Date: October 23, 2018

Subject: Frequently Asked Questions on Defrayal of State Additional Required Benefits

Q1: Will a state that updates its EHB-benchmark plan pursuant to the flexibility finalized at 45 CFR §156.111 be subject to new defrayal requirements as a result of its EHB-benchmark plan selection?

A1: No. In the Final 2019 HHS Notice of Benefit and Payment Parameters,[1] we finalized that, as part of the new EHB-benchmark plan selection options for states at 45 CFR §156.111, we would not make any changes to the policies governing defrayal of state-required benefits at 45 CFR §155.170. That is, whether a benefit mandated by state action could be considered EHB would continue to depend on when the state enacted the mandate (unless the benefit mandated was for the purposes of compliance with federal requirements). Under any of the three methods for a state to select a new EHB-benchmark plan at §156.111, the act of selecting a new EHB-benchmark plan does not alone create new state mandates, but it also does not relieve the state of its obligation to continue defraying the cost of QHPs covering any mandated benefits currently requiring defrayal. In other words, if a state selects a new EHB-benchmark plan under any of the options finalized at §156.111, the benefits included in the state's new EHB-benchmark plan will not be treated as state mandates for purposes of §155.170 defrayal unless they were mandated after December 31, 2011, by the selecting state through legislative or regulatory action separate from an EHB-benchmark plan selection process.

Q2: May states use their discretion in determining whether a state mandate requires defrayal?

A2: No. We remind states that, although it is the state's responsibility to identify which state required benefits require defrayal, states must make such determinations using the framework finalized at §155.170, which specifies that benefits required by state action taking place on or before December 31, 2011, may be considered EHB, whereas benefits required by state action taking place after December 31, 2011, other than for purposes of compliance with federal requirements, are in addition to EHB and must be defrayed by the state. For example, a law requiring coverage of a benefit passed by a state after December 31, 2011, is still a state mandated benefit requiring defrayal even if the text of the law says otherwise.

CMS is monitoring state compliance with the state mandate defrayal requirements at §155.170. CMS also reminds states that they are encouraged to reach out to CMS concerning any state defrayal questions in advance of passing and implementing benefit mandates, and to provide QHP issuers in the state ample time to quantify the cost attributable to each additional required benefit and report these calculations to the state. We also remind states and QHP issuers that the calculations should be done prospectively to allow for the offset of an enrollee's share of

[1] HHS Notice of Benefit and Payment Parameters for 2019; Final Rule, 83 FR 16930 (April 17, 2018).

premium and for purposes of calculating the portion of the premium attributable to EHB for purposes of the premium tax credit and identifying benefits subject to reduced cost-sharing.

Q3: How can states that are concerned about the opioid epidemic make changes to benefits that are covered within their states without triggering a requirement to defray the cost of additional benefits?

A3: Regulations at 45 CFR 156.100(a) define the EHB based on a state-specific EHB-benchmark plan. For plan years 2020 and after, states have greater flexibility to update their EHB-benchmark plans, if they so choose, pursuant to §156.111. We believe that the three options, at §156.111(a)(1)-(3), and in particular option three at (a)(3), may provide states with flexibility to address the opioid epidemic.

We encourage states to consider using this opportunity to address the opioid epidemic by selecting one of the three options for plan year 2021 and beyond.[2] These options include:

Option 1 (45 CFR 156.111(a)(1)): Selecting the EHB-benchmark plan that another state used for the 2017 plan year under §§156.100 and 156.110.

If a state identifies a 2017 EHB-benchmark plan from another state that would better serve its population to address the opioid epidemic, the state could select that EHB-benchmark plan in its entirety. For example, some EHB-benchmark plans may provide stronger coverage for non-pharmacologic pain management such as chiropractic, physical therapy, and acupuncture.

Option 2 (45 CFR 156.111(a)(2)): Replacing one or more categories of EHBs under its EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another state used for the 2017 plan year under §§156.100 and 156.110.

If a state identifies one or more categories of EHB[3] in a 2017 EHB-benchmark plan from one or more states, the state could replace those categories of benefits in its current EHB-benchmark plan with those categories, but otherwise maintain its current EHB-benchmark plan. For example, a state could keep eight categories, of benefits from its 2017 EHB-benchmark plan, and replace the prescription drug coverage category with that category from one state's EHB-benchmark plan used for the 2017 plan year, and the mental health and substance use disorder services (including behavioral health treatment) category from another state's EHB-benchmark plan used for the 2017 plan year.

[2] The deadline for states to select a new EHB-benchmark plan pursuant to the new flexibility finalized at §156.111 has passed for plan year 2020, but states can consider making changes for plan year 2021.

[3] The 10 categories of EHB are: (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).

Option 3 (45 CFR 156.111(a)(3)): Otherwise selecting a set of benefits that would become the state's EHB-benchmark plan.

Under this option, a state would select a set of benefits that would become its EHB-benchmark plan. For example, a state could specify a list of benefits and services that are that state's EHB. A state could create a set of benefits to remove limits on alternative services, while adding alternative therapies such as acupuncture and chiropractic care. In this instance, the state would ensure its proposed EHB-benchmark plan does not exceed the generosity of the most generous of a set of comparison plans using actuarial certification (discussed more below).

We also recognized that the increased flexibility offered to states under this proposed option to define an EHB-benchmark plan could allow a state to embed any desired benefit into the EHB-benchmark plan, without any requirement to defray the cost of QHPs covering the benefit. For this reason, we proposed to apply the benefit mandate defrayal policy under §155.170 to this option, as discussed above.

All three options for a state to select a new EHB-benchmark plan are subject to additional requirements, including EHB coverage and scope of benefits requirements under §156.111(b). These requirements include providing a scope of benefits that is equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category, the scope of benefits provided under a typical employer plan. Section 156.111(b)(2) defines a typical employer plan as either:

(1) one of the selecting state's 10 base-benchmark plan options established at §156.100 from which the state was able to select for the 2017 plan year; or
(2) the largest health insurance plan by enrollment in any of the five largest large group health insurance products by enrollment in the selecting state, as product and plan are defined at §144.103, provided that:
    (a) the product has at least ten percent of the total enrollment of the five largest large group health insurance products by enrollment in the selecting state;
    (b) the plan provides minimum value;
    (c) the benefits are not excepted benefits; and
    (d) the benefits in the plan are from a plan year beginning after December 31, 2013.

Second, the state's EHB-benchmark plan must not exceed the generosity of the most generous among a set of comparison plans, including the EHB-benchmark plan used by the state in 2017, and any of the state's base-benchmark plan options for the 2017 plan year, supplemented as necessary. This generosity standard limits the state's ability to increase the overall scope of benefits in its EHB-benchmark plan. This approach balances the goal to promote State flexibility with the need to preserve coverage affordability. A proposed EHB-benchmark plan that exceeds this generosity limit in one category of EHB would require the state to reduce benefit generosity in another category in order to meet the generosity standard for purposes of selecting its new EHB-benchmark plan, and therefore would not trigger a defrayal requirement.