SSB 5338 – Essential Health Benefits Benchmark Plan Update

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INSURANCE
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Essential health benefits under the Affordable Care Act (ACA)

Essential health benefits under the ACA

The ACA requires non-grandfathered health plans in the individual and small group markets to cover essential health benefits (EHB).

Essential health benefits (RCW 48.43.005):

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health & SUD services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Essential health benefits under the ACA

Under the ACA, each state must designate an EHB "benchmark plan" to serve as a benchmark, i.e. minimum coverage, for all individual and small group health plans offered in the state.

The ACA gave states options to choose from for their benchmark plan:

- Small group health plan with highest enrollment
- State employee health plan
- Federal employee health benefit plan
- HMO plan with highest enrollment

Washington EHB "benchmark plan"

RCW 48.43.715 directs OIC to, by rule, select the largest small group plan in the state by enrollment as the EHB benchmark plan in Washington state.

Most recent designation of the EHB benchmark plan was in 2016.

- Regence BlueShield Regence Direct Gold+ small group plan.

"Additional" essential health benefits

ACA requires states to defray any additional premium costs associated with new mandated benefits applicable to Qualified Health Plans (QHPs) adopted after December 31, 2011, except those needed to comply with federal law (e.g. Mental Health Parity and Addiction Equity Act (MHPAEA)).

Concern that states would add benefits to their EHB benchmark plans, making coverage more costly for consumers and increasing cost of federal Advance Premium Tax Credits.

"Additional" essential health benefits

Defrayal requirement applies to a state-required benefit. Includes care, treatment, and services that a carrier offering a QHP must provide to its enrollees.

- Examples: hearing aids, biomarker testing, fertility treatment.

Defrayal requirement does not apply to:

- Laws relating to providers and benefit delivery methods; e.g., telemedicine payment parity, prior authorization limitations, caps on insulin cost-sharing.
- Changes to comply with federal law; e.g., removing age limitations on benefits.

EHB benchmark plan update option

EHB benchmark plan update option

Final 2019 HHS Notice of Benefits and Payment Parameters gives states an opportunity to update their EHB benchmark plans for years 2020 and beyond.

If a state meets the requirements in the federal rules, including the "typicality" and "generosity" tests, benefits added to the state EHB through this EHB-benchmark plan selection process meet the definition of EHB and are exempt from the ACA defrayment requirement.

EHB benchmark plan requirements

- Equal or exceed the scope of benefits provided under a typical employer plan – "**typicality test.**"
- Not exceed the generosity of the most generous among a set of defined comparison plans – "**generosity test.**"
- Not include discriminatory benefit designs.
- Not have benefits unduly weighted towards any particular service category.
- Provide benefits for diverse segments of the population, including women, children, persons with disabilities, and other groups.

Limitations on benchmark plan update

Flexibility to create richer benefit package is limited by the "**generosity test.**"

Comparison plan for generosity test can be:

- State's 2017 benchmark plan, or
- Any of 10 plan options (e.g., small group market plan; state employee plan) available in Washington state in 2017.

Benchmark plan update process

Deadline for submission of EHB update request and supporting documents – May, two years prior to year the update would take effect.

- E.g., May 2024 for PY 2026.

State must submit to HHS/Center for Medicare & Medicaid Services/Center for Consumer Information and Insurance Oversight (CMS/CCIIO):

- Actuarial certification and report showing that the state meets both the "typicality" and "generosity" tests.
- Benchmark plan description, including benefits and limits.

State must give public notice and opportunity for comment.

Substitute Senate Bill 5338

SSB 5338

OIC must review Washington state's EHB benchmark plan to determine whether to request federal approval to update the plan.

- Requires consultation with interested parties and entities.

Benefits to be reviewed

Must determine potential impacts on plan design, actuarial value, and premium rates if these services were included in the EHB benchmark plan:

- Hearing instruments and associated services
- Fertility services
- Biomarker testing
- Contralateral prophylactic mastectomies
- Donor human milk
- Treatment for pediatric acute-onset neuropsychiatric syndrome (PANS) and pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDA)
- MRI for breast cancer screening

Benefits that must be included…

If OIC seeks approval to modify Washington state's EHB benchmark plan, the updated plan must include the following benefits:

- Donor human milk, per RCW 48.43.815; and
- Hearing instruments and associated services, as described in ESHB 1222.

Any EHB benchmark plan update request must be submitted to CMS/CCIIO by May 1, 2024 to take effect for Plan Year 2026.

Next steps

EHB Benchmark Plan Evaluation Actuarial Services

- OIC posted Request for Proposal (RFP) in May.
- Proposals are due June 27.
- OIC will review proposals and choose an actuarial firm.

OIC EHB Benchmark Plan Update website established

- Anyone can sign up for EHB Benchmark Plan Update email list via GovDelivery.
- Comments can be submitted at policy@oic.wa.gov.

Future public meetings planned with the chosen actuarial firm

Additional opportunities for public comment

EHB Benchmark Plan Updates in Other States

Other states' benchmark plan updates

State	Benefit changes	Plan Year effective
Colorado	Adds: • 15 drugs added as alternatives to opioids • 6 acupuncture visits per year • Annual mental health wellness exam • Gender affirming care	2023
Illinois	Adds: • Naloxone • Topical anti-inflammatory medication • Telepsychiatry care Limits opioid prescriptions for acute pain to no more than 7 days. Removes barriers to medication-assisted treatment (MAT) for opioid use disorder, such as prior auth.	2020

Other states' benchmark plan (cont.)

State	Benefit changes	Plan Year effective
Michigan	Adds: • Naloxone Removes barriers to MAT for opioid use disorder, such as prior auth.	2022
New Mexico	Adds: • Artery calcification testing • Weight loss treatment for obese members • Naloxone • Anti-Hepatitis C agents Removes benefit limit on prosthetics.	2022

Other states' benchmark plan (cont.)

State	Benefit changes	Plan Year effective
Oregon	Adds: • Up to 20 spinal manipulation visits per year. • Up to 12 acupuncture visits per year. • At least 1 intranasal opioid reversal agent (naloxone) Removes barriers to MAT for opioid use disorder such as prior auth.	2022
South Dakota	Adds: • Applied behavioral analysis for the treatment of Autism Spectrum Disorder	2021-2022
Vermont	Adds: • Hearing aids, including hearing aid repair/replacement; batteries; fitting and ear molds.	2024

Questions?

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