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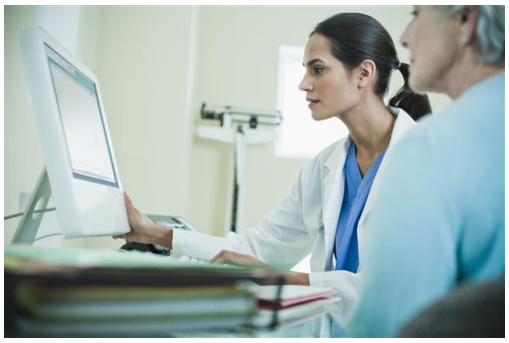
Essential Health Benefits – Why Should Employers Care?

Although it's been years since the implementation of the ACA's market mandates, "essential health benefits" remain a bit of a mystery for employers. Many remain unclear about how essential health benefits play into the health benefits offered to their employees. In this issue, we describe what employers need to know about the evolving concept of essential health benefits and new requirements for 2017.

Background

The Affordable Care Act (ACA) requires non-grandfathered health plans in the individual and small group markets to cover essential health benefits (EHBs). Self-insured, large insured, and grandfathered group health plans are not required to cover EHBs, but may not impose lifetime or annual dollar limits on any EHBs they do cover. (See our February 27, 2013 *For Your Information*.) Additionally, the ACA imposes annual in-network out-of-pocket (OOP) maximums on the amount that an enrollee in a non-grandfathered health plan, including self-insured and large group health plans, must pay for EHBs through cost-sharing. (See our March 14, 2016 *For Your Information*.) To comply with these rules, it is important that plans know which benefits and services are considered EHBs.

The ACA defines EHBs to include the items and services in the following categories:



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

The statute provides these broad categories, but, rather than creating a complete, standard EBH list or plan, the states are given authority to clarify further the benefits and services that make up each of them. To this end, for 2014 and again for 2017, each state had the opportunity to select a benchmark plan from among several options (see sidebar) that offer coverage in each of the ten statutory categories. For states that did not make a selection, the Department of Health & Human Services (HHS) assigned a default benchmark plan — the largest plan by enrollment in the largest product in the state's small group market. The services covered by the selected plan and any limits imposed by that plan define EHBs for that state.

For purposes of applying the lifetime and annual dollar limitation market mandate, a self-insured, large insured or grandfathered group health plan may choose any state's benchmark as a reference plan for defining EHBs. In past FAQs, HHS explained that those plans could choose from among any of the plans a state could have selected as its benchmark plan (see sidebar). Because each state had a choice of ten different plans, the selection of benchmark plans available for employers was in the hundreds.

Options for state benchmark plans

- Any of the three largest small group insurance products, by enrollment, in the state
- Any of the three largest state employee plans by enrollment
- Any of the three largest federal employee plan options by enrollment
- The largest insured HMO offered in the state's commercial market by enrollment

Now that each state has either chosen or defaulted to only one EHB benchmark plan, final regulations narrow the list of permissible EHB benchmark plans for purposes of the annual and lifetime dollar limit mandate. For plan years beginning on or after January 1, 2017, plans must choose among only those EHB benchmark plans states have actually selected (either actively or by default) or one of the three Federal Employees Health Benefits Program (FEHBP) plans.

EHB Benchmark Plan Selection

With the list of potential benchmark plans now condensed, employers should take the following actions:

- Review the current list of EHB benchmark plans chosen by the states for 2017 and the three FEHBP options.
- Choose a plan to define EHB for purposes of the annual and lifetime limit prohibition that best aligns with the employer's health program. Employers may choose any state's plan — they need not choose the plan from their own state. Although all benchmark plans must cover the ten statutory EHB categories, they can vary greatly beyond that, so employers should consult with trusted advisors in making a selection.
- Review the employer health plan(s) to ensure any existing annual or lifetime dollar limits do not apply to the EHBs (as defined under the chosen benchmark plan).

  Example: If the chosen benchmark plan includes applied behavioral analysis for autism treatment as an EHB, the employer's plan cannot impose annual or lifetime limits on that service.
- Review the employer health plans to ensure OOP limits apply to EHBs.

Comment. Employers that have already selected a benchmark plan to determine EHBs should review that selection against the 2017 benchmarks.

In Closing

The current list of EHB benchmark plans selected by the states for 2017 can be found on the Centers for Medicare & Medicaid Services website. Employers should consult with trusted advisors to choose a benchmark plan for the 2017 plan year that is appropriate for them.

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