



## Issue Brief:

# California State Benefit Mandates and the Affordable Care Act's Essential Health Benefits

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## KEY FINDINGS

Beginning in 2014, the federal Patient Protection and Affordable Care Act (ACA) of 2010 required some (but not all) forms of health insurance to cover a set of Essential Health Benefits (EHBs). EHBs are 10 statutory categories of tests, treatments, and services for which coverage is required by federal regulation based on a state plan benchmark.<sup>1</sup>

For 2022, the California Health Benefits Review Program (CHBRP) estimated that 10.8% of Californians are enrolled in commercial health insurance that must cover EHBs.<sup>2</sup>

This issue brief provides:

- Background on EHBs in California and how they interact with current and proposed state benefit mandates.
- California's current options for altering its EHBs and how a number of other states have done so.
- How (although CHBRP is unaware of any that have been determined to have done so) a state benefit mandate could exceed EHBs and potentially trigger a requirement to defray the additional cost.

### *Essential Health Benefits: Overview*

In California, commercial health insurance required to cover EHBs include non-grandfathered commercial plans and policies sold in the individual and small-group markets, the majority of which are sold through Covered California, California's health insurance marketplace.<sup>3</sup>

According to the ACA, although there can be some variation between states as to the details of EHBs, EHBs must include the following broad categories of benefits: (1) Ambulatory patient services, (2) Emergency services, (3) Hospitalization, (4) Maternity and newborn care, (5) Mental health and substance use disorder services, including behavioral health treatment, (6) Prescription drugs, (7) Rehabilitative and habilitative services and devices, (8) Laboratory services, (9) Preventive and wellness services and chronic disease management and (10) Pediatric services, including oral and vision care.<sup>4</sup>

To comply with the ACA and federal guidance by 2014, each state was required to define EHBs based on one of ten possible benchmark plan options already offered in the state, and to add any EHB category not included in the chosen option (but now required by federal law, such as pediatric vision care). As a benchmark plan option, California selected the "largest plan by enrollment in any of the three largest small-group insurance products in the state's small-group market." For California, that was the Kaiser Foundation Health Plan Small Group HMO 30 plan, which was supplemented with additional benefits in order to meet the broad requirements of EHBs.<sup>5</sup>

### State benefit mandates that exceed essential health benefits

For plans and policies required to cover EHBs, the ACA allows a state to require coverage for additional benefits. However, if the state does so, the state may be required to make payments to the enrollee or to their qualified health plan defray the cost of those additionally mandated benefits. State benefit mandates

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<sup>1</sup> Refer to CHBRP's full report below for full citations and references.

<sup>2</sup> See CHBRP's resource, *Estimates of Sources of Health Insurance in California*, available at: [https://chbrp.org/other\\_publications/index.php](https://chbrp.org/other_publications/index.php)

<sup>3</sup> Medi-Cal, California's Medicaid program, is also required by the ACA to cover a set of benefits referred to as EHBs, but, as discussed in Appendix B, Medi-Cal EHBs are separate from and function independently from the EHBs commercial health insurance is required to cover.

<sup>4</sup> 42 U.S.C. §18022

<sup>5</sup> Information on Essential Health Benefits (EHB) Benchmark Plans. *Centers for Medicare and Medicaid Services*. 2019. Accessed on December 16, 2019 at: <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb>

enacted before December 31, 2011 are considered part of that state's EHBs and the requirement that the state defray the costs of these mandated benefits is waived.<sup>6</sup>

For a state benefit mandate to exceed EHBs in California, the following must be true:

- (1) The state benefit mandate applies to qualified health plans or their off-exchange mirror equivalent plans or policies). Qualified health plans are the plans and policies sold through a state marketplace, such as Covered California. Mirror equivalents are plans and policies substantively the same as those sold by a plan or insurer through Covered California.
- (2) The state benefit mandate is not covered in the Kaiser Foundation Health Plan Small Group HMO 30 plan that defines the current EHB benchmark package in California or in the additional specified benefits.
- (3) The state benefit mandate is not covered under basic health care services, as required by the Knox-Keene Health Care Service Plan Act of 1975.<sup>7</sup>
- (4) The state benefit mandate is specific to care, treatment, and/or services, thus meeting the federal definition of a benefit mandate that could exceed EHBs.

Changes to service delivery method, provider types, cost sharing, or reimbursement methods do not fall under category (4) and therefore would not trigger the requirement for the state to defray the cost.

Federal regulations state the "State" is responsible for determining whether a benefit exceeds EHBs, subject to federal oversight. However, the regulations do not designate this responsibility to a specific agency or individual and. At this time, CHBRP is not aware that California has officially determined who or which agency would be responsible. Additionally, although CHBRP has analyzed bills that could have done so, CHBRP is unaware of any state mandate passed into law that has been determined to exceed EHBs.

### *Altering Essential Health Benefits*

The Department of Health and Human Services (HHS) issued a final rule in 2018 (and a similar final rule in 2019) which provided new flexibility for states by allowing three new options for the EHB benchmark plan, in addition to the option of retaining the current EHB benchmark plan, beginning with the 2020 plan year.<sup>8</sup> States could: (1) select an EHB benchmark plan used by another state for the 2017 plan year, (2) replace one or more of the 10 EHB categories in the state's EHB benchmark plan with the same category or categories of EHBs from another state's 2017 EHB benchmark plan, or (3) otherwise select a set of benefits that would become the state's EHB benchmark plan. At a minimum, the EHB benchmark plan must provide a scope of benefits equal to or greater than a typical employer plan. Furthermore, a new "generosity test" requires that EHBs cannot exceed the generosity of the most generous among the set of 10 previous 2017 benchmark comparison plan options.

### *Other States*

A number of other states have secured approval to alter their EHBs.<sup>9</sup> For Illinois, changes were approved for 2020 plan year. For South Dakota changes were approved for the 2021 plan year. For three states, Michigan, New Mexico, and Oregon, changes were approved for the 2022 plan year. For Colorado, changes were approved for the 2023 plan year.

The details of the changes varied. For example, Illinois modified the prescription drug category and mental health substance use disorder services category by altering pain treatment options and expanding

<sup>6</sup> 42 U.S.C. §18031(d)(3)(B) and 45 CFR §155.170(b).

<sup>7</sup> The Kaiser Foundation Health Plan Small Group HMO 30 plan is a DMHC-regulated plan and, as such, is subject to the Knox-Keene Health Care Service Plan Act of 1975 that requires coverage of medically necessary basic health care services. Therefore, medically necessary basic health care services are a part of the EHB coverage requirement in California.

<sup>8</sup> 83 FR 16930 and 84 FR 17454

<sup>9</sup> Information on Essential Health Benefits (EHB) Benchmark Plans. *Centers for Medicare and Medicaid Services*. 2019. Accessed on January 3, 2022 at: <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb>

access to mental health services and South Dakota supplemented its habilitation services category with Applied Behavioral Analysis treatment for Autism Spectrum Disorder.

To obtain approval, states were required to submit actuarial analyses demonstrating that these EHB additions would not exceed the most generous comparison plan, thus satisfying the generosity test.

States that opted not to seek approval for change have continued to use the same EHB-benchmark plan from plan years 2017-2019.

### California Options

By selecting some or all categories from another state's EHB benchmark plan or otherwise selecting a set of benefits, California could include new services that are not currently covered under the California benchmark plan. CHBRP is aware of three specific benefits that are covered by the majority of other state EHB benchmark plans but that are not included in the current Kaiser Foundation Health Plan Small Group HMO 30 plan: chiropractic care services, hearing aids, and infertility services and treatments (most incorporating utilization management and other limits to these benefits).<sup>10</sup>

### Conclusion

HHS's regulations provide an opportunity for states to modify or select a new EHB benchmark plan. Though the regulations allow for considerable flexibility, HHS maintains a minimum scope of benefits floor as well as a "generosity test" ceiling. Within these confines, California can look to states that have already done so and could alter its EHBs for a future plan year.

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<sup>10</sup> See the Cigna document, *Essential Health Benefits: Benchmark Plan Comparison 2021 and Later*, access on January 3, 2022, accessible at: <https://www.cigna.com/assets/docs/about-cigna/informed-on-reform/top-11-ehb-by-state-2017.pdf>

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## CALIFORNIA STATE BENEFIT MANDATES AND THE AFFORDABLE CARE ACT'S ESSENTIAL HEALTH BENEFITS

Beginning in 2014, the federal Patient Protection and Affordable Care Act (ACA) of 2010 required some (but not all) forms of health insurance to cover a set of Essential Health Benefits (EHBs).<sup>11</sup> The EHB coverage requirement interacts with California's existing laws and may interact with proposed health insurance benefit mandate (or repeal) legislation. The California Health Benefits Review Program (CHBRP)<sup>12</sup> produced this issue brief to provide background on EHBs in California and how they could change in future years. Specifically, this brief provides:

- A description of state benefit mandates and enrollees with health insurance subject to state benefit mandates in California; and
- An overview of how EHBs are defined at the federal level and in California, including how federal Department of Health and Human Services regulations allow a state to alter its selection of an EHB benchmark plans and so alter its definition of EHBs.

### What Are State Health Insurance Benefit Mandates?

As defined by CHBRP's authorizing statute,<sup>13</sup> California's health insurance benefit mandate laws can require health insurance products to provide coverage or offer coverage for any of the following: (1) coverage for screening, diagnosis, or treatment of a specific disease or condition; (2) coverage for specific types of health care treatments or services; (3) coverage for services by specific types of health care providers; and/or (4) the provision of coverage with specified terms that may affect cost sharing, prior authorization requirements, or other aspects of benefit coverage. As of 2022, CHBRP is aware of 82 health insurance benefit mandate laws in California.<sup>14</sup>

### Health Insurance Subject to State Benefit Mandates in California

California's state benefit mandates only apply to the benefit coverage of enrollees with health insurance regulated by either the California Department of Managed Health Care (DMHC), which regulates *health care service plans*, or the California Department of Insurance (CDI), which regulates *health insurance policies*.<sup>15</sup> This accounts for approximately 56% of Californians (21.9 million) in 2022.<sup>16</sup>

#### *State benefit mandates in Covered California*

The ACA requires the establishment of health insurance marketplaces that sell health insurance in the small-group and individual markets.<sup>17</sup> California chose to set-up its own state-run marketplace, but states also have the option of allowing the federal government to run the state marketplace or selecting a hybrid partnership alternative with the federal government. Plans and policies certified and sold through the

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<sup>11</sup> 42 U.S.C. § 18022

<sup>12</sup> The California Health Benefits Review Program (CHBRP), established in 2002, responds to requests from the California State Legislature for independent, evidence-based analysis of the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals. Additional information about the program is available on CHBRP's website at: [www.chbrp.org](http://www.chbrp.org).

<sup>13</sup> Available at: [http://chbrp.com/about\\_chbrp/index.php](http://chbrp.com/about_chbrp/index.php).

<sup>14</sup> Annually updated, the CHBRP resource *Health Insurance Benefit Mandates in California State Law* lists state and federal benefit mandate laws applicable to health insurance in California. It is available at: [www.chbrp.org/other\\_publications/index.php](http://www.chbrp.org/other_publications/index.php).

<sup>15</sup> California has a bifurcated system of regulation for health insurance. DMHC regulates health care service plans, which offer benefit coverage to their enrollees through health plan contracts. The California Department of Insurance (CDI) regulates health insurers, which offer benefit coverage to their enrollees through health insurance policies.

<sup>16</sup> See the CHBRP resource, *Estimates of Sources of Health Insurance*. Available at:

[http://chbrp.org/other\\_publications/index.php](http://chbrp.org/other_publications/index.php)

<sup>17</sup> 42 U.S.C. § 18031

marketplace are called qualified health plans (QHPs). QHPs sold through Covered California, California's insurance marketplace,<sup>18</sup> are regulated by DMHC or CDI, and thus are subject to the state's benefit mandates.

## Federal Benefit Mandates

In addition to state benefit mandates, there are also federal benefit mandates, some of which interact with state benefit mandates and EHB coverage requirements (discussed below). Like state benefit mandates, federal benefit mandates generally apply to both the individual and group market, unless a market is specifically excluded. However, federal benefit mandates may also apply to Medicare or to self-insured plans, which are not subject to state benefit mandates. For more detailed information on current federal benefit mandates, see *Appendix A: Federal Benefit Mandates*, as well as CHBRP's resource *Federal Preventive Services Mandate and California Mandates and Health Insurance Benefit Mandates in California State Law*.<sup>19</sup>

## Essential Health Benefits: Overview

### Essential Health Benefits Defined: Federal Requirements and Guidance

The ACA requires the Secretary of the U.S. Health and Human Services (HHS) to define EHBs through regulation, but requires that at least some items and services within 10 specific categories of benefits be included.<sup>20</sup> See Exhibit 1 for the full list.

When defining EHBs within the 10 EHB categories, the Secretary of HHS must ensure that the EHB floor "is equal to the scope of benefits provided under a typical employer plan."<sup>21</sup> The Secretary of HHS is required to take into account: the need for balance between the 10 ACA-specified EHB categories; the needs of diverse segments of the population; and the need to not discriminate against individuals because of age, disability, or expected length of life.

For plan years 2014 through 2019, EHBs for nongrandfathered plans and policies in the small-group and individual markets were defined in a manner that allows for state flexibility.<sup>22</sup> States selected from four benchmark plan options that reflect the scope of services offered by a typical employer plan and then supplemented it to ensure it includes all 10 EHB categories and met the other ACA requirements (e.g., balance between the 10 EHB categories, nondiscrimination). A health plan or policy is required to offer benefits that are "substantially equal" to the benefits of the selected benchmark plan. Plans or policies can substitute coverage within a benefit category, with the exception of the prescription

#### Exhibit 1: The 10 Essential Health Benefit Categories

- 1) Ambulatory patient services;
- 2) Emergency services;
- 3) Hospitalization;
- 4) Maternity and newborn care;
- 5) Mental health substance use disorder services, including behavioral health treatment;
- 6) Prescription drugs;
- 7) Rehabilitative and habilitative services and devices;
- 8) Laboratory services;
- 9) Preventive and wellness services and chronic disease management; and
- 10) Pediatric services, including oral and vision care.

<sup>18</sup> The California Health Benefits Exchange, Covered California, Authorizing Statute is available here: [http://www.leginfo.ca.gov/pub/09-10/bill/sen/sb\\_0851-0900/sb\\_900\\_bill\\_20100930\\_chaptered.html](http://www.leginfo.ca.gov/pub/09-10/bill/sen/sb_0851-0900/sb_900_bill_20100930_chaptered.html) and here: [http://www.leginfo.ca.gov/pub/09-10/bill/asm/ab\\_1601-1650/ab\\_1602\\_bill\\_20100930\\_chaptered.html](http://www.leginfo.ca.gov/pub/09-10/bill/asm/ab_1601-1650/ab_1602_bill_20100930_chaptered.html)

<sup>19</sup> Available at: [www.chbrp.org/other\\_publications/index.php](http://www.chbrp.org/other_publications/index.php).

<sup>20</sup> 42 U.S.C. §18022(b).

<sup>21</sup> 42 U.S.C. §18021(b)(2)(A).

<sup>22</sup> Department of Health and Human Services, Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule. *Federal Register*, Vol. 78, No. 37. February 25, 2013. Available at: [www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf](http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf). Accessed August 27, 2019.

drug benefits category, so long as they do not reduce the value of coverage; the substituted benefits must be actuarially equivalent to the benefits being replaced. States can enforce stricter requirements on benefit substitution or prohibit it entirely.<sup>23</sup>

The rest of this section discusses initial choices defining EHBs. Further regulation that allows modification of the EHB benchmark plan for later plan years is discussed in a later section of this document.

## Exhibit 2. Choosing the Initial “EHB-Benchmark Plan” for Plan Year 2014

To begin to define EHBs, states selected a benchmark plan sold in 2012 from one of several options that reflected the scope of services offered by a typical employer plan.

- The largest plan by enrollment in any of the three largest small-group insurance products in the state’s small-group market;
- Any of the largest three state employee health benefit plans by enrollment;
- Any of the largest three national Federal Employee Health Benefits Plan (FEHBP) options by enrollment; or
- The largest insured commercial non-Medicaid HMO operating in the state.

If a state did not select a benchmark plan, the default benchmark plan was the largest plan by enrollment in any of the three largest small-group insurance products in the state’s small-group market. Enrollment for selection of a benchmark plan was based on the first quarter of calendar year 2012. The benchmark plan selected by a state, or the federal government for a state, is known as the “base-benchmark plan.” The initial base-benchmark plan chosen in 45 states and the District of Columbia is the largest plan by enrollment in any of the three largest small-group insurance products in the state’s small-group market. (a)

As needed, the base-benchmark plan must be supplemented to ensure it includes all 10 EHB categories. If a base-benchmark plan does not provide services within a specific EHB category, it has to be supplemented “by adding that particular category in its entirety from another base-benchmark plan option.” Further, the base-benchmark plan must be assessed to ensure it has a balance between the 10 EHB categories and meets the standards for nondiscrimination, as required by the ACA. The resulting supplemented package is known as the “EHB-benchmark plan.”

*Notes:* (a) Department of Health and Human Services, Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule. *Federal Register*, Vol. 78, No. 37. February 25, 2013. Available at: [www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf](http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf). Accessed August 28, 2019.

## Health Insurance Subject to the Essential Health Benefits Coverage Requirement

As of January 1, 2014, the ACA required most health insurance products in individual and small-group markets to cover EHBs.<sup>24</sup> The ACA requires coverage of EHBs for almost all enrollees in the individual and small-group markets, both inside and outside Covered California (Table 1).<sup>25</sup> Inside Covered California, all QHPs are required to provide coverage of EHBs,<sup>26</sup> while outside Covered California, nongrandfathered plans and policies in the individual and small-group market are required to cover EHBs.<sup>27</sup> Large group, self-insured and grandfathered plans and policies are exempt from the EHB

<sup>23</sup> Essential Health Benefits Final Rule. *Federal Register*, Vol. 87, No. 27. February 25, 2013. Available at: [www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf](http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf).

<sup>24</sup> 42 U.S.C. §300gg-6.

<sup>25</sup> 42 U.S.C. §18022.

<sup>26</sup> 42 U.S.C. §18021.

<sup>27</sup> 42 U.S.C. §300gg-6.



requirements.<sup>28</sup> For 2022, CHBRP estimated that 10.8% of Californians are enrolled in commercial health insurance that must cover EHBs.<sup>29</sup> Medi-Cal, California's Medicaid program, is also required by the ACA to cover a set of benefits referred to as EHBs, but, as discussed in Appendix B, Medi-Cal EHBs are separate from and function independently from the EHBs commercial health insurance is required to cover.

### Exhibit 3. Additional Guidance on the Initial “EHB-Benchmark Plan”

For defining and meeting the requirements for the EHB-benchmark plan for the 10 EHB categories, HHS provided the following additional guidance:

- **Pediatric services, including oral and vision care:** HHS defined pediatric care as up to age 19, but allowed state flexibility to extend pediatric coverage beyond this age limit. In regards to the benefits covered, HHS found that pediatric oral and vision services were generally not covered in the benchmark plan options. Therefore, HHS guidance identified two options states could use to supplement their base-benchmark plan to meet this coverage requirement: (1) the Federal Employees Dental and Vision Insurance Program (FEDVIP) plan with the largest enrollment; or (2) the state's separate Children's Health Insurance Program (CHIP). (a)
- **Habilitative services:** Habilitative services was another area HHS found was not covered as a distinct group of services by insurers. If the base-benchmark plan needed to be supplemented to meet the habilitative services EHB coverage requirement, HHS guidance allowed for one of the following to define habilitative services: (1) states could define the benefits that should be included in this category; or (2) if a state does not define habilitative services, a health insurance issuer must either provide coverage for habilitative services in parity with rehabilitative services or decide what habilitative services to cover.
- **Mental health and substance use disorder services:** Coverage within this EHB category must meet the Mental Health Parity and Addiction Equity Act (MHPAEA), which previously did not apply to the individual market and small group market in California. (b)
- **Preventive and wellness services:** The ACA requires nongrandfathered group and individual market plans and policies to cover certain preventative services without cost sharing. (c) The guidance on EHBs requires coverage of these services to be included to meet the definition of EHBs.

*Notes:* (a) For more detail, CHBRP has a Policy Brief focused on pediatric oral and vision care component of EHBs, available here: [www.chbrp.org/other\\_publications/index.php](http://www.chbrp.org/other_publications/index.php).

(b) The MHPAEA previously only applied to group plans and policies with more than 50 employees ([www.dol.gov/ebsa/newsroom/fsmhpaea.html](http://www.dol.gov/ebsa/newsroom/fsmhpaea.html)). California defines the small group as 50 or fewer employees.

(c) ACA Section 1001, modifying Section 2713 of the Public Health Service Act. CHBRP has a Resource looking at the preventive services coverage requirement in the ACA, available here: [www.chbrp.org/other\\_publications/index.php](http://www.chbrp.org/other_publications/index.php). Also, see Appendix A: Federal Benefit Mandates.

<sup>28</sup> A grandfathered health plan is defined as: “A group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their “grandfathered” status if they make certain significant changes that reduce benefits or increase costs to consumers” ([www.healthcare.gov/glossary/grandfathered-health-plan/](http://www.healthcare.gov/glossary/grandfathered-health-plan/)).

<sup>29</sup> See CHBRP's resource, *Estimates of Sources of Health Insurance in California*, available at: [https://chbrp.org/other\\_publications/index.php](https://chbrp.org/other_publications/index.php)

**Table 1. Required Coverage of Essential Health Benefits (EHBs) in California for Privately Purchased Health Insurance**

	Inside Covered California	Outside Covered California
<b>Individual Market</b>		
Grandfathered	N/A (a)	No
Nongrandfathered	Yes	Yes
<b>Small-Group Market(b)</b>		
Grandfathered	N/A (a)	No
Nongrandfathered	Yes	Yes

Notes: (a) Qualified health plans cannot be grandfathered plans or policies, therefore there are not grandfathered plans or policies sold through Covered California.

(b) Large-group market plans and policies are not currently offered through Covered California. Per 42 U.S.C. §18042, states had the option starting in 2017 to include the large-group market in the state's marketplace, but California did not choose to do so.

### Essential Health Benefits Defined: California

The base-benchmark plan California selected for 2014 (Kaiser Foundation Health Plan Small Group HMO 30 plan) was the largest plan by enrollment in one of the three largest small-group insurance products in the state's small-group market.<sup>30</sup> California chose to supplement this plan with the pediatric oral benefit from its separate CHIP program,<sup>31</sup> and the pediatric vision benefits from the FEDVIP plan.<sup>32</sup> If the selected benchmark plan did not include habilitative services, states or insurers must supplement the benchmark plan to cover this EHB category. California chose to define habilitative services<sup>33</sup> and required that these services be provided "under the same terms and conditions applied to rehabilitative services."<sup>34</sup>

In addition, the Kaiser Foundation Health Plan Small Group HMO 30 plan is a DMHC-regulated plan and, as such, is subject to the Knox-Keene Health Care Service Plan Act of 1975 that requires coverage of medically necessary basic health care services. Therefore, medically necessary basic health care services are a part of the EHB coverage requirement in California.<sup>35</sup>

<sup>30</sup> California Health & Safety Code 1367.005 and Insurance Code 10112.27.

<sup>31</sup> In 2014, California completed transitioning enrollees in Healthy Families, its Separate Children's Health Insurance Program (CHIP) program, into Medi-Cal, becoming a Medi-Cal Expansion CHIP program. The EHB pediatric oral benefits are based on the benefits covered in the Healthy Families Program in 2011–2012, including the provision of medically necessary orthodontic care provided pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009. (H&SC Section 1367.005; IC Section 10112.27)

<sup>32</sup> H&SC Section 1367.005; IC Section 10112.27.

<sup>33</sup> California defined habilitative services as: "Habilitative services means medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment." (H&SC Section 1367.005; IC Section 10112.27)

<sup>34</sup> California Health & Safety Code 1367.005 and Insurance Code 10112.27.

<sup>35</sup> Starting in 2014, CDI-regulated policies subject to the EHB coverage requirement—nongrandfathered small-group and individual market policies—are required to cover basic health care services.

#### Exhibit 4. California's EHB Benchmark Plan, Plan Years 2014-2019

In plan years 2014, 2015 and 2016, the EHB benchmark plan was a plan that was sold in 2012, while in plan years 2017, 2018 and 2019, the benchmark EHB plan was a plan that was sold in 2014. California chose the Kaiser Foundation Health Plan Small Group HMO 30 HMO, the largest plan by enrollment of the three largest small-group plans. This plan did not include the full scope of pediatric benefits, so California selected the pediatric oral benefit from the state CHIP plan and the pediatric vision benefit from the FEDVIP plan. (a)

The EHB benchmark plan options for later years are discussed in a later section of this document.

Notes: (a) Details can be found here: <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-California-Benchmark-Summary.pdf> and here: [https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP\\_CA.zip](https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP_CA.zip).

### State Benefit Mandates That Exceed Essential Health Benefits

The ACA allows a state to require health plans and policies subject to EHBs to cover additional benefits.<sup>36</sup> If the state does so, the state must make payments to defray the cost of the additionally mandated benefits, either by paying the enrollee directly or by paying the QHP. However, application of this requirement can vary. First off, this requirement is not applicable to health plans and policies sold outside of Covered California. In addition, state benefit mandates enacted by December 31, 2011 are considered part of the state's EHBs, and so the requirement to defray is not applicable for those mandates. State benefit mandates enacted after December 31, 2011 that meet the federal definition of a state benefit mandate would be subject to the requirement that a state defray the costs for enrollees in QHPs (plans and policies sold through Covered California). The federal definition of a state benefit mandate that can exceed EHBs is "specific to the care, treatment, and services that a state requires issuers to offer to its enrollees."<sup>37</sup> State rules around service delivery method (e.g., telemedicine), provider types, cost sharing, or reimbursement methods are not considered state benefit mandates that would trigger the requirement for the state to defray the costs even though plans and policies in a state must comply with these requirements.

#### Exhibit 5. Key Points: State Benefit Mandates That Would Exceed Essential Health Benefits

- Enacted after December 31, 2011;
- Apply to the nongrandfathered small-group and individual markets inside a state's health insurance marketplace; and
- Are specific to care, treatment, and services.

For California, it is unclear which entity or person would be responsible for this determination. Federal guidance established the "State" as the entity that would identify when a state benefit mandate exceeds EHBs, however the state entity would be subject to federal oversight.<sup>38</sup> There are no federal guidelines that specifically designate this responsibility. Additionally, California has not officially determined who or which agency would be the responsible party for determining whether a benefit exceeds EHBs. For mandates that do exceed, federal guidance established QHPs as the responsible entity for calculating the

<sup>36</sup> 42 U.S.C. §18031(d)(3)(B).

<sup>37</sup> Essential Health Benefits Final Rule. *Federal Register*, Vol. 87, No. 27. February 25, 2013. Available at: [www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf](http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf).

<sup>38</sup> Frequently Asked Questions on Defrayal of State Additional Required Benefits. *Centers for Medicare and Medicaid Services*. October 23, 2018. Available at: <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-Defrayal-State-Benefits.pdf>.

marginal cost that must be defrayed. However, federal guidance left state flexibility in how this would be calculated; it could be based on “either a statewide average or each QHP issuer’s actual cost.”<sup>39</sup>

As of this time, CHBRP is unaware of any state with a state benefit mandate that have been determined to exceed EHBs.

As this brief will discuss further in a later section, states now have additional flexibility with regard to EHB benchmark plan options. Despite the increased flexibility, the election of alternative EHB benchmark plans will not alleviate a state of defrayal requirements for state benefit mandates that exceed EHBs. Benefits mandated via state legislative or regulatory action after December 31, 2011 will continue to require defrayal if they are included in a new EHB benchmark plan. However, if a new EHB benchmark plan includes additional benefits beyond a previous EHB benchmark plan, these additional benefits would not require defrayal unless the benefits were mandated via state legislative or regulatory action after December 31, 2011.<sup>40</sup>

### *How a state benefit mandate could exceed essential health benefits in California*

For a state benefit mandate to exceed the definition of EHBs in California, thus triggering the requirement that the state defray the costs, the following must be true:

- The state benefit mandate would apply to QHPs sold through Covered California;
- The state benefit mandate is not covered in the Kaiser Foundation Health Plan Small Group HMO 30 plan that defines the EHB benchmark package in California;
- The state benefit mandate is not covered under basic health care services, as required by the Knox-Keene Health Care Service Plan Act of 1975; and
- The state benefit mandate is specific to care, treatment, and/or services, thus meeting the definition of a benefit mandate that would exceed EHBs.<sup>41</sup>

### *Inclusion of whether a bill exceeds EHBs in CHBRP Reports*

The Legislature has requested CHBRP include whether a bill is likely to exceed EHBs within each CHBRP report. Because federal and state regulations are unclear as to who would make the final determination, CHBRP queries both state regulators (DMHC and CDI) and reports their conclusions. CHBRP also examines the EHB benchmark plan, but because not all benefits are explicitly defined in the Explanation of Benefits or Scope of Benefits, CHBRP relies heavily on the regulators.

Since 2013, California enacted multiple health insurance benefit mandates, none of which appears to exceed EHBs.

However, multiple bills have been introduced that, if passed, could have exceed EHBs. Exhibit 6 notes one example of such a bill.

<sup>39</sup> Essential Health Benefits Final Rule. *Federal Register*, Vol. 87, No. 27. February 25, 2013. Available at: [www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf](http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf).

<sup>40</sup> Frequently Asked Questions on Defrayal of State Additional Required Benefits. *Centers for Medicare and Medicaid Services*. October 23, 2018. Available at: <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-Defrayal-State-Benefits.pdf>.

<sup>41</sup> Essential Health Benefits Final Rule. *Federal Register*, Vol. 87, No. 27. February 25, 2013. Available at: [www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf](http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf).

## Exhibit 6. A California Bill with Potential to Exceed Essential Health Benefits

In 2019, CHBRP analyzed Assembly Bill 767 (Wicks), which would have required DMHC-regulated plans and CDI-regulated policies in the large and small group markets to cover infertility treatments (including in vitro fertilization) and mature oocyte cryopreservation. As analyzed by CHBRP, AB 767 likely would have exceeded EHBs because infertility treatment and mature oocyte cryopreservation:

- Are not included in the Kaiser Foundation Health Plan Small Group HMO 30 plan;
- Are not required coverage under (state) basic health care services; and
- Meet the federal definition of a state benefit mandate that would exceed EHBs.

CHBRP estimated the marginal change in the per member per month (PMPM) premium that would result from AB 767 and that the state would be responsible for defraying for each enrollee in a small-group QHP in Covered California would have been \$3.72. For further information, see CHBRP's 2019 report on AB 767 available here: [www.chbrp.org/completed\\_analyses/index.php](http://www.chbrp.org/completed_analyses/index.php).

## Essential Health Benefits and Cost Sharing

### *Annual out-of-pocket maximums*

The ACA places an annual limitation, or annual out-of-pocket maximum, on plans and policies required to provide coverage for EHBs.<sup>42</sup> The annual out-of-pocket maximum for 2020, as set by the federal government, is \$8,150 for self-only coverage or \$16,300 for family coverage, and includes deductibles, copayments, and other forms of cost sharing but does not include the cost of premiums.<sup>43,44</sup> In California, the annual out-of-pocket maximum may be lower depending on an enrollee's income and on the metal coverage level or the plan or policy.<sup>45</sup> Important to note is that the ACA allows the pediatric dental benefit to be covered either through a stand-alone dental insurance carrier or through an enrollee's health insurance carrier.<sup>46</sup> Further guidance from HHS has allowed stand-alone pediatric dental insurance to have a separate annual limit from the annual limit for health insurance.<sup>47,48</sup>

The ACA also requires that "group health plans" adhere to this annual out-of-pocket maximum.<sup>49</sup> Although no large-group market plans or policies are not subject to EHB coverage requirements in California at this time, federal guidance has clarified that the annual out-of-pocket maximum applies to the large group.<sup>50</sup> In California, statute also requires nongrandfathered large group plans and policies that cover EHBs to maintain an annual out-of-pocket maximum that only applies to EHBs.<sup>51</sup>

<sup>42</sup> 42 U.S.C. §18022(c) references Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986, which defines maximum annual out-of-pocket expenses for high deductible health plans (HDHPs). The dollar values provided here are the limits set by the Department of Health and Human Services for 2020.

<sup>43</sup> Available at: <https://www.federalregister.gov/documents/2019/04/25/2019-08017/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2020>.

<sup>44</sup> [42 U.S.C. §18022 (c)]

<sup>45</sup> More information is available at: [www.healthexchange.ca.gov/Pages/Default.aspx](http://www.healthexchange.ca.gov/Pages/Default.aspx).

<sup>46</sup> 42 U.S.C. §18022 (d)(2)(B)(ii).

<sup>47</sup> Essential Health Benefits Final Rule. *Federal Register*, Vol. 87, No. 27. February 25, 2013. Available at: [www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf](http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf).

<sup>48</sup> For more information on the EHB pediatric oral and vision coverage requirement, standalone dental plans, and the annual limit requirements for these plans, see CHBRP's Policy Brief on this issue, available here: [www.chbrp.org/other\\_publications/index.php](http://www.chbrp.org/other_publications/index.php).

<sup>49</sup> 42 U.S.C. §300gg-6.

<sup>50</sup> Essential Health Benefits Final Rule. *Federal Register*, Vol. 87, No. 27. February 25, 2013. Available at: [www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf](http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf).

<sup>51</sup> California Health & Safety Code 1367.006(2) and Insurance Code 10112.28(2).

## *Deductibles*

While the ACA initially included limits on the deductible for plans offered through the small group market, a law signed in 2014 removed these limits.

## **Changes in Essential Health Benefits Regulation**

HHS issued a *Notice of Benefit and Payment Parameters* final rule on April 9, 2018, which contained a number of changes and updates, including some pertaining to EHB benchmark plan selection.<sup>52</sup> This final rule marked the first substantial changes within the EHB realm since the enabling rules were promulgated earlier in the decade. This rule provided for new flexibility for states by allowing three new options for selecting an EHB base-benchmark plan, in addition to the option of retaining the current EHB benchmark plan, beginning with the 2020 plan year. These new options maintain a minimum scope of benefits standard and established a generosity ceiling to limit the range and cost of benefits that could be considered. This section discusses the related changes and how California could access them to alter its definition of EHBs.

### *Essential Health Benefits: Scope of Benefits*

Regardless of the option chosen by a state, the EHB benchmark plan must still provide coverage for items and services within all 10 categories of benefits.<sup>53</sup> The EHB benchmark plan is also subject to the scope of benefits requirements that provide both a floor and ceiling. The five scope of benefits requirements include:

- 1) Scope of benefits equal to or greater than the scope of benefits provided under a typical employer plan, which is defined as either:
  - a) One of the state's 10 benchmark plan options described previously, as sold in 2017
  - b) The largest health insurance plan by enrollment within one of the five largest group health insurance products in the state, provided that: (1) the product has at least 10% of the total enrollment of the 5 largest large group health insurance products in the state, (2) the plan provides a minimum value of 60% of total allowed cost of benefits, (3) the benefits are not excepted benefits (such as workers' compensation, disability income, liability and travel insurances) and (4) the benefits are from a plan year beginning in 2014 or later
- 2) Cannot exceed the generosity of the most generous among a set of comparison plans, including:
  - a) The state's EHB benchmark plan utilized for the 2017 plan year
  - b) Any of the state's benchmark plan options for the 2017 plan year
- 3) Cannot have benefits unduly weighted towards any of the 10 categories of benefits
- 4) Must provide benefits for diverse segments of the population, including women, children, persons with disabilities, and other groups
- 5) Cannot include discriminatory benefit designs that violate the non-discrimination standards (age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions)

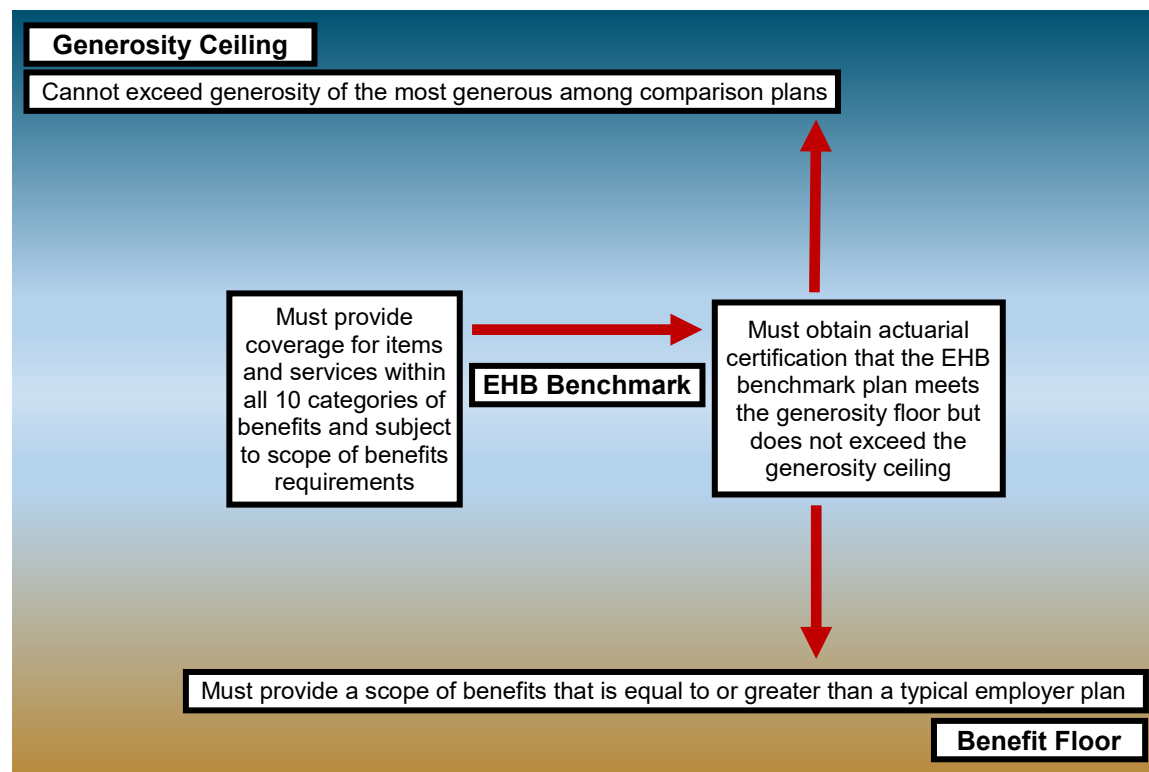
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<sup>52</sup> 83 FR 16930

<sup>53</sup> As explained previously and in 45 CFR § 156.110(a), these include (1) Ambulatory patient services, (2) Emergency services, (3) Hospitalization, (4) Maternity and newborn care, (5) Mental health and substance use disorder services, including behavioral health treatment, (6) Prescription drugs, (7) Rehabilitative and habilitative services and devices, (8) Laboratory services, (9) Preventive and wellness services and chronic disease management and (10) Pediatric services, including oral and vision care.

While a state will confirm in writing that a selected EHB benchmark plan option fulfills the above scope of benefits requirements, the state also must obtain actuarial certification that the EHB benchmark plan meets the generosity floor but does not exceed the generosity ceiling. The certified actuarial report must affirm that the EHB benchmark plan provides a scope of benefits equal to or greater than the typical employee plan (described in item 1 above) without exceeding the generosity of the most generous among the plans listed in item 2 above (Figure A).

**Figure A. Essential Health Benefits Benchmark Scope of Benefits Requirements**



Though the new EHB benchmark plan options provide a means for states to add additional services or treatments to EHB categories, there are important limitations in the rules. The chosen EHB benchmark plan must provide a scope of benefits that is equal to or greater than a typical employer plan, as explained above.<sup>54</sup> In addition to meeting this benefit floor, the EHB benchmark plan cannot exceed a generosity ceiling, as shown in Figure A.

In addition to submitting required documents to HHS, states proposing to use a new EHB benchmark plan were required to provide public notice and an opportunity for public comment on the potential EHB benchmark plan change.

HHS issued a subsequent Notice of Benefit and Payment Parameters final rule on April 25, 2019.<sup>55</sup> Unlike the final rule issued in 2018, 2019's final rule did not lead to any changes in EHB benchmark plan selection. Instead, this rule maintained the previous changes and issued a deadline of May 6, 2019 for states to submit a new EHB benchmark plan for the 2021 plan year. In the April 25, 2019 *Notice of Benefit and Payment Parameters* final rule,<sup>56</sup> HHS issued a deadline of May 8, 2020 for states to submit a new EHB benchmark plan for the 2022 plan year.

<sup>54</sup> 45 CFR 156.111(a)

<sup>55</sup> 84 FR 17454

<sup>56</sup> 84 FR 17454

The 2019 final rule continues to allow states to select from the three EHB benchmark plan option alternatives, in addition to the option of maintaining the same EHB benchmark plan from plan years 2017-2019.<sup>57</sup>

The final rule emphasized the statutory prohibition on EHB discrimination contained in 45 CFR 156.125, which is also summarized in item 5 of *Essential Health Benefits: Scope of Benefits*. This means that any reduction in the generosity of an EHB for subsets of individuals that is not based on clinically indicated, reasonable medical management practices is potentially discriminatory and is thus prohibited.<sup>58</sup> The final rule explained this by discussing the example of an EHB plan inappropriately excluding a particular treatment for an opioid use disorder when the same treatment is covered for other medically necessary purposes. This example and other mentions of the opioid use disorder demonstrate that HHS is particularly concerned by continued discrimination with regard to treatment of this specific disorder. Noting that not all QHPs cover all forms of Medication-Assisted Treatment (MAT) for opioid use disorder, HHS encourages "...every health insurance plan to provide comprehensive coverage of MAT, even if the applicable EHB-benchmark plan does not require the inclusion of all four MAT drugs..."<sup>59</sup> If a state does not make an active EHB selection by May 8, 2020, the state's EHB benchmark plan for the applicable year will be the state's EHB benchmark plan from the prior year.<sup>60</sup>

A number of states have used the new flexibility and have secured approval from HHS to alter their EHBs.<sup>61</sup> For Illinois, changes were approved for 2020 plan year. For South Dakota changes were approved for the 2021 plan year. For three states, Michigan, New Mexico, and Oregon, changes were approved for the 2022 plan year. For Colorado, changes were approved for the 2023 plan year.

The details of the changes varied. For example, as discussed in Exhibit 7, South Dakota chose to enhance their existing EHB benchmark plan starting in 2021 by adding Applied Behavior Analysis Habilitative Services for enrollees with Autism Spectrum Disorder. As required by statute, South Dakota commissioned an actuarial analysis of this additional benefit in the context of the new generosity test.<sup>62</sup> The actuarial analysis revealed that this new benefit would increase the relative EHB benefit value by 0.3% annually, however several comparison benchmark EHB benchmark plans also had +0.3% relative benefit value, as compared to the existing EHB benchmark plan. As such, this actuarial analysis determined that the additional EHB benefit would not exceed the most generous comparison plan, thus satisfying the generosity test.

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<sup>57</sup> Information on Essential Health Benefits (EHB) Benchmark Plans. *Centers for Medicare and Medicaid Services*. 2019. Accessed on December 16, 2019 at: <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb>

<sup>58</sup> Ibid.

<sup>59</sup> Ibid.

<sup>60</sup> 45 CFR 156.111

<sup>61</sup> Information on Essential Health Benefits (EHB) Benchmark Plans. *Centers for Medicare and Medicaid Services*. 2019. Accessed on January 3, 2022 at: <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb>

<sup>62</sup> <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/SD-Plan-Documents.zip>



## Exhibit 7. Examples of Essential Health Benefit Changes

Two states submitted a request to change their EHB benchmark plan in 2020 and/or 2021, both of which were approved by HHS. Both utilized the option of “selecting a set of benefits that would become the state’s EHB benchmark plan.” Using this option, both states maintained their current EHB benchmark plan while supplementing their EHBs with an additional set of benefits.

- **Illinois: 2020-2021**(a): Within the prescription drug category and mental health substance use disorder services category, instituted a new Access to Care and Treatment (ACT) Plan to reduce opioid addiction and expand access to mental health services:
  - Cover alternative therapies for pain like topic anti-inflammatories
  - Limit opioid prescriptions for acute pain to 7 days maximum
  - Remove barriers to obtaining Buprenorphine products for medically assisted treatment (MAT) of opioid use disorder
  - Cover prescriptions for naloxone when high opioid doses are prescribed
  - Cover tele-psychiatry care by both a prescriber and a licensed therapist
- **South Dakota 2021**: Within the “Habilitation Services” category of the 10 EHB categories:
  - Treatment for Autism Spectrum Disorder with Applied Behavioral Analysis (ABA) is covered with the following limits: up to 1300 hours/year through age 6, up to 900 hours/year for ages 7-13, up to 450 hours/year for ages 14-18

Notes: (a) [https://www2.illinois.gov/IISNews/18098-DOI\\_Essential\\_Health\\_Benefit-benchmark\\_plan\\_Release.pdf](https://www2.illinois.gov/IISNews/18098-DOI_Essential_Health_Benefit-benchmark_plan_Release.pdf)  
 (b) [https://dhr.sd.gov/insurance/documents/SD\\_proposed\\_EHB\\_benchmark\\_summary\\_04292019.pdf](https://dhr.sd.gov/insurance/documents/SD_proposed_EHB_benchmark_summary_04292019.pdf)

## Potential Changes for Essential Health Benefits: California Options

For California, as no new EHB benchmark plan was submitted, the Kaiser Foundation Health Plan Small Group HMO 30 plan continues to serve as the state’s EHB benchmark plan.

In the future, California could choose to utilize one of the original options, outlined in Exhibit 2, or select one of the new options, described above, to alter its EHB benchmark plan. By selecting some or all categories from another state’s EHB benchmark plan, California could include new services not currently in the California benchmark plan. For example, CHBRP is aware of three specific benefits that are covered by many other state EHB benchmark plans but that are not included in the current Kaiser Foundation Health Plan Small Group HMO 30 plan:

- **Chiropractic care** services are not currently covered in California’s EHB benchmark plan. Among the 50 state and District of Columbia EHB benchmark plans for the 2019 plan year, 46 of these 51 plans covered chiropractic care services to some extent.<sup>63</sup> Many of these plans incorporated utilization management, such as referrals, prior authorizations or annual visit maximums (i.e. 10 or 25 chiropractic visits per year) to limit the benefit. Chiropractic care services are typically included under the Rehabilitative and Habilitative Services category of EHBs.
- **Hearing aids**, aside from cochlear implants, are not currently covered in California’s EHB benchmark plan. As of the 2019 plan year, 25 states and the District of Columbia include hearing

<sup>63</sup> As the 2017 EHB benchmark plan remained for years 2018 and 2019, this analysis of 2017 EHB benchmark plan covered benefits is still accurate for the 2019 plan year: <https://www.cigna.com/assets/docs/about-cigna/informed-on-reform/top-11-ehb-by-state-2017.pdf>

aids in their current EHB benchmark plan.<sup>64</sup> Nearly all of these plans include age limits, typically covering hearing aids only among enrollees under age 18 or 21. While all of these 25 state plans and the District of Columbia's cover removable hearing aids, several other plans only cover bone-anchored hearing aids. Hearing aids are included under the Rehabilitative and Habilitative Services category of EHBs.

- **Infertility services and treatments**, including in-vitro fertilization (IVF), are not currently covered in California's EHB benchmark plan. As of the 2019 plan year, 25 states and the District of Columbia include some level of infertility services in their current benchmark plan.<sup>65</sup> However, the covered infertility services are almost always limited to diagnostic services and a select few infertility treatment medications. Only a few states, such as Connecticut, Hawaii and Illinois, are known to cover IVF. Among the states that cover IVF, enrollees are limited in the number of covered IVF cycles, often two cycles. When covered, infertility services and treatments are typically incorporated among one or more EHB categories, including Ambulatory Patient Services, Prescription Drugs and Maternity and Newborn Care.

Should California desire to include any of these above benefits, the state could select another state's EHB benchmark plan in whole or in part. California could replace its plan entirely with another state's plan or only replace one category, such as Rehabilitative and Habilitative Services. California could also choose the option of "selecting a set of benefits that would become the State's EHB-benchmark plan,"<sup>66</sup> as Illinois and South Dakota did to alter their EHB benchmark plans.

## Conclusion

HHS's recent regulations provide options for states to modify or select a new EHB benchmark plan. Though the regulations allow for considerable flexibility, HHS maintains a minimum scope of benefits floor as well as a Generosity Test ceiling. Within these confines, California could use one of the three new EHB benchmark plan options to supplement the set of benefits that make up its EHBs. Other states have already done so and so California can look to those states experiences as it decides whether to change its EHB benchmark plan.

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<sup>64</sup> *ibid*

<sup>65</sup> *ibid*

<sup>66</sup> 45 CFR 156.111(a)

## APPENDIX A FEDERAL BENEFIT MANDATES

Federal benefit mandates, like state benefit mandates, may apply to both the individual and group markets. However, federal benefit mandates can apply more broadly than state benefit mandates. For example, federal benefit mandates may apply to Medicare or to self-insured plans. There were federal benefit mandates in place prior to the passage of the ACA, and the ACA added federal benefit mandates that apply to many, but not all, DMHC-regulated plans and CDI-regulated policies in the individual and group markets in California. CHBRP's document *Health Insurance Benefit Mandates in California State and Federal Law*<sup>67</sup> lists the federal benefit mandates currently known to CHBRP.

### *Federal Benefit Mandates Prior to the Affordable Care Act*

CHBRP is aware of four federal benefit mandates that were in effect prior to the ACA:<sup>68</sup>

- The Pregnancy Discrimination Act of 1978 amending Title VII of the federal Civil Rights Act (Pregnancy Discrimination Act);
- The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act);
- The Women's Health and Cancer Rights Act (WHCRA) of 1998; and
- The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.

The first three apply to the group market<sup>69</sup> while the fourth applies to the group and individual markets. Also, the mandates may apply only *if* coverage for the service or treatment is part of the health plan or policy. For example, the Newborns' Act does not require that a group plan or policy cover maternity, but, if maternity is covered, coverage for a minimum length of stay in a hospital following childbirth is required.

### *Federal Benefit Mandates in the Affordable Care Act*

The passage of the ACA added additional federal benefit mandates to products in the individual and group market, with the exception in some cases of grandfathered health plans and policies.<sup>70</sup> These new federal benefit mandates include:

- Prohibitions on lifetime and annual limits on the dollar value of benefits for any individual.<sup>71</sup>
- Where emergency services are provided, requirements that the services are provided: regardless of whether the provider is in or out of network; with the same cost-sharing levels in network as out of network; and without prior authorization.<sup>72</sup>
- Prohibition on requiring prior authorization or referral before covering services from a health care professional who specializes in obstetrics or gynecology.<sup>73</sup>
- Prohibition on denying coverage for children with preexisting conditions.
- Prohibition on denying coverage to anyone with a preexisting condition.<sup>74</sup>

<sup>67</sup> The resource is available at: [www.chbrp.org/other\\_publications/index.php](http://www.chbrp.org/other_publications/index.php).

<sup>68</sup> There may be other federal benefit mandates that are not included in this list. The federal health insurance benefit mandates discussed in this Issue Brief most closely align with the definition of benefit mandates in CHBRP's authorizing statute.

<sup>69</sup> How the group market is defined for federal benefit mandates does not always align with how the group market is defined for state benefit mandates. For example, the Newborns' Act applies to group plans with 15 or more people.

<sup>70</sup> Some of the new federal benefit mandates in the ACA do not apply to grandfathered health plans (ACA Section 1251).

<sup>71</sup> ACA Section 1001 modifying Section 2711 of the PHSA.

<sup>72</sup> ACA Section 1001 modifying Section 2719A of the PHSA.

<sup>73</sup> Ibid.

<sup>74</sup> ACA Section 1201 modifying Section 2704 of the PHSA.

- Requirements for coverage of specified preventive health services without cost sharing, including:<sup>75,76</sup>
  - Evidence-based items or services that have a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force (USPSTF)<sup>77</sup>;
  - Immunizations that have a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC)<sup>78</sup>;
  - Infants, children, and adolescents of evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);<sup>79</sup> and
  - Preventive care and screenings for women provided for in comprehensive guidelines supported by HRSA.<sup>80</sup>

In addition to these new federal benefit mandates in the ACA, the ACA also expands the Mental Health Parity and Addiction Equity Act by applying it to QHPs offered through state marketplaces, like Covered California, "in the same manner and to the same extent as such section applies to health insurance issuers and group health plans."<sup>81</sup> The ACA further expands MHPAEA to include the individual market and the small-group market, which were previously excluded from this parity requirement.<sup>82</sup>

### *The Interaction of Federal and State Benefit Mandates*

Just as state benefit mandates vary and may overlap with each other, federal benefit mandates and state benefit mandates also vary and may overlap across products and markets, as well as the conditions and disorders addressed by the benefit mandates. For example, the federal Newborns' Act requiring a minimum length of stay in a hospital following childbirth, if maternity services are covered, is very similar to a California state benefit mandate.<sup>83</sup> Both the federal and state benefit mandates affect group DMHC-regulated plans and CDI-regulated policies, however, the state benefit mandate affects individual-market DMHC-regulated plans and CDI-regulated policies, whereas the federal benefit mandate does not. It is important to note that plans and policies subject to both state and federal benefit mandates must meet or exceed the more demanding benefit mandate, whether that is the state benefit mandate or the federal benefit mandate.

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<sup>75</sup> ACA Section 1001 modifying Section 2713 of the PHSA.

<sup>76</sup> CHBRP has a Resource looking at the preventive services coverage requirement in the ACA, available at: [www.chbrp.org/other\\_publications/index.php](http://www.chbrp.org/other_publications/index.php).

<sup>77</sup> A list of the USPSTF A and B recommendations is available at: <https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>.

<sup>78</sup> A list of the immunizations recommended by the ACIP is available at: [www.cdc.gov/vaccines/hcp/acip-recs/index.html](http://www.cdc.gov/vaccines/hcp/acip-recs/index.html).

<sup>79</sup> Comprehensive guidelines for infants, children, and adolescents supported by HRSA appear in two charts: the periodicity schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, available at [http://https://www.aap.org/en-us/documents/periodicity\\_schedule.pdf](http://https://www.aap.org/en-us/documents/periodicity_schedule.pdf), and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, available at: <https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/heritable-disorders/rusp/rusp-uniform-screening-panel.pdf>.

<sup>80</sup> A list of the guidelines supported by HRSA for women's preventive care and screening is available at: <https://www.hrsa.gov/womens-guidelines/index.html>.

<sup>81</sup> ACA Section 1311(j).

<sup>82</sup> ACA Section 1563(c)(4) modifying Section 2726 of the PHSA.

<sup>83</sup> California Health and Safety Code 1367.62 and Insurance Code 10123.87

## APPENDIX B MEDICAID AND ESSENTIAL HEALTH BENEFITS

Since 2006, states have had the option to identify Medicaid benchmark plans for certain groups of enrollees under section 1937 of the Social Security Act.<sup>84</sup> The ACA renamed Section 1937 Medicaid benchmark or benchmark-equivalent plans “Alternative Benefit Plans” (ABPs), and specified that they must cover the 10 Essential Health Benefits (as defined in section 1302 of the ACA) to which some commercial health insurance, as specified earlier in this brief, is subject.<sup>85</sup> Adults in the Medicaid Expansion population (i.e. persons eligible under the “modified adjusted gross income standard”) must be covered under ABPs, and states may use an ABP for coverage of any other groups of individuals eligible for Medicaid, which is called Medi-Cal in California.<sup>86</sup>

Section 1937 of the Social Security Act provides the following options for selection of ABPs:<sup>87</sup>

- The benefit package provided by the Federal Employees Health Benefit plan (FEHB) Standard Blue Cross/Blue Shield Preferred Provider Option;
- State employee health coverage that is offered and generally available to state employees;
- The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and
- (Federal Health and Human Services) Secretary-approved coverage, which is a benefit package the Secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage.

The benefits included in California’s ABP (currently Blue Cross Blue Shield/CareFirst Preferred Option 1) are the same benefits as full-scope Medi-Cal benefits, discussed in Attachment 3.1-A and 3.1-B of California’s State Plan.<sup>88</sup>

If state or federal law adds or changes a benefit, Medi-Cal would either need to cover the benefit or list an actuarially equivalent benefit.<sup>89</sup> In that case, the Department of Health Care Services would submit a State Plan Amendment to draw down federal funding for providing these services to beneficiaries.<sup>90</sup>

It is important to note that while Medi-Cal is also required to cover the 10 EHB categories, the specific benefits included in the chosen Medi-Cal benchmark plan may be different from the specific benefits included in the commercial benchmark plan because the EHB benchmark plan is different from the ABP in California.

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<sup>84</sup> 42 U.S.C. §1396u-7.

<sup>85</sup> Like the State Plan, the ABP is a contract between the Department of Health Care Services and the Center for Medicare and Medicaid Services for Title XIX funding for Medicaid Services.

<sup>86</sup> Alternative Benefit Plan Final Rule. *Federal Register*, Vol. 78, No. 135. July 14, 2013. Available at: <https://www.govinfo.gov/content/pkg/FR-2013-07-15/pdf/2013-16271.pdf>.

<sup>87</sup> 42 U.S.C. §1396u-7, as described by the Alternative Benefit Plan Final Rule, cited above.

<sup>88</sup> California’s state plan can be found online at: <https://www.dhcs.ca.gov/formsandpubs/laws/Pages/SPdocs.aspx>. This is also consistent with WIC § 14132.02.

<sup>89</sup> As required by 42 U.S.C. §18022(d).

<sup>90</sup> Communication between CHBRP and the Department of Health Care Services. October 14, 2019.

## ABOUT CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

Detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP analyses and other publications are available at <http://www.chbrp.org/>

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CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at [www.chbrp.org](http://www.chbrp.org).

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