EHB Benchmark Updating: The Benefits Outweigh the Burden

Wayne Turner, Senior Attorney
NAIC Spring 2023, Health Innovations
Roadmap

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

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

- EHBs = Set of benefits that non-grandfathered individual and small group insurance plans and Medicaid Alternative Benefit Plans must cover.
  - Most other plans (e.g., large employer) cannot impose annual or lifetime caps on EHB.

- At a minimum, they must include:
  - Ambulatory patient services;
  - Emergency services;
  - Hospitalization;
  - Maternity and newborn care;
  - Mental health and substance use disorder services;
  - Prescription drugs;
  - Rehabilitative and habilitative services and devices;
  - Laboratory services;
  - Preventive and wellness services (incl. family planning) and chronic disease management;
  - Pediatric services, including oral and vision care.
Essential Health Benefits (EHB)

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

• The ACA requires HHS to “periodically” review and update EHB categories (42 U.S.C. § 18022(b)(4)(H))
  • difficulty in accessing services
  • identify coverage gaps
  • account for new medical/scientific developments

• Drug classification system, plan documents, barriers to accessing services, typical employer plans

• HHS RFI on EHB: “a lack of consumer complaints about exclusions or claims denials.” 87 Fed. Reg. 74098
EHB compliance and enforcement

• Health insurers/PBMs declare certain, high-cost drugs as “non-EHB,” and not subject to ACA cost sharing protections
  • aka “EHB loophole” and “alternative payment model”
  • HHS’ unequivocal affirmation that “plans could exceed the minimum number of drugs required to be covered and that additional drugs would still be considered EHB.” 87 Fed. Reg. 74100
• Clarification: “a non-discriminatory benefit design that provides EHB is one that is clinically-based.” 45 CFR §156.125(a)
Problems with EHB benchmarking

• Leads to vast inconsistencies and coverage gaps
• ACA consumer protections should not be based on commercial health plans
• Most states use small group plan as EHB benchmark
  • Least generous of the benchmark options
  • Embeds discriminatory benefit design
  • Perpetuates disparities
• Out2Enroll – 41 EHB benchmark plans exclude gender affirming care
• See also NHeLP letter to HHS Sec. Becerra – Re: Advancing Health Equity Through Essential Health Benefits
About Defrayal

- CCIIO clarified that states seeking new benefits/mandates through benchmarking will not be subject to defrayal
  - However, switching from state mandate to benchmarking mandate is not permitted (state will have to defray in that case)
- Benefit mandates not subject to defrayal when enacted to comply with federal requirements – see 45 CFR §155.170(a)(2)
  - e.g., Nondiscrimination requirements, Mental Health Parity and Addiction Equity Act
    - See Virginia Bulletin and Washington Memo
    - These mandates are also likely exempt from the generosity limit
- Changes in cost-sharing NOT subject to defrayal
Key considerations for EHB benchmarking

- States have considerable EHB flexibility under federal rules
- Many states have no formal process for EHB benchmark selection
- Forty-two states plus the District of Columbia currently use a small group plan as the state’s EHB benchmark
- Most states can add or improve benefits without exceeding the EHB generosity test and without triggering defrayal
- Seven states have added/improved benefits with minimal actuarial impact and minimal effect on premiums
Substantive changes to EHB benchmarking options for 2019+

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

- New default: previous year’s benchmark
- State flexibility grants - September 15, 2021 to September 14, 2023
- Deadline for new EHB benchmark selection: First Wednesday in May
Who selects EHB benchmark plans?

Inconsistency across states
  ○ Lack of legal (or any formal) process in many states
  ○ General lack of public information

- Broadly, we found states have:
  ○ A legislative selection process
    ○ CA, MD, NH, WA, CO, and NV
    ○ Degree of legislative involvement varies
  ○ A regulatory/delegated selection process
    ○ Express delegation through statute, e.g., NY, UT, NM
  ○ An unclear and/or undefined selection process
    ○ Many states w/ federal default plan (largest small group product in state), e.g., ND, IN, IA, AK, FL, MN, PA, WY, WV
    ○ Many states w/ virtually no authority found, e.g., IA, PA, WY, WV
Procedural requirements for benchmark selection

• **Public Process:** Requires states to provide “reasonable notice and an opportunity for public comment on the state’s selection of an EHB benchmark plan that includes posting a notice on its opportunity for public comment with associated information on a relevant state web site.”
  
45 C.F.R. § 156.111(c)

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

• Best practices include forming a stakeholder group, prioritizing health equity, full transparency
Key considerations for state regulators

- Center health equity using a data-driven process to identify unmet health needs
- Industry groups have more resources and power than consumers
- Educate consumers about the process and what is at stake
- Accountability to ensuring that people informing the process are diverse with regards to race, ethnicity, disability, income, LGBTQ+ etc.
  - Full disclosure of participants, consultants, conflict of interest
  - Post all comments, testimony, etc. received
- Provide light-lift ways for consumer groups to inform the process early (surveys, etc.)
Best Practices for EHB Benchmark Updates

- **Engage** diverse stakeholders early on (including legislators in states that require legislation for benchmarking changes)
- **Ensure** consumer participation through open meetings, trainings, and a robust public comment period
- **Identify** unmet health needs and prioritize closing disparities through a data-driven approach
- **Recognize** that data gaps can perpetuate health disparities
- **Maximize** transparency
- **Establish** a formal regulatory framework for reviewing and updating the state’s benchmark
- **Center** health equity when identifying and prioritizing the greatest unmet health needs
<table>
<thead>
<tr>
<th>State</th>
<th>Changes</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vermont</td>
<td>● Annual hearing exam and one set of hearing aids per year each 3 years</td>
<td>2024+</td>
</tr>
<tr>
<td>Colorado</td>
<td>● Adds annual mental health wellness visit</td>
<td>2023+</td>
</tr>
<tr>
<td></td>
<td>● Adds alternatives for pain management including chiropractic, physical therapy, cognitive therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Adds acupuncture</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Requires gender affirming care</td>
<td></td>
</tr>
<tr>
<td>Oregon</td>
<td>● Mandatory coverage of buprenorphine</td>
<td>2022+</td>
</tr>
<tr>
<td></td>
<td>● Automatic coverage of naloxone when opioids are prescribed at 50 MME or higher</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Adds coverage of non-opioid alternatives to treat pain</td>
<td></td>
</tr>
<tr>
<td>Michigan</td>
<td>● Mandatory coverage of buprenorphine</td>
<td>2022+</td>
</tr>
<tr>
<td></td>
<td>● Automatic coverage of naloxone when opioids are prescribed at 50 MME or higher</td>
<td></td>
</tr>
<tr>
<td>Illinois</td>
<td>● Cover alternative therapies for pain, such as topical anti-inflammatories</td>
<td>2022+</td>
</tr>
<tr>
<td></td>
<td>● Remove barriers to obtaining buprenorphine products for opioid use disorder treatment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Cover at least one intranasal spray opioid reversal agent when initial prescriptions of opioids exceed certain limit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Cover tele-psychiatry care</td>
<td></td>
</tr>
<tr>
<td>New Mexico</td>
<td>● Removes benefit limits for prosthetics</td>
<td>2022+</td>
</tr>
<tr>
<td></td>
<td>● Expands eligibility for weight loss drugs and programs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Adds coverage of 3 naloxone formulations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Adds benefits for artery calcification testing and hepatitis C</td>
<td></td>
</tr>
<tr>
<td>South Dakota</td>
<td>● Adds applied behavior analysis for Autism Spectrum Disorder</td>
<td>2021+</td>
</tr>
</tbody>
</table>
Resources

National Health Law Program

• Essential Health Benefits: Best Practices in EHB Benchmark Selection

• Essential Health Benefits (EHB) benchmarking process

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

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