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Administration’s Proposed Changes to Essential Health Benefits Seriously Threaten Comprehensive Coverage

By Sarah Lueck

The Trump Administration has issued proposed regulations to substantially weaken the Affordable Care Act’s (ACA) Essential Health Benefits (EHB) standard. If these regulations are finalized as proposed, they would open the door to far skimpier benefits in the individual and small-group markets beginning in 2019.

The proposal is among the most consequential of a wide-ranging slate of proposed changes to ACA-related regulations that are open to public comment until November 27.¹ (The Administration has proposed the changes for 2019 plans, not the 2018 plans that are open for enrollment through December 15.) The EHB changes would allow states to drop or sharply limit the benefits that ACA plans cover, give insurers more latitude to deviate from a state’s EHB standard, and could lead to weaker ACA protections against catastrophic out-of-pocket costs in large employer plans. People with pre-existing medical conditions who have ACA-compliant plans could find they lack access to certain services they need, and anyone who faces a health issue could end up having to pay much more out of pocket.

ACA’s Benefit Rules Help Ensure Comprehensive Coverage

The ACA requires plans in the individual and small-group markets to cover ten general categories of essential benefits: emergency services, hospitalizations, outpatient care, maternity and newborn care, mental health and substance use disorder treatment, prescription drugs, rehabilitation services, laboratory services, preventive services and chronic disease management, and pediatric care. Probably, most people purchasing health insurance have always assumed that it covers these basic services. But before the ACA, it frequently didn’t. For example, in 2011, among people in the individual market:

- 62 percent had plans that didn’t cover maternity care;

¹ “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019,” proposed rule, 82 Fed. Reg. 51052-51148, November 2, 2017, <https://www.gpo.gov/fdsys/pkg/FR-2017-11-02/pdf/2017-23599.pdf>.

- 34 percent had plans that didn't cover substance use treatment;
- 18 percent had plans that didn't cover mental health treatment; and
- 9 percent had plans that didn't cover prescription drugs.²

The ACA also requires the Secretary of Health and Human Services to ensure that the “scope” of EHB coverage is equal to the scope of benefits provided under a “typical employer plan,” which helps set a minimum standard for what has to be covered within each general benefit category.

To flesh out the EHB standard, the Obama Administration established a process, through rules and guidance, for states to select an EHB “base benchmark plan” from among a menu of ten plan options, such as the largest three small-group plans or the largest three state employee health benefit plans, measured by enrollment. (Most states chose or defaulted to a small-group plan.³) Certain adjustments to the base benchmark plan were also generally required, often to ensure that all ACA-required benefits were included. The final result, with these adjustments, was the state’s “EHB benchmark,” and all individual market and small-group plans subject to the ACA generally must cover the items and services included in the state’s benchmark.

Proposed EHB Changes Would Provide New Options to Scale Back Benefits

Under the Trump Administration’s proposed rules, states would have several new options for modifying their EHB benchmarks in 2019 and any year after. States could:

- Adopt the EHB benchmark plan that any *other* state used in 2017;
- Use the same EHB benchmark plan as in 2017, but replace one or more benefit categories of that plan with those of other states’ EHB benchmark plans; or
- Create a new EHB benchmark plan from scratch.

The first two options would give a state with a relatively comprehensive EHB benchmark today much more leeway to drop or limit benefits. For example, a state with an EHB benchmark requiring coverage of autism services, bariatric surgery, hearing aids, infertility treatment, or transplant-related travel costs could select another state’s EHB benchmark plan that does not include these benefits.⁴ Then, all ACA-compliant individual-market and small-group plans in the state could drop those benefits too. Or, under the second option, a state could select specific benefit categories from other states’ benchmark plans, possibly leaving out some benefits within a

² Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, “Essential Health Benefits: Individual Market Coverage,” December 16, 2011, https://aspe.hhs.gov/basic-report/essential-health-benefits-individual-market-coverage#_edn2.

³ The current state benchmark plans can be found at: “Final 2017 Essential Health benefits Benchmark Plans,” Centers for Medicare & Medicaid Services, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Final-List-of-BMPs_4816.pdf.

⁴ For several benefits, states vary in whether or not they are included in the EHB benchmark. See, for example, “Essential Health Benefits: Benchmark Plan Comparison 2017 and Later,” Cigna, January 2017, <https://www.cigna.com/assets/docs/about-cigna/informed-on-reform/top-11-ehb-by-state-2017.pdf>.

category that are now included in the state’s benchmark. A state could even piece together a standard by choosing the least-comprehensive state benchmark for each benefit category.

The third option, creating a new EHB benchmark plan from scratch, is potentially more radical. While the state would have to continue including all ten required categories of EHB benefits, it could significantly scale back coverage *within* EHB categories, dropping or severely limiting some items and services within the category.⁵

A state opting to create a new EHB benchmark from scratch would have to show that “the scope of benefits” is equivalent (based on an actuarial calculation⁶) to what certain types of employer plans provide — either a small-group, large-group, or self-insured group plan with at least 5,000 enrollees. This is intended to satisfy the ACA requirement that the scope of benefits reflect that of a typical employer plan. But some employer plans that potentially meet the proposed standard provide very thin coverage and may not be “typical” at all.

For example, some employer plans may sharply limit the number of hospital days or doctor visits available each year. Some employer plans may cover only generic medications, or provide limited coverage of brand-name drugs. It appears the proposed rule might even allow a state to use, as the basis for creating its new EHB benchmark plan, an employer plan that covers only preventive services but not emergency services, prescription medications, or most inpatient hospital services.⁷ A state would have to add benefits to such a plan in order to meet other requirements, including the federal requirement to cover all ten EHB categories, but there would be no point of comparison for the benefits covered in each of those added categories — the choices would be entirely up to the state.⁸ In other words, if such a low-value employer plan has sufficient enrollment to allow a state to use it as the basis for crafting a new EHB benchmark, it would greatly reduce the overall value of the ACA benefit package, giving the state far-ranging new ability to cut back or limit coverage within the EHB categories.

⁵ The state would also be required to ensure that its EHB benchmark plan did not exceed the generosity of the most generous of a set of comparison plans: the state’s 2017 EHB benchmark, or any of the “base benchmark” plan options available to the state for 2017.

⁶ A document released along with the proposed rule provides a “draft example” of a method that actuaries could use to compare a state’s new EHB benchmark plan to a “typical employer plan,” as defined by the new proposed rule. It suggests calculating the expected value of covering all benefits under the typical employer plan, assuming 100 percent of the costs are paid by the plan, and then comparing that result to the expected value of covering all benefits in the state’s proposed EHB benchmark plan. The example says the comparison “should demonstrate” that each benefits category in the selected employer plan has an expected value of “at least 98 percent” of the state’s proposed benchmark plan. The proposed rule does not require use of this method. See: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Example-Acceptable-Methodology-States-EHB.pdf>.

⁷ For publicly available examples of employer plans that cover preventive services only (one type that apparently could be used under the proposed EHB process if they have sufficient enrollment), see 2017 Minimum Essential Coverage Plan from National DCP, https://nationaldcp.com/sites/default/files/public/2017_MECPan.pdf and PanaBridge Advantage 2017 Benefit Guide for KHI Solutions, <https://www.khisolutionsinc.com/docs/Enrollment%20Information%20Packet%202017.pdf>.

⁸ The proposed rule includes requirements for states changing their EHB benchmarks to also ensure that benefits are “not unduly weighted” toward any of the ten required benefit categories and that the benchmark “provides benefits for diverse segments of the population, including women, children, persons with disabilities, and other groups.” The proposed rule also retains existing requirements for EHB coverage of prescription drugs.

Regardless of which of these three proposed options a state might select, and even in states that make *no* EHB changes, insurers in the individual and small-group markets would get more leeway to deviate from the state’s EHB standard under the proposed rule — unless a state prohibits it. The rule would allow insurers to substitute benefits across categories, instead of only within a given category as under current rules. This might permit an insurer to, for example, scale back coverage of hospital care or rehabilitative and habilitative services and then beef up coverage of outpatient physician visits and urgent care to make up the difference. But patients needing costly hospital care or rehabilitation could end up with large gaps in coverage and have to pay more out of pocket.

And, in future years, as states scale back their EHB standards, the rule would allow other states to adopt those weaker requirements as well, so weaker EHB standards could spread extensively over time. The Administration also indicated in the proposed rule that it is considering adopting a “federal default” definition of EHB that would limit what states could require insurers to cover.

Many States Would Likely Take Up Proposed Options to Scale Back Benefits

The proposed rule leaves the decision about whether to modify the EHB standards up to each state, at least for now. It does not require states to make changes. If given the chance, however, many states likely would.

Since the ACA’s passage in 2010, some state officials have complained that it requires plans to cover too expansive a set of benefits. For example, Ohio Lieutenant Governor Mary Taylor wrote in 2011 that under the law, “you would still have to carry insurance that covers pediatric, maternity and newborn care even though you do not need it.”⁹ In a 2017 set of recommendations on health care, Oklahoma officials said the state “plans to re-evaluate and reduce the Essential Health Benefits package that has been mandated by the ACA.”¹⁰

Now that numerous efforts by congressional Republicans to repeal the ACA — which would have allowed states to scale back EHB standards — have failed so far, ACA critics are looking for other avenues to damage the law outside the federal legislative process. For example, Trump Administration’s actions undermining the ACA markets have led to higher 2018 premiums for individual-market enrollees whose incomes are too high to qualify for ACA subsidies.¹¹ (The premium is the cost of buying an insurance plan; subsidized people pay only a portion of their income toward the premium cost, with federal subsidies filling in the rest.) President Trump’s recent executive order could lead to additional changes that destabilize ACA markets and further increase premiums for unsubsidized people.¹²

⁹ Mary Taylor, “Obamacare Suggests Government Knows Best — Not the Consumer,” September 8, 2011, <http://www.insurance.ohio.gov/Newsroom/Pages/09082011LtGovObamacare.aspx>.

¹⁰ A New Horizon: Recommendations for Oklahoma’s Modernized Health Insurance Market, submitted by the Secretary of Health and Human Services, State of Oklahoma, March 2017, p. 23. <https://www.ok.gov/health/documents/1332%20Waiver%20Concept%20Paper.pdf>.

¹¹ Aviva Aron-Dine and Tara Straw, “The Outlook for Marketplace Open Enrollment,” Center on Budget and Policy Priorities, October 30, 2017, <https://www.cbpp.org/research/health/the-outlook-for-marketplace-open-enrollment>.

¹² Sarah Lueck, “Trump Order Could Destabilize Health Insurance Markets, Hurt Those with Pre-Existing Conditions,” October 12, 2017, <https://www.cbpp.org/blog/trump-order-could-destabilize-health-insurance-markets-hurt-those-with-pre-existing-conditions>.

These changes, as well as concerns about other destabilizing federal policies that could be implemented in the future, could pressure states that want to help reduce premium costs for people who lack subsidies to look for ways to bring down the cost of ACA plans. They might seek to do so by weakening EHB standards, even though that approach would raise consumers' out of pocket costs and reduce access to important services for some enrollees.

The Centers for Medicare & Medicaid Services (CMS) estimates that, under the proposal, ten states per year, or 30 states over three years, would opt to modify their EHB standards.¹³ CMS also acknowledges that states are more likely to modify their EHB benchmarks to *reduce* benefits (and therefore premiums) than to increase them.¹⁴

Notably, many potential ideas for scaling back EHB coverage may significantly raise costs for particular groups of beneficiaries without significantly reducing overall premiums. Some of the benefits most often targeted for proposed cutbacks (such as rehabilitative services, habilitative services, and maternity care) account for a relatively small portion of the overall premium, yet scaling back coverage of these benefits would raise out-of-pocket costs significantly for the people who need them. And slashing coverage of more commonly used benefits, such as prescription drugs, might help bring down premium costs, but could raise insurers' costs in other areas over time, if people forgo or delay needed care such as maintenance drugs for a chronic condition and end up needing expensive services such as hospitalization.¹⁵

Changes Could Weaken Cost Protections for People with Large Employer Plans

The proposed rules could adversely affect health benefits for employees of large and self-insured employers as well because key ACA cost protections — specifically, the ban on annual and lifetime benefit limits and the requirement for plans to cap enrollees' yearly out-of-pocket costs — are linked to the definition of essential health benefits. A benefit within a required benefit category that is no longer an *essential* benefit wouldn't be included in these protections. And for purposes of annual and lifetime limits, a large employer plan could (at least under current guidance) select the skimpiest state

¹³ “Supporting statement for Essential Health Benefits Benchmark Plans,” Centers for Medicare & Medicaid Services, October 27, 2017, available at <https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10448.html?DLPage=1&DLEntries=10&DI.Sort=1&DI.SortDir=descending>.

¹⁴ “HHS Notice of Benefit and Payment Parameters for 2019,” *op cit.*, pp. 51134. The Congressional Budget Office similarly found that states with up to half the population would take up waivers under the House-passed repeal bill and the failed Senate Republican leadership repeal bill, both of which would seriously weaken EHB requirements in response to other aspects of those bills. Congressional Budget Office, “H.R. 1628; American Health Care Act of 2017,” May 4, 2017, <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf>. And “H.R. 1628; Better Care Reconciliation Act of 2017,” June 26, 2017, <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52849-hr1628senate.pdf>.

¹⁵ Linda J. Blumberg and John Holahan, “The Implications of Cutting Essential Health Benefits: An Analysis of Nongroup Insurance Premiums under the ACA,” July 2017, https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf438507.

EHB standard to determine which items and services could be limited, even if the employer is not located in that state and has no employees there.¹⁶

Some experts are already questioning whether the proposed EHB changes are legal.¹⁷ And questions remain about how they would work in practice, even if they could be implemented as is. But there's no question that the proposed changes could put comprehensive benefits at risk for enrollees in the individual and small-group markets, and possibly weaken protections against catastrophic costs for people with large-employer coverage as well.

¹⁶ Matt Fiedler, "Allowing states to define 'essential health benefits' could weaken ACA protections against catastrophic costs for people with employer coverage nationwide," Brookings Institution, May 2, 2017, <https://www.brookings.edu/2017/05/02/allowing-states-to-define-essential-health-benefits-could-weaken-aca-protections-against-catastrophic-costs-for-people-with-employer-coverage-nationwide/>

¹⁷ Nicholas Bagley, "Trump and the Essential Health Benefits," The Incidental Economist blog, October 30, 2017, <https://theincidentaleconomist.com/wordpress/legal-problems-with-relaxing-the-essential-health-benefits/>.