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Health Care Reform Management Alert Series

Issue 36

Essential Health Benefits To Be Defined by "Benchmark" Plans

This is the thirty-sixth issue in our series of alerts for employers on selected topics in health care reform. (Click here to access our general summary of health care reform and other issues in this series.) This series of Health Care Reform Management Alerts is designed to provide an in-depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.

The Affordable Care Act prohibits group health plans from imposing lifetime dollar limits and requires plans to phase out annual dollar limits on "essential health benefits" by 2014. The Act did not define the term "essential health benefits." Instead, it outlined ten broad categories of benefits, to be further defined by the Secretary of Health and Human Services (HHS) at a later date. Instead of providing a uniform national definition, HHS announced that it intends to propose that "essential health benefits" be defined by a benchmark plan to be selected by each state.

[✔] Applies to grandfathered plans

[✔] Applies to new health plans and plans that lose grandfathered status

Background: Dual Significance of Essential Health Benefits

Beginning in 2014, non-grandfathered insured plans in the individual and small group markets (including those offered in a state-based health insurance exchange) must cover "essential health benefits." Nothing in the Act, however, requires self-funded plans or insured plans in the large group market to cover essential health benefits. Instead, group health plans (including grandfathered plans) and insurers must phase out dollar limits on the essential health benefits they do offer.

As we reported in *Issue 7*, Interim Final Rules issued in June, 2010 indicated that until regulations are issued defining essential health benefits, the Departments of Treasury, Labor and Health and Human Services would take into account good faith efforts to comply with a reasonable interpretation of essential health benefits. Although regulations have not been issued, HHS has issued a Bulletin and Frequently Asked Questions proposing that each state will be permitted to define essential health benefits by selecting one of the following four benchmarks:

- the largest plan by enrollment in any of the three largest insurance products in the state's small group market (generally, the "small group market" includes group health plans with fewer than 100 participants);
- any of the largest three state employee health benefit plans by enrollment;
- any of the largest three national Federal Employee Health Benefit Plan options by enrollment; or
- the largest insured commercial non-Medicaid HMO operating in the state.

Under this guidance, states would have to select one of the benchmarks by the third quarter of 2012, and the benefits and

services included in the selected benchmark plan would be the essential health benefits package in that state for 2014 and 2015. Plans would be permitted to modify coverage within a benefit category, provided that the plan was substantially equal to the benchmark plan in both scope of benefits and limitations on those benefits (e.g. visit limits).

Impact of Benchmarks on Self-Funded Plans

As stated above, by 2014, self-funded group health plans must remove all dollar limits on essential health benefits covered under the plan. The HHS guidance provides that the Departments will consider these plans to have used a permissible definition of essential health benefits if they select a benchmark plan as described in the guidance. Under the benchmarking approach, every benefit offered within the benchmark will be considered an essential health benefit, regardless of whether it fits cleanly into any of the previous ten categories of essential health benefits, and regardless of whether the benchmark actually includes a dollar limit on the benefit.

Essential Health Benefits

The Affordable Care Act listed ten general categories of essential health benefits, including:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care.

Unanswered Questions

While the guidance brings greater clarity in determining exactly what constitutes an essential health benefit, it still leaves much uncertainty, including:

- **Good Faith Interpretation**. The Interim Final Rules indicated that a good faith interpretation of "essential health benefits" would suffice until regulations defining essential health benefits were issued. Now that HHS has issued guidance, it is unclear whether a good faith interpretation is sufficient if it is not based upon a benchmark. (There is some indication that the good faith interpretation standard continues to apply until final regulations are issued, but the agencies have not officially opined on this.) If plans must choose a benchmark, it is unclear by when the benchmark must be chosen. Cautious plan sponsors may consider shifting to a benchmark as early as third quarter of 2012.
- **Using a Benchmark**. While states have the option to choose between four different benchmarks, it isn't clear whether employer-sponsored plans have the same flexibility or whether an employer plan must choose the option selected by a state. Also, it isn't clear what options are available to plans covering participants in multiple states. The guidance simply suggests that the Departments will use enforcement discretion assuming the plan sponsor makes a "good faith effort" to use a definition of essential health benefits authorized by HHS, including any available benchmark option.

Seyfarth Shaw will continue monitoring developments and issue an alert when the agencies issue further guidance.

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