Health Care in Motion

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Still Essential:
Administration's Proposal Would Weaken EHB Requirements

On November 2, 2017, the Trump Administration released proposed regulations that would substantially undermine the Affordable Care Act's (ACA) Essential Health Benefits (EHBs). EHBs are minimum standards of coverage in ten health care categories, including prescription drugs and physician services, which insurers must cover in order to sell health plans on the Marketplaces. The EHB standard ensures that health insurance plans sold to consumers include a comprehensive suite of benefits and services. Unfortunately, these proposed regulations, if enacted, would give states far more control over EHBs and only encourages states to reduce the comprehensiveness of their EHBs. Such "flexibility" is particularly concerning for people with high health needs, such as those living with chronic illnesses and disabilities, who rely on access to comprehensive care that the ACA guarantees.

Advocates should:

- **Review and understand how the Proposed Rule affects the EHB requirements and how it will harm access to care for those living with chronic health conditions.**
- **Submit comments to the Proposed Rule opposing any scaling back of the ACA's EHB requirements. Consumers may prepare their own written comments or may use template comments, available here.**

Essential Health Benefits Under the ACA

The ACA introduced a requirement that all health plans sold in either the individual or small-group markets must cover certain items and services as "essential health benefits." These EHBs specify ten categories of benefits that 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 including oral and vision care. These coverage requirements were a breakthrough for individuals living with chronic conditions, as many health plans did not cover certain key services prior to the ACA. For example, in 2014, 62 percent of individuals purchasing their own health plan did not have coverage for maternity coverage, 34 percent did not have access to substance abuse services, 18 percent did not have coverage of mental health services, and 9 percent lacked prescription drug coverage.

However, while the ACA states that these ten categories must be covered, the law left the specifics of which particular items and services must be covered within each of the categories to the discretion of the Secretary of the Department of Health and Human Services (HHS). Under the Obama Administration, HHS established a "benchmark" approach, whereby states selected a benchmark plan among a closed menu of ten plan options already available within the state. This benchmark plan then set the standard for the state, and all health plans sold in the state must cover the particular items and services covered by state's benchmark plan.

Under the Obama era rules, states can select a benchmark 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 so states would comply with the ACA's mandate that EHBs be equal in scope to a typical employer plan.[1]

Proposed Regulations Gives States Tools to Reduce Benefits

On November 2, HHS published a Notice of Payment and Benefit Parameters for 2019 (the Proposed Rule). This annually released rule defines the operation and contours of the ACA's Marketplaces where consumers purchase health coverage. The Proposed Rule proffers many changes for 2019 that would delegate a substantial amount of authority and oversight of health insurance to state regulators. Among these many changes, the most concerning proposal is the dramatic reshaping of the EHB benchmark selection process.

The Proposed Rule would give states four options to select their EHB benchmark plans beginning in the 2019 plan year. States could: (1) keep their 2017 benchmark plans, (2) select a different state's 2017 benchmark plan, (3) replace individual EHB categories from other states' 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 and is no more generous than any of the previously available benchmark options.

Options 2 and 3 would give states the ability to limit or drop benefits from their EHBs altogether by picking a less comprehensive plan offered in a different state. Given the chance, some state officials would likely take up this option. For example, Ohio Governor John Kasich recently called for reducing the EHBs required under the ACA. Under the Proposed Rule, Ohio could simply select another state's benchmark plan (or EHB category) that does not cover as many services. This would mean that all plans sold on the individual and small-group markets in Ohio could cover fewer services than in 2017 and still be ACA-compliant.

Option 4 is even more concerning. While states would remain obligated to include all ten EHB categories, a state could significantly reduce the scope of required coverage by limiting or eliminating items and services within each category. The Proposed Rule would require a state to demonstrate that this new benchmark would be equivalent to a typical employer plan, defined in the Proposed Rule as any employer plan with at least 5,000 enrollees. While this option is intended to comply with the mandate requiring EHBs to reflect the benefits of a typical employer plan, benchmarks selected through this option could severely reduce services, contrary to the ACA's intent of a national floor of coverage.

Additionally, under the new proposals, if a state's new benchmark results in additional services being mandated, states

[1] 2017 benchmark plans for all states can be found here.

will be required to defray the costs of these services from already-stretched state budgets.[2] This sets up a system in which the additional flexibility the Proposed Rule purports to give states will only translate in to flexibility to reduce the comprehensiveness of their EHB coverage benchmarks.

This proposal is extremely concerning for people with significant health needs. HHS notes in the Proposed Rule that states are more likely to modify their benchmarks to reduce benefits, forcing those that need services no longer covered to either pay additional out-of-pocket costs or forego care and treatment. As HHS notes, people with specific health needs would be negatively impacted if their state allows less comprehensive plans.

Further, weakening the EHB requirement will also roll back other important consumer protections in the ACA. The ACA protects consumers from annual or lifetime limits on benefits and high out-of-pocket costs, but these provisions only apply to services in the EHBs. Thus, if states opt to scale back required EHB coverage, they also scale back the scope of these protections, forcing more costs onto those that need to use their health coverage the most.

Opportunity for Advocates to Voice Concerns

As this is still only a Proposed Rule, advocates have an opportunity to make their voices heard. Any proposed federal regulation must go through a "notice and comment" period during which anyone may voice their concerns about the regulation's proposals. The comment period for this proposed rule is open until 5:00 PM on November 27. Comments can be submitted online here. To help facilitate comment submissions, the Center for Health Law and Policy Innovation has developed customizable, consumer-friendly template comments addressing the EHB issue discussed above. You can find these template comments here. We encourage you to tailor these comments so that your communities' concerns are heard.

[2] While this requirement currently exists with respect to state-mandated benefits, applying it to the new EHB benchmark process would create a financial penalty for selecting a more comprehensive benchmark.

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