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(1) The largest plan by enrollment in the second largest product by enrollment in the State's small group market, as defined in §155.20 of this subchapter (except for pediatric oral and vision benefits);

(2) The largest plan by enrollment in the third largest product by enrollment in the State's small group market, as defined in §155.20 of this subchapter (except for pediatric oral and vision benefits);

(3) The largest national FEHBP plan by enrollment across States that is offered to federal employees under 5 USC 8903 (except for pediatric oral and vision benefits);

(4) The plan described in paragraph (b)(2)(i) of this section for pediatric oral care benefits; and

(5) The plan described in paragraph (b)(3)(i) of this section for pediatric vision care benefits.

(d) *Non-discrimination.* Not include discriminatory benefit designs that contravene the non-discrimination standards defined in §156.125 of this subpart.

(e) *Balance.* Ensure an appropriate balance among the EHB categories to ensure that benefits are not unduly weighted toward any category.

(f) *Determining habilitative services.* If the base-benchmark plan does not include coverage for habilitative services, the State may determine which services are included in that category.

[78 FR 12866, Feb. 25, 2013, as amended at 80 FR 10871, Feb. 27, 2015]

§ 156.111 State selection of EHB-benchmark plan for plan years beginning on or after January 1, 2020.

(a) Subject to paragraphs (b), (c), (d) and (e) of this section, for plan years beginning on or after January 1, 2020, a State may change its EHB-benchmark plan by:

(1) Selecting the EHB-benchmark plan that another State used for the 2017 plan year under §§156.100 and 156.110;

(2) Replacing one or more categories of EHBs established at §156.110(a) in the State's 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; or

(3) Otherwise selecting a set of benefits that would become the State's EHB-benchmark plan.

(b) A State's EHB-benchmark plan must:

(1) *EHB coverage.* Provide coverage of items and services for at least the categories of benefits at §156.110(a), including an appropriate balance of coverage for these categories of benefits.

(2) *Scope of benefits.* (i) Provide a scope of benefits equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at §156.110(a), the scope of benefits provided under a typical employer plan, defined as either:

(A) One of the selecting State's 10 base-benchmark plan options established at §156.100, and available for the selecting State's selection for the 2017 plan year; or

(B) The largest health insurance plan by enrollment within one of the five largest large group health insurance products by enrollment in the State, as product and plan are defined at §144.103 of this subchapter, provided that:

(*1*) The product has at least 10 percent of the total enrollment of the five largest large group health insurance products in the State;

(*2*) The plan provides minimum value, as defined under §156.145;

(*3*) The benefits are not excepted benefits, as established under §146.145(b), and §148.220 of this subchapter; and

(*4*) The benefits in the plan are from a plan year beginning after December 31, 2013.

(ii) Not exceed the generosity of the most generous among a set of comparison plans, including:

(A) The State's EHB-benchmark plan used for the 2017 plan year, and

(B) Any of the State's base-benchmark plan options for the 2017 plan year described in §156.100(a)(1), supplemented as necessary under §156.110.

(iii) Not have benefits unduly weighted towards any of the categories of benefits at §156.110(a);

(iv) Provide benefits for diverse segments of the population, including women, children, persons with disabilities, and other groups; and

(v) Not include discriminatory benefit designs that contravene the nondiscrimination standards defined in §156.125.

(c) The State must provide reasonable public notice and an opportunity for public comment on the State's selection of an EHB-benchmark plan that includes posting a notice on its opportunity for public comment with associated information on a relevant State website.

(d) A State must notify HHS of the selection of a new EHB-benchmark plan by a date to be determined by HHS for each applicable plan year.

(1) If the State does not make a selection by the annual selection date, or its benchmark plan selection does not meet the requirements of this section and section 1302 of the PPACA, the State's EHB-benchmark plan for the applicable plan year will be that State's EHB-benchmark plan applicable for the prior year.

(2) [Reserved]

(e) A State changing its EHB-benchmark plan under this section must submit documents in a format and manner specified by HHS by a date determined by HHS. These must include:

(1) A document confirming that the State's EHB-benchmark plan definition complies with the requirements under paragraphs (a), (b) and (c) of this section, including information on which selection option under paragraph (a) of this section the State is using, and whether the State is using another State's EHB-benchmark plan;

(2) An actuarial certification and an associated actuarial report from an actuary, who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies, that affirms:

(i) That the State's EHB-benchmark plan provides 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 at §156.110(a), the scope of benefits provided under a typical employer plan, as defined at (b)(2)(i) of this section; and

(ii) That the State's EHB-benchmark plan does not exceed the generosity of the most generous among the plans listed in paragraphs (b)(2)(ii)(A) and (B) of this section.

(3) The State's EHB-benchmark plan document that reflects the benefits and limitations, including medical management requirements, a schedule of benefits and, if the State is selecting its EHB-benchmark plan using the option in paragraph (a)(3) of this section, a formulary drug list in a format and manner specified by HHS; and

(4) Other documentation specified by HHS, which is necessary to operationalize the State's EHB-benchmark plan.

[83 FR 17068, Apr. 17, 2018]

§156.115 Provision of EHB.

(a) Provision of EHB means that a health plan provides benefits that—

(1) Are substantially equal to the EHB-benchmark plan including:

(i) Covered benefits;

(ii) Limitations on coverage including coverage of benefit amount, duration, and scope; and

(iii) Prescription drug benefits that meet the requirements of §156.122 of this subpart;

(2) With the exception of the EHB category of coverage for pediatric services, do not exclude an enrollee from coverage in an EHB category.

(3) With respect to the mental health and substance use disorder services, including behavioral health treatment services, required under §156.110(a)(5) of this subpart, comply with the requirements of §146.136 of this subchapter.

(4) Include preventive health services described in §147.130 of this subchapter.

(5) With respect to habilitative services and devices—

(i) Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings;

(ii) Do not impose limits on coverage of habilitative services and devices that are less favorable than any such