Selecting a State EHB-Benchmark Plan:

Updated Timeline Under New Regulations

In the Notice of Benefit and Payment Parameters (NBPP) for 2025, the annual rule that establishes standards for insurance plans sold on the ACA Individual and Small Group markets, CMS implemented important changes to the Essential Health Benefit (EHB) benchmark selection process. Under this rule, states are not only permitted to include routine non-pediatric dental services as Essential Health Benefits (EHBs) but have new flexibilities to expand coverage of benefits without having to take on additional costs. This document briefly explains those changes to support State advocates when engaging key decision-makers over the next three years.

The specifics of the EHB-benchmark selection process vary by state, including which entities are responsible for selecting the EHB-benchmark plan. Community Catalyst developed a policy memo outlining marketplace rules by state to help State advocates identify those decision-makers.

Additional questions about changes to the EHB-benchmark selection process may be directed to Colin Reusch at CReusch@communitycatalyst.org.

Plan Year 2025

HHS Notification Deadline:

The window to notify HHS of the selection of a new EHB-benchmark plan to take effect for the 2025 plan year has passed.[i]

State Mandated Benefits and the Defrayal Requirement:

Starting in the 2025 plan year, the following policies will apply to state mandated benefits enacted after December 31, 2011:

- If a State mandated benefit is also covered under a State's EHB-benchmark plan, a State is not required to defray the cost.
- If a State mandated benefit is not covered under a State's EHB-benchmark plan, a State is required to defray the cost.
- If a State removes a benefit from its benchmark plan, and a state mandate remains in place, a State is required to defray the costs as outlined in 45 CFR § 155.170.

Additionally, if a State mandated benefit enacted after December 31, 2011 is also covered under the State's EHB-benchmark plan such benefit will retain its EHB status. Such benefit will therefore remain subject to EHB rules including the prohibition on discrimination, limitation on cost sharing, and restrictions on annual or lifetime dollar limits.[ii]

Plan Year 2026

HHS Notification Deadline:

May 1, 2024

Options to Change EHB-Benchmark Plans:

CMS consolidated the options for States to change EHB-benchmark plans at § 156.111(a) to reduce the burden on states to decide between three functionally identical choices. Subject to other EHB-benchmark selection requirements, a State may change its EHB-benchmark plan by selecting a set of benefits that would become the State's EHB-benchmark plan.

Generosity & Typicality Standards:

Selecting an EHB-benchmark plan will follow new generosity and typicality standards starting in the 2026 plan year:

> Generosity Standard: Removed
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> Typicality Standard: The EHB-benchmark plan must provide a scope of benefits that is as or more generous than the scope of benefits in a State's least generous typical employer plan and as or less generous than the scope of benefits in a State's most generous typical employer plan.[iii]

Formulary Drug List Requirement:

Starting for the 2026 plan year, a State is not required to submit a formulary drug list when notifying HHS that the State is selecting a new EHB-benchmark plan unless a State is seeking to change its prescription drug EHB.

Plan Year 2027

HHS Notification Deadline:

May 7, 2025

Adding Adult Dental:

A State may add adult dental to its EHB-benchmark plan starting in the 2027 plan year. Adding adult dental to an EHB-benchmark plan will follow the updated benchmark processes outlined above.

[i] 45 Code of Federal Regulations §156.111(d)
[ii] 45 CFR §156.125; 45 CFR § 156.130; 45 CFR § 147.126
[iii] A typical employer plan is defined at § 156.111(b)(2)(i)(A) and § 156.111(b)(2)(i)(B) as either: (1) one of the ten base-benchmark plan options available for a state's selection for the 2017 play year, or (2) the largest health insurance plan by enrollment provided that, among other requirements, the product has at least 10% of the total enrollment of the five largest large group health insurance products in the state.