adopted health care reforms. Notably, the "Made for Maine Health Coverage Act", enacted in 2020, gives the superintendent of the Bureau of Insurance (the "Superintendent") broad powers "necessary to carry out the purposes" of the new State market. Me. Rev. Stat. tit. 22, § 5404. For 2022, the Superintendent is to choose a "clear choice design" of essential health benefits for individual and small group plans. Me. Rev. Stat. tit. 24-A, § 2792(1).* *Thus, moving forward, the Superintendent appears to have the authority to make changes to the State's benchmark plan/EHBs.*	*The Superintendent may develop such clear choice plans in consultation with working groups consisting of consumers, carriers, health policy experts and other interested persons. Me. Rev. Stat. tit. 24-A, § 2793. Yearly, the Superintendent will consider annual changes based on factors such as inflation, actuary value, and annual maximum out-of-pocket limits. Id.*	**In the past, ME has not selected an EHB benchmark plan. However, in 2020, the Made for Maine Health Coverage Act established that the Bureau of Insurance is to select the State's "clear choice design," which includes EHBs.*
OR	No	Oregon Department of Consumer and Business Services (DCBS)	There are numerous publicly available benchmark plan documents and analysis available here.	For plan years beginning on and after January 1, 2017, OR regulations prescribe that the EHB benchmark plan is "the PacificSource Health Plans Preferred CoDeduct Value 3000 35 70 small group health benefit plan, including prescription drug benefits," subject to certain exclusions and modifications (including the addition of pediatric dental and vision benefits) *See* Or. Admin. R. 836-053-0012(3) and (7). The 2017-2021 state-required benefits reported to CMS are found, here. For plan years beginning on or after January 1, 2022, EHBs are to include additional benefits for spinal manipulation, acupuncture; and coverage for opioid use disorder. *Id.* at §.836-053-0017. Further information regarding CMS' approval of the 2022	The DCBS is delegated with authority to promulgate regulations to establish the EHB benchmark plan. Or. Rev. Stat. Ann. § 743B.130(2). Pursuant to that authority, the DCBS has promulgated EHB regulations for each relevant plan year. For example, for 2022, DCBS promulgated regulations adding certain benefits beginning on and after the 2022 plan year. Or. Admin. R. 836-053-0017. Thus, it appears that the DCBS has the authority to select the states EHB Benchmark plan and to make changes to EHBs.	The DCBS promulgates EHB benchmark requirements through regulations subject to notice and comment. *E.g.*, Public Comment for 2016 is available, here. For the 2022 plan year, the DCBS convened the EHB Rulemaking Advisory Committee to, among other things review and consider the states 2022 plan options. The Committee's meetings were public and open to public comment. While the public comment period closed (May 6, 2020), changes in the future will be available through the DCBS.	

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				EHB Benchmark benefits for Oregon is available here. The 2022-2023 EHB Benchmark Plan Information is available, here.			
NM	No	NM's Office of Superintendent of Insurance	Yes. See 2012 Essential Health Benefits Work Group Report, here. Other publicly available information available, here.	The Superintendent is granted authority to define EHBs under state law subject to certain guardrails, including ensuring EHBs take into account health care needs of segments of the population. N.M. Stat. Ann. § 59A-18-16.2 Neither state statute nor regulation appears to otherwise define or set forth the selection process for the EHB benchmark. The 2017-2021 state required benefits are reported to CMS, here. For plan years beginning on or after January 1, 2022, EHBs are to include opioid use disorder treatment, obesity treatment, prosthetics and anti-Hepatitis C treatment. Further information regarding CMS' approval of the 2022 EHB Benchmark benefits for Oregon is available here. The 2022-2023 EHB Benchmark Plan Information is available, here.	As noted, the Superintendent is granted authority to define EHBs under state law. N.M. Stat. Ann. § 59A-18-16.2 . Further, the Superintendent is to "periodically update the essential health benefits … to address any gaps in access to coverage or changes in the evidence base identified by the superintendent." N.M. Stat. Ann. § 59A-18-16.2(C)(6). Thus, it appears that the Superintendent has authority to make changes to NM's EHBs without express legislative approval.	NM published a public comment period in the Superintendent accepted public input on their proposed EHB-benchmark plan changes. Now that the state has selected its EHB benchmark for 2022, it is unclear when the state will take notice and comment, next. There is no formal process for soliciting public comment.	
IL	No	Illinois Department of Insurance (IDOI)	We did not find EHB benchmark plan analysis.	EHBs are defined under IL regulation as the benefits set forth in Section 1302(a) of the ACA. Ill. Admin. Code tit. 50, § 2001.1(c)(1). The regulation also expressly provides for the EHB benchmark plan for plan years 2017-19 and 2020 onwards (the "Access to Care and Treatment Plan", published by CMS). *Id.*, at 2001.1(c)(2). For plan years 2020 onwards, IL become the first state to change its EHBs pursuant to the flexibility provided in the 2018 EHB Final Rule. CMS approved changes to the Illinois EHB-benchmark plan (ZIP) to include measures to reduce opioid	Because the EHB Benchmark plan is codified in Illinois regulations, under the jurisdiction of the IDOI, it appears that the IDOI has the authority to change EHBs (legislation not specifically required) within the state.	IL does not appear to have a public process for EHB/Benchmark selection in state statute or regulation. According to a Press Release regarding the approval if its 2020 EHB changes, it appears that IDOI held two public comment periods and solicited feedback from other stakeholders. Our research suggest that IDOI announces its proposal email and on its website. However, stakeholders were only given a limited period to evaluate	*In April 2018, CMS announced that states had until July 2, 2018 to submit changes for plan year 2020. IDOI submitted a request for certain changes to address mental health and substance use disorder. IDOI reports that these changes were made

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				addiction and expand access to mental health services in Illinois.*		and comment on the proposed changes.	in consultation with expert recommendations, and feedback from public comment periods.
AR	No	Arkansas Insurance Commissioner (Commissioner)	Yes, in 2012, the state published an EHB Issue Brief, analyzing the state's selection of its EHB Benchmark plan, available here. AR has a number of other related publications, available on the Arkansas Bureau of Legislative Research website.	AK regulations broadly define EHBs as those required under Section 1302(b) of the ACA. *See* Code Ark. R. 054.00.103-3. The regulation also provides that the Commissioner has the authority to select the AK EHB Benchmark plan. For the FY 2017-2021 plan, the Commissioner selected the Small Group Gold 1000-1 product. The current state required benefits reported to CMS are found here.	According to the Bureau of Legislative Research, AK established the Plan Management Advisory Committee in 2012 to advise regarding the EHB selection process in the state. The Committee recommended a plan, however the State's Exchange Steering Committee selected a different plan for 2012. Ultimately, it appears that the Commissioner selects the EHB benchmark pursuant to authority in Code Ark. R. 054.00.103-1 et seq., which defines the criteria and standards serving as the basis for the selection of the State's EHB benchmark. *See* Code Ark. R. 054.00.103-3. The regulations also provide certain factors the Commissioner is to consider in selecting an EHB Benchmark. Code Ark. R. 054.00.103-4. Thus, changes to the EHB Benchmark and EHBs can be made by the Commissioner.	The Commissioner is required to consider the following in selecting an EHB benchmark plan: advisory committee, public and healthcare industry comments and recommendations and actuarial studies for EHB benchmark plan options. Code Ark. R. 054.00.103-4	
MS	No	Mississippi Insurance Department (MID)*	The Mississippi Health Insurance Exchange Advisory Board published 2012 Analysis re the State's EHB selection process, available here.	It appears that the state selected a plan from largest small group product (the Network Blue insurance product with supplemental coverage for pediatric dental and vision, and habilitation services). However, EHBs and/or the EHB benchmark plan are not defined in statue law. The current state required benefits reported to CMS are found here.	As noted, in 2012, the Mississippi Health Insurance Exchange Advisory Board conducted an analysis and made recommendations to the MID regarding the state's EHB benchmark selection. While there do not appear to be either statues or regulations in the state governing the EHB benchmark selection process, this suggests that the MID, which governs health insurance products in the states, both has the authority and made a determination regarding the selection process.	There is no defined public process in MS.	*It appears that, at least in 2012, the MID chose the state's EHB health plan. However, there are not statutes or regulations in that state which appear to govern the EHB benchmark selection process.

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CT	*Maybe**	*The Board of Directors, Connecticut's Health Insurance Exchange ("Access Health CT")*	*Yes, the Health Plan Benefits and Qualification Committee's original recommendations to the CT Health Insurance Exchange Board of Directors are available, as well as detailed materials regarding the 2017 Benchmark plan analysis. Further, meetings and meeting materials of the Committee are public.*	*In CT, individual and small employer group market products are required to include coverage of EHBs. EHBs are broadly defined under CT law as the same categories listed under Section 1302 of the ACA. See C.G.S.A. §§ 38a-518q, 38a-492q.* *The current State-required benefits reported to CMS are available here.*	*The relevant statutes do not provide detail with respect to the selection of the State's benchmark plan and/or the selection of EHBs. While not necessarily exhaustive, we found no such authority elsewhere in State statute or regulation.* *The Insurance Commissioner is permitted to adopt regulations specifying the health care services and benefits that fall within each EHB category under state law. G.S.A. §§ 38a-518q(d), 38a-492q(d). Thus, the Commissioner may have some ability to change services and benefits within an EHB category, as defined under state law. However, it does not appear that the Commissioner has authority to make changes to the EHB categories, absent additional legislative authority.* *Changes to the benchmark plan appear to be made through specific access health CT committees that make recommendations to its Board of Directors regarding the benchmark plan.*	*The Health Plan Benefits and Qualifications Advisory Committee (the Committee) is composed of 15 members, chosen to represent a broad array of stakeholders. Members have affiliations with the health insurance industry, health care providers, consumer advocates, academia, and employers.* *The Committee originally conferred with various state and federal agencies, and stakeholders, before making its EHB recommendations to the State's exchange.* *The Committee meets regularly and the meetings are open to the public (See PPT regarding 2017 CT EHB Benchmark Plan selection). In addition, the Advisory Committee on Consumer Experience and Outreach also provides recommendations on benchmark plans and has public meetings. It appears that advocacy efforts could start with these particular committees.*	**While it appears that the Insurance Commissioner has authority to adopt regulations specifying services and benefits within an EHB category, and Access Health CT has the ability to select the benchmark plan, there may also need to be legislative activity to amend EHB benefits categories set forth in state statute.*
KY	*Probably Not*	*Department of Insurance**	*None found. KY statute requires the Department of Insurance to submit financial impact statements regarding*	*We have not found any allusion to the benchmark plan and/or EHBs in State law or regulation. The KY Department of Insurance's website alludes to the EHB benchmarking process, but does not cite to state authority. Notwithstanding, it appears that the*	*There is a dearth of authority either in State statute or regulation governing the State's benchmark plan/ EHBs. Notwithstanding, several sources state that the Kentucky Department of Insurance ultimately decided the State's EHB-Benchmark plan. See, e.g., Capital Projects & Bond Oversight Committee Meeting*	*We did not find any authority governing a public process for Kentucky's EHB Benchmark plan selection process. As stated, the selection process appears to be governed by the Kentucky Department of Insurance. Contact*	**While there is a dearth of authority in Kentucky governing EHB and/or benchmark plan selection, it appears that the*

[3] States are required to provide "reasonable public notice" and an "opportunity for public comment" on the State's selection of an EHB-benchmark Plan, which is to be available online. 45 C.F.R. § 156.111.

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			"mandated health benefits," (including EHBs) to the State's General Assembly. Ky. Rev. Stat. Ann. § 6.948. However, the reports remain confidential until expressly authorized for public distribution. We did not find any related publications upon our (non-exhaustive) review.	*Department selected the State's benchmark plan (a UnitedHealthcare product).* *The current State-required benefits reported to CMS are available here.*	*(July 17, 2012). Absent express statutory or regulation governing the selection process, it seems likely that the Department of Insurance would have the authority to make changes to the EHB Benchmark plan, absent legislation.*	*information for the Department is available here.*	*State's Department of Insurance has the authority to make said determinations, absent any legislative changes.*
ND	*No.*	*It does not appear that any governmental agency in ND is tasked with selecting the EHB benchmark plan, however, the N.D. Insurance Department may, arguably, have such authority.*	*In 2020, the ND Insurance Department conducted a study for the legislature addressing a range of health insurance issues, with a brief discussion of the EHB benchmark plan. The study can be found on the Insurance Department's website.*	*ND has not selected an EHB benchmark plan through State statute or regulation. We have found no allusion to the benchmark plan and/or EHBs in State law or regulation. As such, the benchmark plan in North Dakota is the Federal default plan from largest small group product in the State. For plan years 2017-2022, that is the Blue Cross Blue Shield of North Dakota small group Exchange plan, BlueCare Gold 90 500.* *The current State-required benefits reported to CMS are available here.*	*Since the State has not selected an EHB benchmark plan, or further established any criteria regarding EHBs, ostensibly State statute, regulation, or even determinations by the N.D. Insurance Department, which broadly regulates insurance products in the State, could make changes to the benchmark plan and/or EHBs in the State.*	*There is no defined public process in North Dakota.*	
VA	*Maybe**	*It does not appear that any governmental agency in VA is tasked with selecting the*	*Yes, the State's "Preliminary Analysis of EHBs, Benefit Mandates, and Benchmark Plans" is available*	*EHBs are broadly defined under VA statute as the same categories listed under Section 1302 of the ACA, plus pediatric dental coverage. See Va. Code Ann. § 38.2-6500; id., § 38.2-3451(B) (pediatric dental).*	*In VA, individual and small group health products are required to include EHBs pursuant to Va. Code Ann. § 38.2-3451. EHBs are defined broadly in Va. Code Ann. § 38.2-6500. Neither statute provides detail with respect to the selection of the State's benchmark plan*	*The VA Health Insurance Reform Commission is required to complete an assessment of EHB coverage. Va. Code Ann. §30-339 et seq. Further, a joint assessment by the Bureau of Insurance and the Joint*	**As noted, while the VA Health Insurance Reform Commission monitors the state's ACA*

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		EHB benchmark plan, however, *the VA Health Insurance Reform Commission, reports on EHBs to the legislature. See H.B. 2138 (2013); Va. Code Ann. § 30-342.*	*here. Further, the Health Insurance Reform Commission is required to submit EHB reports to the legislature. See Va. Code Ann. § 30-342.4.*	*The current State-required benefits reported to CMS are available here.*	*and/or the selection of EHBs. While not necessarily exhaustive, we found no such authority elsewhere in VA statute. While the VA Health Insurance Reform Commission is tasked with monitoring ACA implementation, and making recommendations to the legislature regarding EHBs, it does not appear to have authority to actually make changes absent legislative approval. It follows that legislative approval may be necessary to make changes to the State's EHBs/Benchmark plan, although our research is not conclusive.*	*Legislative Audit and Review Commission, is required to address the social and financial impact of the EHB benchmark, and proposed mandates and changes to VA's EHBs. See Va. Code Ann. § 30-343. We did not find additional information regarding a public process.*	*implementation and submits reports to the legislature, it appears that legislative approval may be necessary to change the VA EHB benchmark plan.*
HI	*Maybe**	*Unclear. While it does not appear that any agency in HI has been tasked with selecting the EHB benchmark plan, it appears that related reports are to be provided to the State legislator for review and consideration prior to any legislative measures being adopted.*	*Yes. See Oliver Wyman, 2012 EHB Selection Analysis. Further, the State Auditor is to prepare a report and submit to the legislature a report assessing social and financial impacts of any proposed mandates impacting health insurance.*	*We have found no allusion to the benchmark plan and/or EHB selection in State law or regulation.* *Notwithstanding, according to CMS, HI's current benchmark plan is the Hawai'i Medical Service Association's Preferred Provider Plan 2010, with supplemental coverage for pediatric oral and pediatric vision.* *The current State-required benefits reported to CMS are available here.*	*As noted, we did not find much in the way of authority related to HI's benchmark/EHB selection. State law provides that before any legislative measure can be considered mandating health insurance in the individual and group health insurance market, there shall be concurrent resolutions passed requesting the State auditor to prepare and submit to the legislature a report assessing social and financial impacts of the proposed mandate. Haw. Rec. Stat. Ann § 23-51, see also id., § 23-52 (establishing assessment report requirements).* *While not exhaustive, we found the House Committee on Health and Consumer Protection & Commerce resolution to include infertility coverage, but not other resolutions related to the State's Benchmark Plan/EHBs.*	*In 2017, the HI legislature adopted House Bill No. 552,[4] which established the state's Affordable Health Insurance Working Group ("Working Group") to address the complexities of the health care system in Hawaii and the related uncertainty over the future of the ACA. Among its obligations, the Working Group is tasked with considering and making recommendations on EHBs.* *In 2018, the Working Group published its report (2018 Report of the Working Group). HB No. 552 did not contemplate any further meetings of the Working Group following this report.*	**While we did not find State statute or regulation formally establishing HI's benchmark plan/EHBs, it appears the legislative approval may be required to make changes to the State's benefits. For example, the legislature's Working Group is tasked with making EHB recommendations, the State Auditor submits reports to the legislature*

[4] The originally introduced version of HB No. 552 was much more robust and was designed to preserve some of the ACA provisions in case of repeal, including the individual mandate and minimum EHBs.

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					As discussed further under the State's public process, the HI legislature established the State's Affordable Health Insurance Working Group (the "Working Group"), which, among other functions, is tasked with consider making EHB recommendations. However, it is unclear whether the working group is still active. See the Working Group's Website. *Absent apparent authority, ostensibly, the states benchmark plan and/or EHBs could be changed through legislation, regulation, or through sub-regulatory action.*	*Our review did not find additional information related to a public process in the State.*	*regarding the EHB benchmark.*
IN	*No**	*It does not appear that any governmental agency in Indiana is tasked with selecting the EHB benchmark plan, however, the Indiana Department of Insurance may have such authority.*	*No. Reference to the benchmark plan summary is found on the Indiana Insurance Department website, but without further detail.*	*EHBs are defined in regulations related to the state's Healthy Indiana Plans as those EHBs required for alternative benefit plans in 42 C.F.R. § 440.347. 405 Ind. Admin. Code §§ 10-7-2, 10-7-3.* *There's essentially no other allusion to the benchmark plan and/or EHBs in either State statute or regulation.* *Indiana has not selected an EHB benchmark plan through state statute or regulation. As such, the benchmark plan in Indiana is the Federal default Plan from largest small group product in the state. For plan years 2017-2022, this is the Blue 6.0 Blue Access PPO Option 14, Rx G from Anthem.* *The current state required benefits reported to CMS are found here.*	*Since the state has not selected an EHB benchmark plan, or further established any criteria regarding EHBs, ostensibly state statute, regulation, or determinations by the Department of Insurance Commissioner. The Insurance Commissioner has provided guidance regarding the selection of EHBs in the past. See Department of Insurance, Bulletin 198 (May 2, 2013).*	*There is no defined public process in Indiana.*	**It appears that Indiana did not select a benchmark plan/EHBs. Ostensibly, legislation could change the state's EHBs, however this does not appear to be necessarily required given the authority delegated to the Indiana Department of Insurance (which regulates health insurance products in the state).*
IA	*No**	*It does not appear that any governmental agency in Iowa is tasked with selecting the EHB*	*No.*	*State statute defines EHBs as the benefits "defined" in section 1302 of the ACA (notwithstanding that § 1302 does not actually define EHBs). Iowa Code Ann. § 249N.2. There is essentially no other allusion to the benchmark plan and/or EHBs.*	*Since the state has not selected an EHB benchmark plan, or further established any criteria regarding EHBs, ostensibly state statute, regulation, or even determinations by the Iowa Insurance Division, which broadly regulates insurance products in the state, could make changes to the benchmark plan and/or*	*There is no defined public process in Iowa.*	**It appears that Iowa did not select a benchmark plan/EHBs. Ostensibly, legislation could change the state's*

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		benchmark plan, however, the Iowa Insurance Division may, arguably, have such authority.		*Iowa has not selected an EHB benchmark plan through state statute or regulation. As such, the benchmark plan in Iowa is the Federal default Plan from largest small group product in the state. For plan years 2017-2022, this is the Wellmark Complete Blue 2000 plan.* *The current State-required benefits reported to CMS are available here.*	*EHBs in the state. It is unlikely such measures would be taken between the 2017-2022 plan year.*		*EHBs, however this does not appear to be necessarily required given the authority delegated to the Iowa Insurance Division (which regulates health insurance products in the state).*
AK	No	Unclear*	We did not find EHB benchmark plan analysis.	We did not find allusion to the EHB benchmark or EHBs in AK state law or regulation. The state does not appear to choose a benchmark plan, suggesting that the state relies upon the Federal Default (the Plan from largest small group product, which is the "Alaska Heritage Select Envoy" product, plus rehabilitative, habilitative and pediatric dental). The only substantive guidance we found related to the EHB selection in AK is annual "Alaska ACA Form and Rate Guidance" published annually by the Alaska Division of Insurance. The 2022 Guidance is available, here. The 2017-2021 state required benefits are reported to CMS, here.	As noted, the only guidance we found related to AK's benchmark plan and/or EHBs is set forth in the annual Rate Guidance. The Guidance appears to be published by the Alaska Division of Insurance (ADI), which among other things, regulates health insurance products in Alaska. Ostensibly, the ADI could make changes to the benchmark plan and/or EHBs in the state.	There is no defined public process in Alaska. There was a ballot initiative titled the "Quality Health Insurance for Alaskans Act of 2018" (here), which would have put into state law various provisions of the ACA, including laws related to EHBs. However, the ballot initiative did not pass.	*As noted, it appears that AK did not choose an EHB benchmark plan. Ostensibly, the ADI has the authority to select the EHB benchmark and/or EHBs in the state. However, it is not clear.
FL	No	Office of Insurance Regulation (OIR)	Yes. *See* 2019 Analysis by Florida's Insurance Commissioner available, here.	"EHB-benchmark plan" is ascribed the same meaning as provided in 45 C.F.R. § 156.20. Effective June 25, 2019, health insurers and HMOs issuing or delivering individual or group health insurance policies are required to create health policies/contracts that must include at least one service or coverage under each of the 10 EHBs required under Section 1302(b) of the ACA. Ch. 627, § 627.443(2)(a), Fla. Statutes.	Beyond the aforementioned EHB-benchmark plan definition in state law, there is uncodified guidance in 2019 requiring OIR to submit a study to the Governor re EHBs. *See* Ch. 2019-129, § 10 Florida Statutes. This suggests OIR and/or the Governor's office may have the authority to make changes to EHBs win FL. However, there is no authority related to the EHB selection process in the state.	Florida OIR conducted a study to evaluate Florida's EHB benchmark plan and submit a report to the Governor in 2019. See Ch. 2019-129, § 10 Florida Statutes. OIR solicited comments and substitute benchmark plans from stakeholder. Regulation provides that plans may submit to the OIR for consideration as part of the OIR's study of FL's	

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				Florida does not appear to choose a benchmark plan, suggesting that the state relies upon the Federal Default (the Plan from largest small group product, which is the Blue Cross Blue Shield of Florida, Inc. BlueOptions PPO product). The current state required benefits reported to CMS are found, here.		EHB benchmark plan, and may also be submitted to the OIR for evaluation as equivalent to the current state EHB-benchmark plan or to any EHB-benchmark plan created in the future. *Id.* at § 627.433(3)-(4). There is no other public process.	
MA	Unclear*	The Governor has designated the Division of Insurance (DOI) to select the benchmark plan. *See* 956 CMR 8.02 (noting that the benchmark plan is chosen by the state through the DOI).	Yes, for example, DOI has published charts noting the various benchmark plan options in past years. *See also* DOI, Health Insurance Info Session Notice.	State regulation defines EHBs as the health benefits listed in Section 1302(b) of the ACA, and health benefits defined as essential in regulations promulgated pursuant thereto. 956 CMR 5.02. Regulation simply defines the EHB benchmark plan as the health benefit plan required Section 1302(b) and chosen by the DOI Commissioner, pursuant to 45 CFR § 156.100. 956 CMR 8.02. For plan years 2017-2022, the EHB benchmark plan chosen by DOI is the HMO Blue New England $2000 Deductible product. The current state required benefits reported to CMS are found here. The DOI has also published some information regarding the HMO Blue New England Plan and state mandated benefits here.	MA has a Center for Health Information that is tasked with examining proposed new mandates or changes in existing mandates to determine the health and economic effect of such laws. MGLA 3 § 38C (noting that mandated health benefit proposals moving through legislature require review and evaluation by center for health information). Ostensibly, DOI could adopt recommended changes presented by the Center. While the DOI is delegated authority to choose the MA EHB Benchmark, the legislature examines proposed EHB mandates and changes. (MGLA 3, § 38C). It is unclear whether legislative approval is required to adopt the DOI's determinations.	It appears that the state had stakeholder meetings in 2012 around the initial choice of a benchmark plan, however, there was not a lot of specific information. Documentation around the 2014 plan year indicated that DOI "coordinated an analysis of the 10 possible plan options," and then made a recommendation of which plan to select.	* As noted, while the DOI is delegated authority to select the state EHB benchmark, EHB decisions are examined by the legislature and it is unclear whether formal legislative approval is required.
MN	No	Unclear, however it could be the Minnesota Department of Health or the Minnesota Commerce Department (which regulates health insurance).	Yes, see 2014 EHB study, here. While not specific to EHBs, MN also has an HMO Certificate of Coverage Reviewer Checklist of Required Medical Benefits under state and federal law, here.	EHBs are defined as the 10 benefits set forth in 1302(b) of the ACA, as well as the benefits included in the MN state selected EHB-benchmark plan. Minn. Stat. Ann. § 62Q.81(4). While MN has law governing minimum benefits for qualified plans (*Id.* at § 62E.06) and prohibitions re lifetime and annual limits for EHBs (*Id.* at § 62Q.677), the state does not appear to choose a EHB benchmark plan. This suggests that MN relies upon the Federal Default (the Plan from largest small	Since it appears that MN has not selected an EHB benchmark plan, or further established any criteria regarding EHB selection, ostensibly changes to the state's EHBs could be made through changes to state statute or regulation. While not presently contemplated under MN law, the Minnesota Health Department, which broadly regulates insurance products in the state, could also potentially make changes to the benchmark plan and/or EHBs in the state.	There is no defined public process in Minnesota.	

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Select State EHB Benchmark and Selection Processes
(3) UNCLEAR EHB BENCHMARK / EHB SELECTION PROCESS

State	Legislative Approval Required to change EHBS?	Which state office, agency or governmental body selects the EHB benchmark plan?	Is the benchmark plan analysis available to the public?	What are the current state-required benefits in the 2017-2022 EHB benchmark plan?	How are (can) changes to the benchmark plan and/or EHBs be made?	What is the state's public process?[3]	Other Notes
				group product, which is the HealthPartners HLPT-129123512 product). The current state-required benefits reported to CMS are found (here).			
PA	Probably not	Pennsylvania Insurance Department (PID). *See* 2017 EHB Benchmark Plan Recommendations.	Yes, *see* EHB Benchmark Comparison 2017.	There's essentially no allusion to the EHB benchmark plan and/or EHBs under PA state law or regulation. (We found proposed legislation which would define EHBs as the 10 ACA categories of EHBs). The state did not select an EHB benchmark plan in 2013, which means that the state was assigned the Federal default plan. Although not definitive, it appears in 2017 that the PID selected the Gold Premier HMO product. *See* 2017 EHB Benchmark Plan Recommendation. The current state-required benefits reported to CMS are found here.	Since it appears that PA has not selected an EHB benchmark plan, or further established any criteria regarding EHB selection, ostensibly changes to the state's EHBs could be made through changes to state statute or regulation. While not expressly contemplated under PA law, the PID, which broadly regulates insurance products in the state, has submitted EHB Plan recommendations. This suggests that the PID could also potentially make changes to the benchmark plan and/or EHBs in the state.	The state Insurance Department collects written comments on the selection of a new benchmark plan, and after review and analysis recommends a particular plan. *See, e.g.*, 2017 EHB Benchmark Plan Recommendation.	
WY	No	Unclear	We did not find EHB benchmark plan analysis.	We did not find allusion to the EHB benchmark or EHBs in WY state law or regulation. The state does not appear to choose a benchmark plan, suggesting it is the Federal Default Plan from largest small group product (the "BlueSelect PPO" product). The current state required benefits reported to CMS are found here.	Since WY has not selected an EHB benchmark plan, or further established any criteria regarding EHBs, ostensibly state statute, regulation, or even determinations by the Wyoming Department of Insurance, which regulates insurance products in the state, could make changes to the benchmark plan and/or EHBs in the state.	There is no defined public process in Wyoming.	
WV	Unclear, but likely*	Unclear, but likely the Office of the Insurance Commissioner (OIC).	We did not find EHB benchmark plan analysis.	There is essentially no allusion to the EHB benchmark plan and/or EHBs in WV State law or regulation. It also appears that WV did not select a benchmark plan for plan years 2017-2022. *See* WV Info Letter No. 186A. As such, the EHB benchmark plan in WV appears to be the Federal default plan from largest small group product in the State (the Gold Shared Cost PPO $1000 product).	Since the state has not selected an EHB benchmark plan, or further established any criteria regarding EHBs, ostensibly state statute, regulation, or even determinations by the OIC, which broadly regulates insurance products in the state, could make changes to the benchmark plan and/or EHBs in the state.	WV does not seem to have any public process for selection of either the benchmark plan or EHBs.	*In general guidance, the OIC noted the potential for "backfills," "which pertain to benefits not currently found in the West Virginia benchmark plan

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Select State EHB Benchmark and Selection Processes

(3) UNCLEAR EHB BENCHMARK / EHB SELECTION PROCESS

State	Legislative Approval Required to change EHBS?	Which state office, agency or governmental body selects the EHB benchmark plan?	Is the benchmark plan analysis available to the public?	What are the current state-required benefits in the 2017-2022 EHB benchmark plan?	How are (can) changes to the benchmark plan and/or EHBs be made?	What is the state's public process?[3]	Other Notes
				The current state required benefits reported to CMS are found here.			but become required due to enactments of the West Virginia Legislature." WV Info Letter No. 186A.