ALSTON + BIRD LLP

Employee Benefits & Executive Compensation ADVISORY

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Health Care Reform Update: What's Essential About "Essential Health Benefits"— HHS Bulletin Creates Issues for All Group Health Plans

On December 16, 2011, the Department of Health and Human Services (HHS) issued the Essential Health Benefits Bulletin (the "Bulletin")[1] relating to the definition of essential health benefits (EHB) under the Affordable Care Act (ACA). The Bulletin sets forth the approach HHS intends to take in defining EHB and solicits comments on this intended approach.[2] The definition of EHB is especially important for small group health coverage, whether offered through or outside of an Exchange; however, this definition is also significant for all types of group health plans subject to ACA,[3] including self-insured plans and plans in the large group market, as follows:

- Non-grandfathered fully-insured small group health plans, as well as individual market policies offered inside and outside Exchanges, must include the EHB, effective for plan years beginning on or after January 1, 2014.
- Self-insured group health plans (including small group plans) and large group plans are *not* required to offer the EHB;[4] however, the definition of EHB is relevant for such plans because ACA's restriction on annual and lifetime dollar limits applies to all ACA covered plans with respect to benefits that are EHB.

This article focuses on the significance of EHB for large group and self-funded group health plans for purposes of applying the restriction on annual and lifetime limits.

Background: Statutory Provisions Defining EHB

ACA's statutory provisions provide that HHS is to define EHB, subject to parameters set forth in the statute.[5] Specifically, ACA provides that EHB are to include, but are not necessarily limited to, the following 10 general categories and items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and

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1 The Bulletin may be found at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

2 The comment deadline is January 31, 2012.

3 The health care reforms added to Part A of title XXVII of the Public Health Service Act do not apply to "excepted benefits" as defined under HIPAA, or to "retiree only" plans.

4 The Bulletin confirms that such plans are not required to offer EHB; *see* Bulletin at p. 1, including footnote 1.

5 ACA § 1302(b).

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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; and pediatric services, including oral and vision care. In addition, EHB are to reflect the "typical" employer plan. In order to help inform HHS regarding the typical employer plan, ACA provides that the Department of Labor (DOL) is to conduct a survey of employer plans. In response to this statutory directive, the DOL submitted a report to HHS in April 2011 discussing survey data relating to benefits in employer plans.[6]

Restriction on Lifetime and Annual Limits[7]

Lifetime limits: ACA prohibits group health plans, including grandfathered group health plans, from imposing lifetime limits on the dollar value of EHB. This prohibition is part of the first wave of health care reforms, and applies for plan years beginning on or after September 23, 2010.

Annual limits: ACA also generally prohibits group health plans from imposing annual limits on the dollar value of EHB for plan years beginning on or after January 1, 2014. For plan years beginning on or after September 23, 2010, and before January 1, 2014, a group health plan may impose restricted annual limits on the dollar value of benefits, as follows:

- $750,000 for plan years beginning on or after September 23, 2010, but before September 23, 2011
- $1.25 million for plan years beginning on or after September 23, 2011, but before September 23, 2012
- $2 million for plan years beginning on or after September 23, 2012, but before September 23, 2013

Determining EHB for purposes of the restrictions on annual and lifetime limits: Under interim final regulations issued in June 2010,[8] the Departments of HHS, Treasury and Labor stated that, for plan years beginning before the issuance of regulations defining EHB, for purposes of enforcement, the Departments will take into account "good faith" efforts to comply with a reasonable interpretation of the term EHB. Pending issuance of regulations defining EHB, group health plan sponsors have been applying this "good faith" standard. Depending on the particular benefit involved, plan sponsors may look to a number of sources in order to provide support for a good faith determination, starting with the 10 categories of benefits listed in the statute. For example, a common interpretation is that vision and dental benefits for adults are not EHB, because only pediatric vision and dental benefits are listed in the statute. Thus, for example, if dental benefits are bundled in a major medical plan so that they are not excepted benefits under HIPAA, such benefits may be subject to annual dollar limits (as was typically the case before ACA). In other cases that might not be so clear—e.g., for benefits

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[6] This report is available on the DOL's EBSA website, the letter of transmittal to HHS may be found at http://www.dol.gov/ebsa/pdf/ACAresearchtransmittalltr041511.pdf and the report and related information may be found at http://www.bls.gov/ncs/ebs/smb_health.htm.

[7] *See* Section 2711of the Public Health Service Act (PHSA), which is incorporated by reference into ERISA and the Internal Revenue Code (the "Code").

[8] 75 Fed Reg 37188 (June 28, 2010).

that might fit into one of the 10 categories, depending on how they are ultimately defined—plan sponsors often consider whether the benefit is offered under a "typical" employer plan. A number of sources may be used to inform this determination, such as the survey data published by the DOL, private surveys conducted by consulting firms or other entities, and information regarding insurance company practices. If a benefit is offered only subject to strict limits, this might also be a factor taken into account in some cases. As a result of the lack of specific guidance, different plan sponsors and insurers may have taken different positions on whether certain items and services are EHB for purposes of the restrictions on annual and lifetime dollar limits under the good faith standard.

Further discussion of the regulations and other guidance relating to the restrictions on annual and lifetime limits, including the temporary waiver program established by HHS, may be found at:

Alston & Bird Health Care Reform Update: HHS Annual Limit Waiver Program Will Close on September 22, 2011; No Waiver Application Required for Certain HRAs (Aug. 21, 2011)

Alston & Bird Health Care Reform Update: New Prescription Requirement for OTC Medicines and Drugs Will Impact Administration of FSAs, HRAs and HSAs; and Guidance on Waiver Process for "Mini-Med" (Sept. 15, 2010)

Alston & Bird Health Care Reform Update: Departments Issue Core Interim Regulations (June. 29, 2010)

The EHB Bulletin

As noted above, the Bulletin describes the approach that HHS intends to take when issuing regulations defining EHB. The Bulletin does not contain a detailed list of EHB; rather, HHS largely leaves the determination of EHB to each state. Thus, under the approach in the Bulletin EHB, may vary by state.

Under the Bulletin, EHB will be defined by a "benchmark" plan selected by the state. This approach is similar to the approach established for the Children's Health Insurance Program (CHIP) and certain Medicaid populations. A state may choose one of the following as the benchmark plan for 2014 and 2015:

(1) the largest plan by enrollment in any of the three largest small group insurance products in the state's small group market;

(2) any of the largest three state employee health benefit plans by enrollment;

(3) any of the largest three national FEHBP plan options by enrollment; or

(4) the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state.

HHS intends to assess the benchmark process for the year 2016 and beyond based on evaluation and feedback.

HHS has an ambitious timeframe for determination of the benchmark plan to be used for 2014—enrollment data is to be based on the first two quarters of 2012, and the state selection is to be made in the third quarter of 2012 (i.e., by the end of September of this year). If a state does not select a benchmark health plan, the default benchmark for that state would be the largest plan by enrollment in the largest product in the state's small group market.

The Bulletin also provides rules for supplementing the benchmark plan if it does not contain all the required EHB, which vary by benefit.

In order to provide additional information on the proposed method for determining EHB, HHS separately released a list of the products with the three largest enrollments in the small group market in each state using data from HealthCare.gov. HHS provides the names of the three largest products in each state ranked by enrollment, as well as a list of the top three nationally available Federal Employee Health Benefit Program (FEHBP) plans based on enrollment. This list may be found at http://cciio.cms.gov/resources/files/Files2/01272012/top_three_plans_by_enrollment_508_20120125.pdf.

What Does the EHB Bulletin Mean for Large Group Plans and Self-Funded Plans?

The EHB Bulletin is helpful in that it reconfirms that large group plans (including fully insured plans) and self-funded plans (including both large and small group plans) are not required to offer EHB.

With respect to what EHB means for such plans in terms of applying the restrictions on annual and lifetime dollar limits, however, the Bulletin is not so helpful. The Bulletin does not address issues that may arise with self-funded plans. The reliance on states to determine EHB will be particularly problematic for self-funded plans that are not subject to state law because of ERISA preemption. Further, many large group plans, including both fully insured and self-insured, apply to a broad group of employees in different states, and it is not clear how EHB would be determined in such cases. The EHB Bulletin does address one specific benefit, indicating HHS' intent to exclude non-medically necessarily orthodontia from the definition of EHB.

At this point, in the absence of more specific guidance on EHB, the good faith standard should continue to apply for purposes of defining EHB in applying the restrictions on annual and lifetime limits. Going forward, however, if HHS does not address the specific issues for plans that are not required to offer EHB, then such plans may be forced to look to state law. For a multistate plan, including an insured plan, it is not entirely clear what this will mean. For example, it is not clear whether a plan would be able to follow the EHB determination where the plan is sitused or whether plans will be required to provide benefits consistent with all state requirements in which their participants reside. Focusing on state law is particularly troublesome for self-funded plans that currently are not familiar with or subject to state rules as a result of ERISA preemption. It is to be hoped that the regulatory agencies will address these concerns and provide a workable rule before guidance is formally issued.

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