

# Health Care in Motion

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## Administration Finalizes Rule Weakening EHB Requirements

Last November, we [wrote](#) about the Administration's proposed regulations that would have substantially undermined the Affordable Care Act's (ACA) [Essential Health Benefits](#) (EHBs). EHBs are the minimum package of benefits that every ACA insurance plan must provide. This week, the Trump Administration released the [finalized version](#) of these regulations, cementing this proposal over the objections of advocates concerned about affordable access to comprehensive health care services. The final rules released this week make a number of technical and policy changes related to the operation of the private insurance Marketplaces. In this Health Care in Motion dispatch, we will discuss the contours of the final rules, focusing on the changes to EHBs, their potential impact on access to care for vulnerable populations, and action steps advocates can take to soften the new rules' negative effects on health insurance.

### A Brief History of EHBs

One of the primary goals of the ACA is to ensure not only that the cost of insurance is more affordable, but also that insurance plans cover items and services essential to health and well-being. To achieve this second objective, the ACA introduced a requirement that most health plans sold to individuals (as opposed to group health coverage usually offered by large employers) must cover certain categories of items and services deemed "essential health benefits." Ten categories of benefits must be covered: outpatient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services and chronic disease management, and pediatric services.

In a nutshell, the EHB requirement placed a minimum floor of benefits that all health plans sold through the ACA's Marketplaces must include. The EHB package was a breakthrough for individuals living with chronic health conditions, as many health plans did not cover key services these individuals need to effectively manage their health prior to the ACA. For example, in [2014](#), 62 percent of individuals purchasing their own health insurance did not receive coverage for maternity services, 34 percent did not have access to substance abuse disorder treatment, 18 percent did not have coverage of mental health services, and 9 percent lacked prescription drug coverage.

However, while the ACA requires that health insurance plans must cover the ten categories discussed above, the law leaves the specifics of which particular items and services must be covered within each category to the discretion of the Secretary of the [Department of Health and Human Services](#) (HHS). During the implementation of the ACA, HHS established a "benchmark" approach whereby states selected one particular plan (deemed a "benchmark") from a closed menu of ten plan options already available within the state. This benchmark plan then set the minimum standard of coverage for health plans sold on the state's ACA Marketplace.

Under rules crafted by the Obama administration, state insurance regulators had the choice of identifying a benchmark

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plan from: (1) any of the three largest small group plans sold in the state, (2) any of the three largest employee health plan options available to state employees, (3) any of the three largest [Federal Employees Health Benefits Program](#) plan options, or (4) the largest non-Medicaid plan offered by a [health maintenance organization](#) in the state. HHS selected these ten options to comply with the ACA's mandate that the EHB package is equal in scope to the benefits offered under a typical employer plan which, [prior to the ACA](#), generally had more robust coverage than plans sold on the individual market. While this may have fallen short of explicitly defining a national floor of coverage, this process markedly improved the robustness of benefits individuals have access to.

## New Regulations Give States Tools to Cut Back Benefits

The final regulations published by the Trump Administration this week considerably alter the process by which states select their benchmark plans. Under the new rules, state regulators are given four options to select their EHB benchmark plans from beginning in 2020. States may: (1) keep their [2017 benchmark plans](#), (2) select a different state's 2017 benchmark plan, (3) replace individual EHB categories from another state's 2017 benchmark plans, or (4) select a set of benefits that would become the EHB benchmark, so long as the new benchmark is comparable to a typical employer plan. Let's talk about why this change matters.

Options 2 and 3 would give states the ability to limit or completely drop benefits from their EHBs by selecting a less comprehensive plan offered in a different state. There is good reason to fear that, given the chance, some state officials would likely exercise these options to downgrade the minimum package of benefits. For example, Ohio Governor [John Kasich](#) has previously [called](#) for reducing the generosity of EHBs required under the ACA. Option 4 is especially concerning. While states remain obligated to include all ten EHB categories, state officials could reduce the scope of required coverage by limiting or eliminating items and services within each category.

The rule ostensibly mitigates the negative implications of the new options by mandating that any benchmark must be equivalent to a typical employer plan. This is defined in the rule as either: (1) one of the previously available options from the 2017 benchmark selection process described above, or (2) any of the five largest group health insurance plans by enrollment in the state, so long as the selected plan has at least 10 percent of the total enrollment out of all five plans. While this new comparison requirement will supposedly ensure that states do not use the new flexibility provided under the rule to reduce benefits, some plans that would meet the second prong may limit services in way that plans currently sold on the Marketplace do not. In implementing this change, state regulators are far more likely to redefine their EHB benchmarks to be less comprehensive due to additional limitations imposed by these regulations.

## Silver Lining Quickly Tarnished

While this additional flexibility to define the scope of EHBs may sound promising as a potential avenue to expand the scope of what states define as their EHB package, other provisions of the rule dash any hope of this possibility. Specifically, two additional limitations on the new EHB selection options make it virtually impossible for states to expand the scope of their EHB package.

First, HHS specifies that it will apply a "generosity test" to all potential EHB benchmark plan options. Under the generosity test, a state may not select a new EHB benchmark plan that exceeds the most generous among a set of comparison plans. These comparison plans include the state's 2017 EHB benchmark plan and any of the state's three largest small group health plans by enrollment. Second, HHS notes that under the new options, if a state's benchmark selection results in

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new benefit coverage mandates, states will be required to defray the cost of these services from already-stretched states budgets. The combined effect of these provisions sets up a system in which the additional flexibility the new rules purport to give the states will only translate into flexibility to reduce the comprehensiveness of their EHB benchmarks.

These changes are concerning for people with significant health needs. Describing the potential effects of the new options, [HHS notes](#) that individuals with specific health needs stand to be negatively impacted if their state allows less comprehensive plans that do not provide coverage of services they previously had access to. Further, reducing the robustness of the EHBs will also roll back other important consumer protections in the ACA. The ACA protects consumers from annual or lifetime limits on benefits as well as unconscionably high out-of-pocket costs, but these protections only apply to services in the EHB package. Thus, if a state opts to scale back required EHB coverage, they also reduce the scope of these protections, forcing more costs onto those that need to use their health coverage the most.

It is also worth noting that the rule codifies many of the ACA's statutory EHB requirements. For example, the rule explicitly requires that EHB benchmark plans must provide an appropriate balance of coverage among the ten EHB categories, not unduly weight benefits toward any one of the categories, include benefits for diverse segments of the population, and prohibits designing benefits in a way that discriminates against an individual based on age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. However, as we have [discussed previously](#) and explicitly reiterated by the rule here, HHS is largely abdicating its oversight and enforcement role over these and other requirements related to the ACA's consumer protections in favor of deferring to state regulators. Without sufficient guidance and financial supports to do so, states will be ill-equipped to be the primary enforcers of these requirements.

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While the new rules surrounding EHBs do not go into effect until 2020, advocates should not wait to take action. This change vests even broader discretion in the hands of state insurance regulators. Advocates should strengthen relationships with state insurance regulators, particularly Governors' offices and state departments of insurance, as these officials are key decision-makers under new authority granted by the rules. Advocates should begin educating these policymakers as to the importance of access to comprehensive health services, particularly for vulnerable populations such as individuals living with chronic health conditions.

While these changes open up the possibility that coverage may become less meaningful for people living with chronic health conditions, state policymakers cannot ignore a community unified in opposition. Advocates should be aware that the new rules require states to notify their constituents of any planned modifications to EHBs and provide an opportunity for public comment. If your state plans to weaken their EHB benchmark, be prepared to show up and be loud.

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