

# Joint State Advisory 17-32: Proposed Changes to Essential Health Benefits Affect Medicaid Expansion Population

December 5, 2017

States

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Last month, the Centers for Medicare & Medicaid Services (CMS) published the [2019 Notice of Benefit and Payment Parameters](#), which includes significant changes to the implementation regulations of the Affordable Care Act (ACA). 82 Fed. Reg. 51,052 (Nov. 2, 2017). Although the Notice of Benefit and Payment Parameters does not propose changes to the Medicaid regulations, its proposed changes to the private market's Essential Health Benefits rules will impact the Alternative Benefit Plan package that States must provide to the ACA low-income adult group. We summarize and analyze this impact below.

## Background

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The ACA requires that non-grandfathered health plans in the individual and small group markets cover "Essential Health Benefits," which includes items and services in 10 statutory benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

Under the ACA, the new eligibility category of low-income adults must receive "Alternative Benefit Plan" (ABP) coverage, see ACA § 2001(a)(2); Social Security Act (SSA) § 1902(k)(1), and ABP coverage must meet the Essential Health Benefits (EHB) standards, see ACA § 2001(c); 42 C.F.R. § 440.347; 45 C.F.R. § 156.110.

We described the process for developing Alternative Benefit Plans that cover Essential Health Benefits in more detail in: ACA Advisory #116, ACA Advisory #149, and Advisory 16-5.

## Proposed Changes to the Essential Health Benefits Regulations for 2019

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Under rules adopted by the Obama Administration, the Essential Health Benefits package is developed based on state "benchmarks." See 45 C.F.R. Part 156, Subpart B. State insurance regulators create an "EHB-benchmark plan" based on the benefits in a "base-benchmark plan," which is either chosen by the State from a list in the CMS regulations or is "the largest plan by

enrollment in the largest product by enrollment in the State's small group market." § 156.100. To the extent the base-benchmark does not cover all 10 EHB categories, the base-benchmark plan must be supplemented with benefits from one of the other base-benchmark plan options to become the State's EHB-benchmark.

Health plans in the individual and small group markets are required to provide coverage that is "substantially equal" to the coverage in the State's EHB-benchmark plan. § 156.115(a)(1). Issuers can "substitute" for EHB-benchmark benefits, provided that: the new benefit(s) are in the same Essential Health Benefits category as the benefit(s) being replaced; the new benefit(s) are actuarially equivalent to the benefit(s) being replaced; and the benefit(s) being replaced are not prescription drug benefit(s). § 156.115(b).

The proposed rules make significant changes to the process for defining Essential Health Benefits, effective January 1, 2019. First, instead of going through the complex, multi-step process described above for developing an EHB-benchmark, States would be able to choose an EHB-benchmark through one of several more straightforward processes:

1. Retaining the State's 2017 EHB-benchmark. (This is the default for a State that takes no action.)
2. Use an EHB-benchmark developed and approved for any other State for the 2017 plan year.
3. Retain the State's 2017 EHB-benchmark, but "[r]eplac[e] one or more categories of EHBs" in its 2017 EHB-benchmark "with the same category or categories of EHB" used in any other State's 2017 EHB-benchmark.
4. "Otherwise selecting a set of benefits", provided that the benefit package does not "exceed the generosity of the most generous among" the following plans: (i) the State's EHB-benchmark plan for the 2017 plan year or (ii) any of the State's base-benchmark plan options for the 2017 plan supplemented as necessary under the Essential Health Benefits regulations.

Proposed 45 C.F.R. § 156.111(a).

In addition, the proposed rules would require that, effective January 1, 2019, EHB-benchmark plans: "Be equal in scope of benefits to what is provided under a typical employer plan", which CMS proposes to define as: (a) an insurance plan product that covers in the aggregate at least 5,000 enrollees in the small group or large group markets in one or more States; or (b) a self-insured group health plan with at least 5,000 enrollees. Proposed § 156.111(b).

CMS also proposes to codify in regulation the statutory requirements that the EHB-benchmark provide: "an appropriate balance of coverage" among the 10 Essential Health Benefits categories; "[n]ot have benefits unduly weighted" toward any of the 10 categories; and provide "benefits for diverse segments of the population, including women, children, persons with disabilities, and other groups." *Id.*

The proposed rules would also give insurers more flexibility in substituting benefits. Specifically, insurers would be able to substitute benefits across Essential Health Benefits categories, "as long as the plan with substitutions still provides benefits that are substantially equal to the EHB-benchmark plan, provides an appropriate balance among the EHB categories such that benefits

are not unduly weighted towards any category, and provides benefits for diverse segments of the population.” Proposed 45 C.F.R. § 156.115(b)(1)(ii).

## **Federal Default Definition of Essential Health Benefits?**

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In the preamble to the proposed regulations, CMS states that, for plan years after 2019, it is “considering establishing a Federal default definition of EHB,” and solicits comments on that possibility. 82 Fed. Reg. at 51,102.

CMS explains the competing considerations in developing a default plan: “The benefits of a Federal default could outweigh the potential impact on flexibility afforded to States, but we are also considering allowing States continued flexibility to adopt their own EHB-benchmark plans, provided they defray costs that exceed the Federal default.” *Id.* One option under consideration is establishing a “national benchmark plan standard for prescription drugs” only. *Id.*

## **Implications for Medicaid Expansion Population**

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The ACA expressly requires that the Medicaid expansion population receive Alternative Benefit Plan coverage that includes Essential Health Benefits, and the proposed rules would not (and cannot) change that statutory requirement. However, the increased flexibility that the proposed rules give States with respect to defining Essential Health Benefits also means that States have more flexibility in defining the Essential Health Benefits for purposes of Alternative Benefit Plan coverage.

Under current CMS rules for developing Medicaid ABPs, States must replicate the process used in the individual and small group market in defining Essential Health Benefits. That is, state Medicaid programs must choose a base-benchmark plan (which can be different than the State’s base benchmark for the commercial market), supplement as necessary to create an EHB-benchmark, and ensure the ABP coverage is substantially equal to the EHB-benchmark in the 10 EHB categories. 42 C.F.R. §§ 156.100; 156.110. States may develop different ABP packages for different target populations, and States may use different base-benchmark plans to establish EHB coverage for their various ABPs. 42 C.F.R. § 440.347(c).

The proposed rules would effectively give state Medicaid programs more options for developing an ABP package that covers EHB. Instead of being limited to the base-benchmark structure, state Medicaid programs could use any of the four options proposed above for developing an EHB package covered by the State’s ABP. And, as discussed above, one of those options allows States to choose an EHB-benchmark by “otherwise selecting a set of benefits”, provided that the benefit package does not “exceed the generosity of the most generous among” the following plans: (i) the State’s EHB-benchmark plan for the 2017 plan year or (ii) any of the State’s base-benchmark plan options for the 2017 plan supplemented as necessary under the EHB regulations. Proposed 45 C.F.R. § 156.111(a).

Under the current system, States cannot add a prior authorization or other utilization limit that is not in the benchmark plan that it has selected. However, the proposed rule permitting a benchmark plan to be one that the State has “otherwise select[ed]” gives States greater flexibility, although other requirements (such as mental health parity or certain requirements of Section 1937) may still apply.

## States

State Medicaid EHB-benchmarks would still be subject to all of the ACA's statutory limitations, including the following: coverage of some benefits and all 10 EHB categories, 42 U.S.C. § 18022(b)(1); the scope of Essential Health Benefits equal to the scope of benefits provided under a typical employer plan, 42 U.S.C. § 18022(b)(2); an appropriate balance among the 10 categories such that benefits are not unduly weighted toward any category, 42 U.S.C. § 18022(b)(4)(A); and non-discrimination in benefit development against individuals due to their age, disability, or expected length of life, 42 U.S.C. § 18022(b)(4)(B).

This information is not intended as legal advice. Readers should seek specific legal advice before acting with regard to the subjects mentioned herein.