ESSENTIAL HEALTH BENEFITS AND OTHER ACA PROTECTIONS

NEW RULE POSES THREAT TO BENEFITS FOR CHILDREN AND FAMILIES

Advocacy Action Guide for AAP Chapters

Overview

- In The 2019 Notice of Benefit and Payment Parameters (NBPP) final rule gives states sweeping new authority to change their **essential health benefits (EHB)** benchmarks by choosing from new EHB benchmark options and by substituting benefits between EHB categories. These new options and a new "generosity standard" ceiling allow states to provide fewer benefits in their EHB packages if they so choose.

- **Chapters are encouraged to advocate that EHB benefit packages not be weakened by state selection of a less robust EHB option, or by allowing for benefit substitution between EHB categories.** Chapters may also use the opportunity of the 2020 EHB selection to make improvements to state EHB packages, but should first ensure that any changes do no harm.

- **States had until July 2, 2018 to make a new EHB benchmark selection for the 2020 plan year**. If a state does not make a new selection for a given year, the state will retain the EHB benchmark for the plan year currently in use.

- The new rule also makes EHB benchmark selection an annual activity, so states may change EHB benchmarks next year, or in the future.

- **Should a state choose a less robust EHB benchmark, children and families in individual and small group coverage (those plans to which EHB requirements apply) will have fewer needed benefits covered.**

- A less robust EHB package would also impact coverage in large group and self-insured plans, as the ACA annual and lifetime dollar limits and out-of-pocket spending protections are for EHB benefits. If a service is removed from EHB, these ACA protections will no longer apply to that service. Large employers can choose *any state's* EHB benchmark for purposes of these protections.
- Other changes made by the NBPP final rule follow, with additional opportunities for advocacy.

- **Chapters and advocates should review these changes to ensure they are familiar with them and to ensure no state modifications are made that diminish access to care in CHIP or Medicaid.**

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Details

- The US Department of Health and Human Services released its **Notice of Benefit and Payment Parameters (NBPP) final rule** for 2019, which gives states options to significantly weaken several Affordable Care Act (ACA) protections, most notably with respect to essential health benefits (EHB) coverage.

- **States had until July 2, 2018 to make a new EHB selection for the 2020 plan year and will have opportunities every year moving forward to change EHB. Such changes may mean less coverage than is currently provided in your state's EHB benefit package. Chapter advocacy may be necessary to prevent harmful changes with this EHB selection and in other ACA provisions covered by the final rule.**

- This NBPP final rule follows recently proposed federal rules to allow for expanded use of Association Health Plans (AHPs) and short term, limited duration (STLD) insurance plans, which would not comply with the several ACA protections. Guidance from the AAP on AHPs and STLD plans is available here. Taken together, these steps represent a concerted effort to weaken existing ACA consumer protections and expand access to insurance products without them.

NBPP Enables States to Weaken Essential Health Benefits (EHB)

- The ACA established a set of 10 health care benefit service categories, known as essential health benefits (EHB), that individual and small group plans both inside and outside the Marketplace must cover:

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

- To finalize the EHB package, states were required to select a "base benchmark" EHB plan from the following choices:
    1. 3 largest small group plans in the state by enrollment
    2. 3 largest state employee health plans by enrollment
    3. 3 largest federal employee health plan options by enrollment
    4. The largest HMO plan offered in the state's commercial market by enrollment

- States were then required to supplement their "base benchmark" plan with any EHB benefit categories missing from the selection, to create the EHB benchmark. States that did not select an EHB option defaulted to the largest small group plan in the state. Current state EHB benchmarks for the 2017-2019 plan years are available here.

- The NBPP final rule significantly weakens EHB by giving states new options to create an EHB benchmark that offers more limited coverage, and by allowing for substitution of benefits *across* EHB categories.

New EHB Benchmark Options

- The NBPP final rule allows states to change their EHB benchmark with 1 of 3 new options. States that do not choose one of these new options will keep the EHB benchmark currently in use for the 2020 plan year:

    1. Selecting the EHB benchmark plan used in another state for the 2017 plan year
    2. Replacing 1 or more existing EHB benefit categories with the same categories of benefits used in another state's EHB benchmark plan for the 2017 plan year
    3. Selecting a new set of benefits that would provide the state's EHB benchmark

- Both #1 and #2 would allow states to choose either an entire EHB benchmark plan or EHB benefit categories from another state that offers more limited coverage. Choice #3 would effectively allow states to create a new EHB benchmark plan altogether.

- There are some limits on these new selections, including that there be an "appropriate balance" of all 10 EHB categories, that EHB benchmarks account for diverse health needs and not discriminate against individuals, that EHB selections must be at least equal to the scope of benefits provided under a "typical employer plan" (a floor), and that EHB benefits not exceed a newly created "generosity standard" (a ceiling).

- The "typical employer plan" (floor) is defined as any of the 10 base benchmark options available to the state in 2017, or the largest plan by enrollment of 1 of the 5 largest large group health insurance products in the state (that also meets other requirements).

- The final rule also creates a "generosity standard" (ceiling) that for the first time imposes a maximum set of benefits for all state EHB plans starting in 2020. This generosity standard requires that no EHB package include more generous benefits by actuarial value than the most generous of the 10 benchmark plan options available to the state in 2017. This generosity standard will make it difficult for states to offer more robust benefits than they did in the 2017 EHB selection. States are required to submit an actuarial value certification when submitting their new EHB benchmark choices to HHS.

Benefit Substitution

- Currently, a benefit can be substituted for another benefit *within* an EHB category. The NBPP final rule would give states the flexibility to allow for the substitution of benefits *between* EHB benefit categories, as long as the benefit substituted is not a drug benefit and is actuarially equivalent to the benefit being replaced.

- This would allow plans to effectively eliminate specific benefits in certain categories and be substituted with others of a different EHB category. It is likely that plans would therefore remove services for higher cost populations and replace them with less costly services more likely to be utilized by healthier individuals.

- In the final rule, HHS argues that existing EHB nondiscrimination protections and the "appropriate balance" requirement for EHB benefits (ie, so that benefits are not unduly weighted toward any one category) would prevent plans from eliminating EHB benefit categories altogether. However, it is likely that substitution across categories will lead to medically necessary services becoming no longer covered.

- Notably, the ACA requirement that pediatric preventive services be provided in accordance with *Bright Futures* without cost-sharing is in addition to the ACA EHB preventive services category requirement. Therefore, pediatric preventive services should continue to be provided without cost sharing, even under a scenario where benefits are substituted.

Why These Changes Are Important

- Allowing states to weaken EHB benefit packages has the potential to harm children and families in 2 ways. First, those with individual or small group coverage in states that amend their EHB packages may no longer have access to medically necessary services that were previously covered. Less robust benefit packages are particularly important for children with special health care needs (CSHCN) and those who may need specific, higher cost services.

- Second, while the EHB benefit package itself does not apply to large group coverage or self-insured plans, the ACA annual and lifetime dollar limits and out-of-pocket spending limits for all plans are specifically linked to EHB benefits. Moreover, large employers may choose *any state's* EHB benchmark for purposes of these protections.

- Therefore, large employers ostensibly could select any state's EHB benchmark for purposes of the ACA's annual/lifetime dollar limits and out-of-pocket spending protections; children and families in such plans may suddenly face both annual and lifetime dollar limits for services that fall out of the EHB package and would lose the ACA's out-of-pocket spending protections on those services as well.

EHB Selection Timetable

- The final rule set an aggressive timetable for states to select a new EHB package for 2020, with a due date of July 2, 2018. States that did not choose a new package for 2020 retain the 2017 package currently in use.

- The final rule also allows states to change their EHB package annually, replacing the current system where EHB changes are called for at intervals by HHS. While HHS has not identified a timetable for EHB selection beyond 2020, AAP chapters should become familiar with state mechanisms for EHB selection now—even if your state doesn't change its EHB package for 2020—as it may do so in the future.

AAP Chapter Advocacy Guidance

- Chapters are strongly encouraged to ensure that EHB benefit packages are not weakened, either through selection of a new benchmark or benefit substitution across EHB categories. Chapters may take the opportunity to seek a more robust EHB package but should first ensure that no harm is done to the existing EHB benchmark.
- This National Health Law Program (NHeLP) resource provides significant detail on steps states may take to update their EHB benchmarks; chapters can follow these basic steps:

1. **Determine your state's notice and comment period:** The NBPP final rule requires states to provide a public notice and comment period if the state chooses to change the EHB benchmark but does not provide additional details. Your state may already have an EHB notice and comment period in place or may create one for this purpose if it has not chosen EHB in the past. Ensure there is appropriate public notice and become familiar with your state's process.

2. **Determine who selects EHB in your state**: Your state may or may not have an EHB selection process in place – during the last EHB selection period, 26 states made no selection and defaulted to the largest small group plan. Some states require legislative approval of EHB benchmarks, while in other states your Insurance Commissioner or even Governor's office may select the EHB benchmark. Chapters are encouraged to work with other advocates to identify and connect with the authority making the EHB selection.

3. **Review current EHB**: Current state EHB benchmark documents for the 2017-2019 plan years are available here. Review your state's documents to better understand which benefits are provided in EHB (and, if available, which categories these benefits fall into), whether there are any soft limits (ie, prior authorization, visit caps) on services, and how benefits are supplemented in any categories not covered by the benchmark. Chapters may use the AAP's *State Roles in Defining Essential Health Benefits (EHB)* for specific guidance.

4. **Ascertain state EHB plans for the plan year and review any changes**: Talk to other advocates and state contacts and review state websites/notices to determine whether your state plans to make changes to EHB for the upcoming plan year. Your chapter may advocate that the state simply not undertake changes to EHB at this time. However, if your state decides to make a new EHB selection:

a. **Review the new benchmark plan selection and compare it to the existing EHB benchmark.** Should a state choose from one of the new EHB benchmark options, review plans in detail to determine how benefits will be changed. Advocate for more robust EHB benefits, but first ensure that benefits are not weakened. Advocates can appeal to EHB safeguards that require a final EHB to reflect balance among all 10 categories, account for diverse health needs across populations, and not discriminate against individuals because of age, disability, or life expectancy. Final EHB benchmarks must also be at least as robust as the "typical employer plan" (floor) selected by the state on an actuarial value basis.

b. **Advocate that the state prohibits substitution of benefits across EHB categories.** Chapters can advocate that the state prohibits plans from substituting benefits across categories, effectively replacing some benefits with others; this will ensure that all benefits in EHB are provided. As an example, California prohibits insurers from substituting EHB required benefits (CA Insurance Code § 10112.27(c))

c. **Pay particular attention to any state choice on the "typical employer plan."** States that make a new selection for 2020 will also have to choose a "typical employer plan." The "typical employer plan" selection will become the new benchmark floor for EHB in your state, and states have several options from which to choose. Selecting a limited benefit package as a "typical employer plan" will mean your state will be able to provide a less robust EHB, as any future EHB benchmark will only have to be as robust as that new baseline. In particular, states may choose 1 of the 5 largest large group health insurance products in the state as the "typical employer plan" – this choice is likely to provide fewer benefits than are currently found in your state's EHB selection. Advocate for as robust a "typical employer plan" selection as possible.

5. **Work with other advocates to make strong recommendations for a robust EHB benefit package and defend against any cuts.** While the EHB benchmark choice window offers chapters the opportunity to advocate for stronger EHB benchmarks, the new "generosity standard" ensures that benefits can be no more robust than any of the 10 EHB choices for 2017 on an actuarial value basis. This limits the opportunities for EHB to be strengthened; moreover, the NBPP final rule provides several ways for states to weaken EHB selections. As such, chapters should spend some time examining any proposed state changes to EHB to determine their exact impact. Advocate at public forums and file written comments painting a picture of how weakening EHB will directly hurt children and families, and work to ensure the state maintains as strong an EHB benefit package as possible. States may even choose to maintain EHB in state statute as **Connecticut** has recently done.

Other ACA Changes

The NBPP final rule makes other changes to ACA protections, offering states new flexibilities in some areas. These are briefly summarized below with guidance for AAP chapters:

- **Medical Loss Ratio (MLR)**: The NBPP final rule allows states to request an MLR adjustment if it determines there is a "reasonable likelihood" lowering the MLR below 80% will help stabilize the market. CMS provides information, including new technical guidance, for states seeking to lower their MLR here. A reduced MLR would

mean fewer premium dollars going toward the actual provision of medical care; AAP chapters should work with other advocates to ensure no inappropriate MLR reductions are made.

- **Rate Review**: The NBPP final rule changes the definition of an "unreasonable" health plan premium increase from 10% to 15%, and has issued guidance for states that would like a review threshold higher than 15%. Premium increases below the threshold do not have to undergo review and do not require justification. AAP chapters should work with other advocates to ensure states do not seek inappropriately high rate review thresholds.

- **Risk Adjustment**: The ACA's risk adjustment program is intended to transfer funds from insurers with a low-risk enrollee population to those with a relatively high-risk enrollee population, with a goal of reducing incentives for insurers to avoid high-risk enrollees. The NBPP gives states the ability to request a reduction in risk adjustment transfers of up to 50%, but states must demonstrate that such a reduction would only result in less than 1% increase in premiums. AAP chapters should advocate against reductions in risk adjustments that would negatively affect premiums, particularly for CSHCN.

- **Navigators**: The NBPP final rule eliminates the requirement that marketplaces have at least 2 navigator entities and that 1 must be a community-based nonprofit organization. Further, navigators will no longer be required to maintain a physical presence in the state. AAP chapters should work to maintain funding for navigators to ensure there a sufficient number to service all consumers, and guarantee those operating in the state are effectively guiding enrollees toward proper coverage.

- **Income inconsistencies**: The NBPP final rule changes requirements around income attestations, requiring marketplaces to end advanced premium tax credits if an enrollee cannot provide documentation demonstrating income above 100% of the federal poverty level (FPL) in cases where data matching sources may indicate a different income. Chapters are encouraged to ensure marketplace plans are not inappropriately removing people from coverage.

We're Here to Help

- The NBPP final rule is the latest federal effort to weaken ACA protections and to expand access to cheaper, less robust coverage, most notably by allowing states to offer altered EHB packages with fewer benefits. AAP chapters are encouraged to work with other physician and patient and family advocacy organizations in reviewing any state plans to change EHB benchmarks and to advocate for the strongest EHB package possible.

- AAP chapters are also encouraged to review other ACA-related changes made as a result of the NBPP and to advocate for the maintenance of child and family consumer protections.

- AAP chapters are encouraged to contact the AAP at stgov@aap.org with questions or for consultation and technical assistance on these issues.