KILPATRICK TOWNSEND

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Essential Health Benefits for Self-Insured Plans

The meaning of “essential health benefits” is an issue for self-insured plans in several contexts, including the annual and lifetime limit restrictions and the determination of whether the plan provides minimum value. For purposes of determining minimum value, employers will have to select a benchmark plan against which to measure their plan. Although, they aren’t required to offer the same benefits that are provided in the benchmark plan.

In 2010, the agencies issued interim guidance regarding the annual and lifetime limit restrictions in which they defined essential health benefits by reference to Section 1302(b) of the Affordable Care Act and the regulations issued thereunder which, at that time, had not been issued. Until regulations are issued, plan sponsors were directed to adopt a reasonable, good faith interpretation of the term essential health benefits. Earlier this year, the agencies issued final regulations regarding the meaning of essential health benefits for purposes of Section 1302(b). 78 Fed. Reg. 12834 (Feb. 25, 2013). These rules apply to insured plans sold in the individual market and the small group market. They do not apply to self-insured plans. In the preamble, HHS states that for purposes of the annual and lifetime limit restrictions, the agencies will consider self-insured plans to have used a permissible definition of “essential health benefits” if “the definition is one that is authorized by the Secretary of HHS (including any available benchmark option, supplemented as needed to ensure coverage of all ten statutory categories).” A similar statement was included in a set of FAQs issued by HHS.

This language could easily be read as a safe-harbor, meaning employers are not required to define essential health benefits by reference to a state benchmark plan, but if they do, they will be deemed to be in compliance. Alternatively, it could be read more broadly to mean that employers must define essential health benefits for purposes of the annual and lifetime limit restrictions by reference to a state benchmark plan. We understand that HHS has informally confirmed the second interpretation. One approach would be to adopt a benchmark state and plan until guidance comes out which addresses this issue directly.

There is nothing in the regulations which prevents a plan sponsor from adopting any state’s benchmark plan, even if the employer has no employees in that state or any other connection to the state. We understand that HHS has also informally confirmed this interpretation. The question of which state benchmark plan to use is a plan-specific determination. The only way to fully assess which benchmark plan is best to use is to compare the proposed benchmark plan to the employer’s plan. Areas where coverage may differ significantly in each of the benchmark plans include coverage for infertility treatments, applied behavioral therapy for autism and adult hearing aids. Some states have adopted a benchmark plan that provides a particularly low bar as to what has to

be covered.