

EBIA Weekly Archives

Are Self-Insured Health Plans Required to Provide Essential Health Benefits?

From the April 16, 2015 EBIA Weekly

QUESTION: We understand that health care reform requires some plans to cover certain “essential health benefits.” Is our self-insured health plan required to cover essential health benefits?

ANSWER: No; self-insured health plans are not required to include essential health benefits. However, as discussed below, they are prohibited from imposing annual or lifetime dollar limits on any essential health benefits they do offer. HHS has established a process for self-insured plans to identify essential health benefits, based on rules applicable in the individual and small group markets.

Health care reform requires insured health plans in the individual and small group markets to contain an “essential health benefits package.” The basic building block of the essential health benefits package is a benchmark plan designated by each state (or by HHS, in the absence of state action), based on the largest insurance products sold in the state. The statutory definition of “essential health benefits” includes items and services in ten general categories:

- 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; and
- Pediatric services, including oral and vision care.

Although your self-insured plan is not required to cover essential health benefits, you still need to understand what constitutes essential health benefits under your plan—because if your plan imposes any annual or lifetime dollar limits, you will need to ensure that the limits are not applied to essential health benefits. For this purpose, your plan may use as its definition of essential health benefits your choice of any HHS-approved benchmark plan from any state. HHS has indicated that the benchmark plan you select must be “supplemented as needed to ensure coverage of all ten statutory categories,” although there is no specific guidance on how to do this.

If your plan does not impose any annual or lifetime dollar limits, then you will not need to define the scope of benefits subject (and not subject) to the limits, so your plan may not need to adopt a definition of essential health benefits. And keep in mind that although your plan is not required to offer essential health benefits, there are other mandates that may require your plan to cover certain services, such as preventive care services.

For more information, see EBIA's **Health Care Reform** manual at Sections IX.A (“Lifetime and Annual Dollar Limits”) and XXI.C.2 (“What Is an Essential Health Benefits Package?”). See also EBIA's **Self-Insured Health Plans** manual at Section XIII.F.1.a (“What Are ‘Essential Health Benefits’ for Purposes of Complying With the Dollar-Limit Prohibitions?”).

Contributing Editors: EBIA Staff.

© 2015 Thomson Reuters/Tax & Accounting. All rights reserved.

