Addressing Health Disparities Through the Essential Health Benefits

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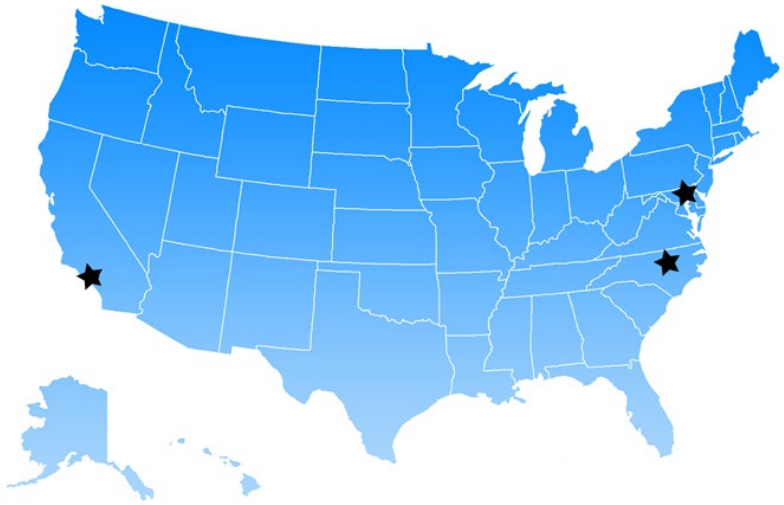
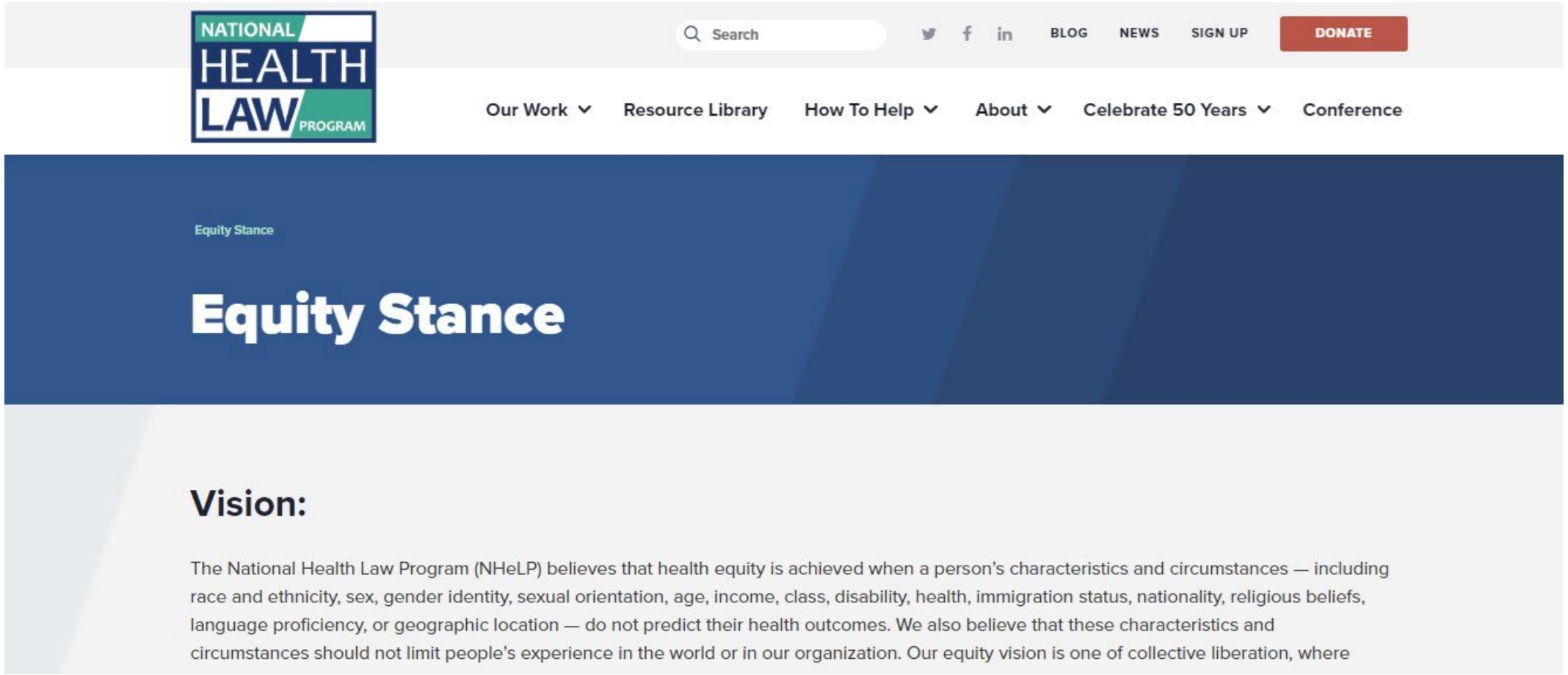
About the National Health Law Program

- National non-profit committed to improving health care access, equity, and quality for underserved individuals and families
- State & Local Partners:
  - Disability rights advocates – 50 states + DC
  - Poverty & legal aid advocates – 50 states + DC
- National Partners
- Offices: CA, DC, NC



Our Equity Stance



https://healthlaw.org/equity-stance/

Roadmap

- EHB authorities and compliance
  - HHS review and updating process
- The defrayal problem
- The generosity limit
- Best practices in EHB benchmark updating
  - State selection processes
  - Identifying unmet health needs
  - Engaging consumers and other stakeholders

Background on EHBs

- Pre-ACA - many plans had coverage gaps
  - 40% of plans did not cover maternity care

- EHBs = Set of benefits that non-grandfathered individual and small group insurance plans and Medicaid Alternative Benefit Plans must cover.
  - Most other plans (e.g., large employer) cannot impose annual or lifetime caps on EHB.
- At a minimum, they must include:
  - Ambulatory patient services;
  - Emergency services;
  - Hospitalization;
  - Maternity and newborn care;
  - Mental health and substance use disorder services;
  - Prescription drugs;
  - Rehabilitative and habilitative services and devices;
  - Laboratory services;
  - Preventive and wellness services (incl. family planning) and chronic disease management;
  - Pediatric services, including oral and vision care.

Essential Health Benefits (EHB)

- Sec. 1302 of the ACA: “the Secretary shall define the essential health benefits, except that such benefits shall include *at least*…”
  - Reflect balance among categories;
  - Account for diverse health needs across populations; and
  - Do not discriminate against individuals based on age, disability, or expected length of life

EHB compliance and enforcement

- HHS leaves it largely to states to define and enforce EHB
  - Before 2019: states select a benchmark plan from 10 commercial plans
  - After 2019: states keep their selected benchmark plan, select the benchmark plan from another state in its entirety, select categories of EHB from benchmark in another state, or create a new benchmark altogether
- HHS RFI on EHB: “a lack of consumer complaints about exclusions or claims denials.” 87 Fed. Reg. 74098
- Clarification: “a non-discriminatory benefit design that provides EHB is one that is clinically-based.” 45 CFR §156.125(a)

About Defrayal

- ACA requires states to defray the cost of new benefit mandates (post-2011)
- CCIIO clarified that states seeking new benefits/mandates through benchmarking will not be subject to defrayal
  - However, switching from state mandate to benchmarking mandate is not permitted (state will have to defray in that case)
- Benefit mandates not subject to defrayal when enacted to comply with federal requirements – see 45 CFR §155.170(a)(2)
- Changes in cost-sharing NOT subject to defrayal

Problems with EHB benchmarking

- Leads to vast inconsistencies and coverage gaps
- ACA consumer protections should not be based on commercial health plans
- Most states use small group plan as EHB benchmark
  - Least generous of the benchmark options
  - Embeds discriminatory benefit design
  - Perpetuates disparities
- Out2Enroll – 41 EHB benchmark plans exclude gender affirming care
- Only 2 states selected benchmarks that explicitly cover methadone for OUD
- See also NHeLP letter to HHS Sec. Becerra – *Re: Advancing Health Equity Through Essential Health Benefits*

Substantive changes to EHB benchmarking options for 2019+

EHB benchmark plan options:

- Selecting EHB benchmark plan used by another state in 2017
- Replacing one or more categories from the state's 2017 benchmark plan with the same category from another state's 2017 benchmark plan
- Selecting new benefits to create a whole new benchmark plan

- New default: previous year's benchmark

- State flexibility grants - September 15, 2021 to September 14, 2023

- Deadline for new EHB benchmark selection: First Wednesday in May

Benchmarking Process: Limits on Benchmark Options

Generosity Test (Ceiling):

Benchmark plan may not include more generous benefits than the most generous of the ten benchmark options the state had available in 2017

Typical Employer Plan (Floor):

Benchmark plan may not be less comprehensive than any one of the 2017 benchmark options or largest employer plan in the state

Key considerations for EHB benchmarking

- States have considerable EHB flexibility under federal rules
- Many states have no formal process for EHB benchmark selection
- Forty-two states plus the District of Columbia currently use a small group plan as the state's EHB benchmark
- Most states can add or improve benefits without exceeding the EHB generosity test and without triggering defrayal
- Nine states have added/improved benefits with minimal actuarial impact and minimal effect on premiums

Who selects EHB benchmark plans?

Inconsistency across states

- Lack of legal (or any formal) process in many states
- General lack of public information

- Broadly, we found states have:
  - A legislative selection process
    - CA, MD, NH, WA, CO, and NV
    - Degree of legislative involvement varies
  - A regulatory/delegated selection process
    - Express delegation through statute, e.g., NY, UT, NM
  - An unclear and/or undefined selection process
    - Many states w/ federal default plan (largest small group product in state), e.g., ND, IN, IA, AK, FL, MN, PA, WY, WV
    - Many states w/ virtually no authority found, e.g., IA, PA, WY, WV

Procedural requirements for benchmark selection

- Vague and ill-defined, but CMS has discretion to reject benchmark plan selections if state fails to comply with procedural requirements
- Public Process:
  - Notice
  - Public comment period
  - Posting “associated information” on the relevant state website

45 C.F.R. § 156.111(c)

- Best practices include:
  - forming a stakeholder group
  - engaging consumers
  - full transparency
  - prioritizing health equity

EHB benchmark selection processes can perpetuate health disparities

- Generosity cap plus potential impact on premiums limit what benefits states can add or improve through EHB
- Many states have no process for EHB benchmark selection
- Who wins?
  - Well-resourced conditions/constituencies
  - Politically connected interests/lobbyists
  - Insurers, provider groups, drug companies
- Who loses?
  - Underserved and marginalized populations
  - BIPOC, persons with disabilities, chronic conditions, LGBTQI+

➢An open, more equitable process that prioritizes the greatest health needs

Advancing health equity through EHB

- Center health equity using a data-driven process to identify unmet health needs
- Industry groups have more resources and power than consumers
- Educate consumers about the process and what is at stake
- Accountability to ensuring that people informing the process are diverse with regards to race, ethnicity, disability, income, LGBTQ+ etc.
  - Full disclosure of participants, consultants, conflict of interest
  - Post all comments, testimony, etc. received
- Provide light-lift ways for consumer groups to inform the process **early** (surveys, etc.)

Adding/improving benefits to comply with federal requirements does not depend on EHB benchmarking

- Mental Health Parity and Addiction Equity Act
  - Virginia Bulletin requiring plans to cover Autism Spectrum Disorder treatment
  - Washington Memo on covering behavioral health emergency services
- Section 1557
- Pre-existing conditions exclusions/discrimination (42 U.S.C. §§ 300gg-3; 300gg–4)
- EHB nondiscrimination provision (42 U.S.C. § 18022(b)(4) - 45 C.F.R. §156.125(a) "a non-discriminatory benefit design that provides EHB is one that is clinically-based.")
  - Colorado Letter on state law requiring plans to cover infertility treatment

- We have been asking CCIIO to clarify that these mandates are also exempt from the generosity limit

Best Practices for EHB Benchmark Updates

- **Engage** diverse stakeholders early on (including legislators in states that require legislation for benchmarking changes)
- **Ensure** consumer participation through open meetings, trainings, and a robust public comment period
- **Identify** unmet health needs and prioritize closing disparities through a data-driven approach
- **Recognize** that data gaps can perpetuate health disparities
- **Maximize** transparency
- **Establish** a formal regulatory framework for reviewing and updating the state's benchmark
- **Center** health equity when identifying and prioritizing the greatest unmet health needs

State Changes to EHB Benchmark Plans as of September 2023

Virginia	• Medical formula • Medically necessary myoelectric, biomechanical, or microprocessor-controlled prosthetic devices	2025+
North Dakota	• Hearing aids – one per 36 months • Nutritional benefits (screening and counseling) • Weight loss drug • Periodontal disease – acute or chronic • PET scans • Opioids – limits opioid prescriptions to 7 days, ends prior auth for OUD treatment • Insulin/Insulin supplies – limits cost sharing	2025+
Vermont	• Annual hearing exam and one set of hearing aids per year each 3 years	2024+
Colorado	• Adds annual mental health wellness visit • Adds alternatives for pain management including chiropractic, physical therapy, cognitive therapy • Adds acupuncture • Requires gender affirming care	2023+
Oregon	• Mandatory coverage of buprenorphine • Automatic coverage of naloxone when opioids are prescribed at 50 MME or higher • Adds coverage of non-opioid alternatives to treat pain	2022+
Michigan	• Mandatory coverage of buprenorphine • Automatic coverage of naloxone when opioids are prescribed at 50 MME or higher	2022+
Illinois	• Cover alternative therapies for pain, such as topical anti-inflammatories • Remove barriers to obtaining buprenorphine products for opioid use disorder treatment • Cover at least one intranasal spray opioid reversal agent when initial prescriptions of opioids exceed certain limit • Cover tele-psychiatry care	2022+
New Mexico	• Removes benefit limits for prosthetics • Expands eligibility for weight loss drugs and programs • Adds coverage of 3 naloxone formulations • Adds benefits for artery calcification testing and hepatitis C	2022+
South Dakota	• Adds applied behavior analysis for Autism Spectrum Disorder	2021+

Resources

National Health Law Program

- Essential Health Benefits: Best Practices in EHB Benchmark Selection
- Essential Health Benefits (EHB) benchmarking process
- NHeLP Letter to CCIIO Director, Ellen Montz, Re: Request for Modifications to the Federal Prescription Drug and Maternity Care Essential Health Benefit Standards
- NHeLP letter to HHS Sec. Becerra – Re: Advancing Health Equity Through Essential Health Benefits

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