COMMUNITY CATALYST

The Advocate's Guide to:

ESSENTIAL HEALTH BENEFITS

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Problem: Adequate Coverage

Health insurance provides critical protection against high medical bills, but the extent of that protection depends on whether the plan covers a comprehensive set of benefits with affordable out-of-pocket costs. When plans exclude coverage of needed services or impose dollar limits on covered services, consumers face high out-of-pocket costs, causing medical debt or even delayed or forgone care.[1] In addition to the importance of ensuring access to affordable coverage, insurance adequacy is a key consideration for consumer protection.

Potential Solution: State Options to Bolster Essential Health Benefits

As the primary regulators of insurance, states can ensure access to comprehensive health insurance through a mechanism created by the Affordable Care Act (ACA): Essential Health Benefits. Since its enactment, the ACA has relied on states to implement these benefit requirements, allowing a certain amount of flexibility to establish a state "benchmark" plan as a standard for adequate coverage in the individual and small group markets. States can use this authority to ensure that consumers have access to a comprehensive set of benefits.

What are the Essential Health Benefits?

Prior to the ACA, individual health plans often failed to provide coverage for vital health services, such as maternity care and prescription drugs.[2] To address this "Swiss cheese" coverage and prevent insurers from cherry picking healthy customers through benefit design, the ACA established a set of health services that non-grandfathered plans offered in the small group and individual market must cover, known as the Essential Health Benefits (EHB).[3]

The EHB were enacted as an outline, codified in federal law as 10 categories of coverage (see table). Under the ACA, the Department of Health and Human Services (HHS) has the authority to further define the EHB "equal to the scope of benefits provided under a typical employer plan."[4] Beyond these requirements, HHS has broad authority to determine the scope of the EHB.

The EHB standard is tied to other important consumer protections under the ACA. Insurers must measure the actuarial value (AV) of a plan based on coverage of the EHB categories and the annual limit on out-of-pocket costs applies to EHB services. An AV and out-of-pocket limit based on a skinnier EHB benchmark will provide less financial protection.[5]

State Benchmark Plan Selection

The Obama administration gave states the authority to define the EHB by selecting a benchmark plan from among active health insurance products, such as state employee health benefit plans or small group plans with high enrollment.[6] States that took no action to select an EHB benchmark plan defaulted to the small group market plan with the highest enrollment. States that actively chose their benchmark plan were not required to provide a public comment period, but many solicited some

The ACA's 10 Essential Health Benefits

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity & newborn care
- Mental health & substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

form of public feedback prior to plan selection, along with conducting a comprehensive analysis of plans. Ultimately, most states opted for a small group plan with high enrollment, either by default or through a selection process.[7]

Non-grandfathered individual and small group plans must cover a set of benefits that is "substantially equal" to the benchmark plan. While a benchmark plan is required to cover at least the ten EHB categories, states may impose coverage requirements beyond their benchmark plan, but are responsible for defraying the cost of additional benefit mandates.

New Flexibility Under the Trump Administration

Regulations issued in 2018 provide states with new options for selecting an EHB benchmark and give insurers greater flexibility to meet the standard.[8] States can now annually change their EHB benchmark by selecting another state's EHB benchmark, replace one or more EHB categories of benefits with the same categories of benefits from another state's EHB benchmark plan, or create a new EHB benchmark, so long as the scope of coverage under the benchmark falls within federally defined minimum and maximum values. In addition, states can allow insurers to substitute benefits within and across EHB categories other than prescription drugs. If allowed to do substitution across EHB categories, insurers can use the leeway to design benefits that reduce coverage of certain high-cost services, for example, hospitalization, so long as coverage of other services is enhanced.

Policy Considerations

State Considerations

States should keep the goal of consumer protection in mind when exercising their authority to select or alter benchmark plans. Relaxing EHB standards could allow insurers to design health insurance products that exclude coverage of some health services. While this practice may lower premiums, consumers who need comprehensive coverage will have to pay out-of-pocket to obtain services not covered under their plan. To ensure that everyone has adequate coverage, states should design benchmark plans that work for consumers with a range of health care needs, including prescription drugs, maternity care and mental health and substance use disorder services.

Use new flexibility to meet public health needs: Changes to a benchmark plan under the new federal rules can help states tailor benefits to respond to public health needs. For example, Illinois made adjustments to its benchmark plan to address the opioid epidemic by increasing coverage for evidence-based substance use treatment and alternative pain therapies.[9] These alterations, allowable under the new federal rules, result in more adequate health insurance rather than giving

up comprehensive coverage to lower premiums for healthy people.

Given the authority that HHS has to further reduce EHB requirements, states can take steps to protect access to comprehensive coverage by codifying current EHB standards into their insurance code and exercising existing state regulatory authority. Doing so would also ensure regulators have clear authority to enforce EHB standards, particularly if the pending legal challenge to the ACA (Texas v. Azar) results in loss of federal EHB requirements.

Codify EHB into state law: States can enact the current EHB categories into state law. For example, during the 2018 legislative session, Connecticut passed a law that codified the ACA's EHB categories, as well as preventive services recommended by the United States Preventive Services Task Force for women, children and adolescents.[10] States may also consider codifying their benchmark plan to guard against weaker federal standards for defining the EHB. California, for example, has codified both the 10 EHB categories and its benchmark plan.[11]

Use regulatory authority to fill in coverage gaps: State insurance regulators can use existing regulatory authority to establish benefit requirements that protect consumers' access to comprehensive plans. For instance, if HHS were to rescind the Obama administration's requirement that insurers cover at least one prescription drug in each U.S. Pharmacopeia category and class, state regulators can use their rulemaking authority to promulgate a similar standard, ensuring adequate prescription drug coverage.[12] States may also want to use their regulatory authority to fill gaps identified through an assessment of their current EHB standards, taking new medical treatments and technology into consideration.

Advocate Considerations

Advocates working to protect consumers' access to comprehensive coverage should consider how states will use the new flexibility under the Trump administration, and push state governments to bolster state EHB requirements to protect consumers in the face of federal deregulation.

Engage in state discussions on changes to the EHB benchmark: The new federal standards for EHB benchmark plans offers states the opportunity to address coverage gaps. However, it also leaves the door open for lowering current standards. Recently, 20 states received federal grants to support state implementation of the ACA's EHB requirements as well as planning for federal market reforms, with several states exploring changes to their EHB benchmark plans.[13] The deadline for states to submit required documents for new benchmark plan selections is May 6, 2019 for the 2021 plan year and May 8, 2020 for the 2022 plan year. Under federal rules, states must provide a reasonable notice and comment period on proposed changes prior to submission and conduct an analysis of the impact on access and premiums. Two states, Illinois and Alabama, submitted proposed benchmark changes last year, though Illinois only provided an opportunity to comment before there was a proposed benchmark plan to review and Alabama only provided a two-week comment period.[14] Advocates should reach out to their state regulators to confirm that there will be adequate notice and comment prior to any proposed changes to their state benchmark plan, particularly in the states that have received federal funding to review their EHB benchmark plans.

Reducing premiums may shift additional costs onto consumers: Some states plan to put grant funds towards examining ways to reduce premiums through changing the state's EHB benchmark plan.[15] A state's plan to lower premiums through benchmark alterations may indicate plans to reduce

the depth or breadth of coverage. Advocates should have a voice in state efforts to evaluate EHB benchmark plans to advance a consumer protection agenda and keep attempts to curtail benefits in check. Where states are seeking to reduce benefits, it's important to keep in mind that consumers may bear the full cost of obtaining services under benefits removed from EHB and without the protection of the ACA's annual limit on out-of-pocket costs for those services.

Beware of substitutions: Beyond state benchmark changes, advocates should be aware that states may give issuers flexibility to meet the state's EHB benchmark with substitutions across EHB categories, so long as states give notice to CMS of their decision to allow substitution by the same dates required for states pursuing approval of a new EHB benchmark plan. Though not required under federal regulations, advocates should press states to provide a reasonable notice and comment period for this decision, as well. At a minimum, allowing substitution across benefit categories will make it harder for consumers to compare plans with certainty that the covered benefits are comparable. More significantly, issuers could use this flexibility to diminish coverage or avoid consumers with preexisting conditions.

Opportunities to address health disparities: States can use the opportunity to update their EHB benchmark plan to address health disparities. For example, a state review could assess the adequacy of the benchmark plan in addressing conditions associated with health disparities, such as maternal mortality, heart disease, or diabetes. At a minimum, any changes to the EHB benchmark plan should not exacerbate disparities or have a disparate impact on specific populations, such as people with disabilities or racial/ethnic minorities.

Strategies for codifying the EHB: Advocates should weigh the various options for codifying EHB protections into state law. States may consider codifying the EHB categories, their benchmark plan, or both. By enacting legislation that codifies the current benchmark plan, states may be boxing themselves in; the lack of flexibility provided by this option could inhibit a state from making a change that would expand access to crucial health services. On the other hand, codifying the categories may leave them vulnerable to broad interpretation. Advocates should consider the costs and benefits of each approach for their particular state's needs.

Conclusion

States have greater flexibility under new rules for selecting an EHB benchmark plan. States can use that flexibility to improve benefits, for example, to respond to a public health issue or to address gaps in coverage, or to reduce benefits. States can also give insurers flexibility to substitute benefits across EHB categories when designing a plan that meets the state's benchmark. Beyond these options for making changes to EHB benchmark plans, policymakers and advocates may consider codifying the EHB categories or benchmark plan into state law, to ensure clear authority to enforce these standards and protect against threats to strong standards through federal regulatory changes or legal challenges to the ACA. In all cases, advocates should engage with state policymakers considering changes to their EHB and push for reasonable public notice and comment of any state decisions affecting the state's EHB standards.

This policy brief was developed with the support of Rachel Schwab, Dania Palanker and JoAnn Volk of Georgetown University's Center on Health Insurance Reforms. For questions please contact Ashley Blackburn, Policy Manager, at ablackburn@communitycatalyst.org

Endnotes

[1] Cynthia Cox and Bradley Sawyer, "How Does Cost Affect Access to Care?" Jan. 17, 2018. Accessed at https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care/ - item-start.
[2] Dania Palanker, JoAnn Volk and Justin Giovannelli, "Eliminating Essential Health Benefits Will Shift Financial Risk Back to Consumers," To the Point, the Commonwealth Fund, Mar. 24, 2017. Accessed at https://www.commonwealthfund.org/blog/2017/eliminating-essential-health-benefits-will-shift-financial-risk-back-consumers?redirect_source=/publications/blog/2017/mar/eliminating-essential-health-benefits-financial-risk-consumers.
[3] Grandfathered plans are those that were in existence prior to enactment of the ACA on March 23, 2010. Grandfathered individual plans are barred from newly enrolling individuals, so there are likely very few left. Grandfathered employer plans lose that status if they substantially reduce benefits or increase costs under the plan. The Kaiser Family Foundation's annual Employer Health Benefits Survey estimates that 16 percent of American workers with employer-sponsored coverage were enrolled in a grandfathered employer plan in 2018. See Kaiser Family Foundation, "2018 Employer Health Benefits Survey," Oct. 3, 2018. Accessed at https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey/.
[4] 42 U.S.C. § 18022 et seq. (2010).
[5] Actuarial Value (AV) is the measure of the percentage of health care costs covered by the plan across a specified population. Generally, the higher the AV, the lower an average consumer's out-of-pocket costs will be, though individual consumers will pay more or less, depending on their specific use of health care services.
[6] 45 C.F.R. § 156.100 (2015).
[7] Sabrina Corlette, Kevin Lucia and Max Levin, "Implementing the Affordable Care Act: Choosing and Essential Health Benefits Benchmark Plan," Mar. 2013. Accessed at https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2013_mar_1677_corlette_implementing_aca_choosing_essential_hlt_benefits_reform_brief.pdf.
[8] Fed. Reg Vol. 83 No. 74, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019."
[9] Illinois Department of Insurance, Press Release: "Illinois becomes first and only state to change Essential Health Benefit-benchmark plan," Aug. 27, 2018. Accessed at https://www2.illinois.gov/IISNews/18098-DOI_Essential_Health_Benefit-benchmark_plan_Release.pdf.
[10] Connecticut H. 5210 (2018).
[11] Cal. Ins. Code § 10112.27
[12] Corlette et. al, "Stepping into the Breach: State Options to Protect Consumers and Stabilize Markets in the Wake of Federal Changes to the Affordable Care Act," Aug. 2017. Accessed at https://chir.georgetown.edu/sites/chir/files/state_options_unwinding_the_aca.pdf.
[13] Rachel Schwab, "Federal Flexibility Grants highlight State Priorities for Market Stability," CHIRblog, Sep. 24, 2018. Accessed at http://chirblog.org/federal-flexibility-grants-highlight-state-priorities-market-stability/.
[14] Alabama withdrew their proposed benchmark plan from consideration for the 2020 plan year.
[15] ibid.