

## Details on New Rules Regarding Flexibility for Essential Health Benefit Plans

On April 9, 2018, the Centers for Medicare and Medicaid Services (CMS) finalized the Benefit and Payment Parameters (NBPP) rule for 2019. The NBPP is an annual rule that outlines the major changes that CMS intends to implement for the next Marketplace plan year. In the 2019 NBPP, CMS finalized options to give states additional flexibility to define their essential health benefits (EHBs) annually beginning with the 2020 plan year.

Section 1302 of the Affordable Care Act (ACA) requires that health insurers in the individual and small group markets must offer plans that cover services in ten categories of EHBs:

- Ambulatory patient services
- Hospitalization
- Mental health and substance use disorder services
- Rehabilitative and habilitative services and devices
- Preventive and wellness services
- Emergency services
- Pregnancy, maternity, and newborn care
- Prescription drugs
- Laboratory services
- Pediatric services, including oral and vision care

Beginning with the 2020 plan year, states may elect to maintain their current 2017 EHB-benchmark plan or redefine their EHB-benchmark plan using one of three options:

1. Select another state's entire 2017 EHB-benchmark plan,
2. Replace one or more of its EHB categories using another state's 2017 EHB-benchmark plan, or
3. Select a new EHB-benchmark plan that is at least equal in scope to a typical employer plan (see below).

The final new benchmark can be no more generous than the "most generous comparison plan". This test requires the state to compare the value of the new benchmark to the most generous of a set of comparison plans, which include the 2017 EHB-benchmark plan and the three largest small group products from the base benchmark options for the 2017 plan year. A "typical employer plan" can be one of the state's ten base benchmark plan options from the 2017 plan year, or the plan with the largest enrollment in one of the five largest group major medical health insurance products, by enrollment, in the state if:

1. The plan's product has at least ten percent of the total enrollment among those products;
2. The plan provides minimum value as defined under the ACA;
3. The benefits are not excepted benefits; and
4. The benefits are from a plan year beginning after December 31, 2013.

State EHB-benchmark plans must include coverage for all ten EHB categories and the state will be required to confirm that its benchmark plan selection meets all EHB requirements. For example, there must be an appropriate balance among the ten categories so that benefits are not unduly weighted toward any category, plans and rates cannot be designed to discriminate against individuals, and that plans take into account the health care needs of diverse segments of the population including women, children, and persons with disabilities.

CMS will continue its policy on additional state benefit mandates. Under this policy, a state does not have to defray the cost of a benefit mandated prior to or on December 31, 2011 but must defray the costs of benefits mandated after that date. If a state selects another state's benchmark plan (or category) that includes benefits mandated by an originating state that are EHB, those benefits will be incorporated into the selecting state's EHB-benchmark plan and the selecting state will not have to defray costs for the other state's mandated benefits.

States must provide a "reasonable" notice and public comment when they select an EHB-benchmark plan and post a notice on the opportunity to provide public comment on a relevant state website. States must comply with four new data collection requirements beginning in plan year 2020 and provide:

1. a document that identifies the state's EHB-benchmark plan and confirms that the plan complies with federal requirements;
2. an actuarial certification and report that affirms that the selected plan is no more generous than the most generous comparison plan and equal in scope to a typical employer plan;
3. a summary of the selected plan that reflects benefits and limitations, a schedule of benefits, and potentially a drug formulary; and
4. any other documentation that might be required, such as an EHB summary chart for the CMS website.

To modify their EHB-benchmark plan for 2020, states must submit these materials to CMS by July 2, 2018.