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Excepted Benefits Rules Changed

Issue Date: December 30 2013

The Departments of the Treasury, Labor, and HHS (the Departments) have released proposed rules that would amend regulations regarding excepted benefits. Excepted benefits are generally exempt from the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Affordable Care Act (ACA). The proposed rules address the requirements necessary for dental and vision plans, and Employee Assistance Plans (EAPs), to be treated as excepted benefits.

With respect to vision and dental benefits, the proposed regulations would allow self-insured plans to offer dental and vision benefits to employees without charging an employee contribution in order to qualify as an excepted benefit.

The rules also propose a new type of excepted benefits that would apply to employer sponsored "wraparound" coverage offered to employees who qualify for subsidized individual coverage through a public exchange.

Effective Date

Through 2014 (or until final regulations are released if later), the Departments will consider dental and vision benefits, and EAP benefits, meeting the conditions of these proposed regulations to qualify as excepted benefits. Final regulations will not be effective prior to January 1, 2015.

Excepted Benefits Background

Current statutory provisions and regulations establish four categories of excepted benefits. Benefits described in the first category are excepted benefits in all cases. Benefits in the remaining categories are excepted only if certain conditions are met.

Current Categories of Excepted Benefits

A. Benefits that are generally not health coverage: Benefits such as automobile insurance, liability insurance, workers compensation, and AD&D.h4
B. Limited excepted benefits: Health flexible spending arrangements (HFSAs), limited-scope vision or dental benefits, long-term care, and nursing, home health, or community-based care. To be excepted under this second category, limited benefits must either; (1) be provided under a separate policy, certificate, or contract of insurance; or (2)otherwise not be an "integral part of a group health plan" (see more below).
C. Non-coordinated excepted benefits: Coverage for a specified disease or illness (such as cancer-only policies), and hospital indemnity or other fixed indemnity insurance.
D. Supplemental excepted benefits: Benefits must be: (1) coverage supplemental to Medicare, CHAMPVA, Tricare, or coverage that is supplemental to coverage under a group health plan; and (2) provided under a separate policy, certificate, or contract of insurance.

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Dental and Vision Benefits

Under existing regulations, vision and dental benefits are excepted if they are limited in scope (described as benefits, substantially all of which are for treatment of the eyes or mouth) and are either: (1) provided under a separate policy, certificate, or contract of insurance; or (2) otherwise not an integral part of a group health plan. Only fully insured coverage may qualify as provided "under a separate policy, certificate, or contract of insurance."

For employers to meet the second test (not an integral part of a group health plan) current regulations require participants must have the right to elect not to receive coverage for the benefits, and if participants elect to receive coverage, they must be required to pay an additional contribution.

Following enactment of the ACA, employers have argued that, where employers are providing dental and vision benefits on a self-insured basis, employers should not be required to charge a small contribution from participants simply for the benefits to qualify as excepted benefits.

No Employee Contribution Required

In an attempt to level the playing field between fully insured and self-insured coverage, the proposed regulations would eliminate the requirement that participants pay an additional contribution for limited-scope vision or dental benefits.

However, the proposed regulations continue to impose the requirement that participants must be given the right to elect not to receive coverage. Consequently, to qualify for excepted benefit status, employers sponsoring self-funded dental and vision plans may need to modify current enrollment polices so that participants are allowed to waive dental or vision coverage, even if no employee contribution is required.

Employee Assistance Programs

To the extent an EAP provides benefits for medical care, it would generally be considered group health plan coverage, which would be subject to the HIPAA and ACA requirements, unless the EAP qualifies as an excepted benefit.

The Departments issued guidance on September 13, 2013, which stated, "…through at least 2014, the Departments will consider an EAP to constitute excepted benefits only if the EAP does not provide significant benefits in the nature of medical care or treatment…employers may use a reasonable, good faith interpretation of whether an EAP provides significant benefits…"

The proposed regulations set forth criteria for an EAP to qualify as excepted benefits beginning in 2015.

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A. The program cannot provide significant benefits in the nature of medical care. The Departments are taking comments on how to define "significant."

B. The EAP cannot be coordinated with benefits under another group health plan.

C. Employees cannot be required to make a contribution to participate in the EAP.

D. There can be no participant cost sharing (such as a co-pay) under the EAP.

Limited Wraparound Coverage

The Departments have also created a new type of excepted benefit that will allow employers to offer "wraparound" coverage to employees who purchase subsidized individual health insurance through a public exchange. These proposed regulations would be effective for plan years starting in 2015.

It is also important to note that wraparound excepted benefits will not satisfy an applicable large employer's shared responsibility (pay or play) requirements under section 4980H. The rules are designed to allow employers to offer additional benefits to employees who are also eligible for employer sponsored minimum value coverage.

As discussed in the preamble to the proposed regulations, in some cases, employer plans may be unaffordable (as defined by the ACA) for some employees. These individuals might purchase coverage through an Exchange and be eligible for a premium tax credit. Some group health plan sponsors have asked whether wraparound coverage could be provided for employees for whom the employer premium is unaffordable and who obtain coverage through an Exchange.

Wraparound coverage would qualify as excepted benefits under limited circumstances. It would be considered to be an excepted benefit only if it is used to provide additional coverage to individuals enrolled in individual health insurance coverage and for whom coverage under the employer's group health plan is offered but unaffordable.

Under these proposed regulations, limited wraparound coverage would be treated as an excepted benefit if certain conditions are met:

- The employer sponsored coverage can wrap around only certain coverage provided through the individual market.
- The limited wraparound coverage must be specifically designed to provide benefits beyond those offered by the individual health insurance coverage.
- The plan sponsor offering the limited wraparound coverage must sponsor another group health plan

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meeting minimum value (as defined by the ACA).

- The limited wraparound coverage must be limited in amount. Specifically, the total cost of wraparound coverage must not exceed 15% of the cost of coverage under the primary plan.
- The limited wraparound coverage must not differentiate among individuals in terms of eligibility, benefits, or premiums based on any health factor of an individual.
- The limited wraparound coverage must not impose any preexisting condition exclusion.
- Both the primary coverage and the limited wraparound coverage must not discriminate in favor of highly compensated individuals.

Summary

The modifications to the excepted benefit rules will be a welcome change for employers who sponsor self-insured dental and vision plans, and move closer to defining when an EAP plan will qualify as an excepted benefit.

It is expected that employer adoption of wraparound plans will be limited for several reasons. The proposed rules are designed so that the wraparound coverage could not replace group coverage for employers who do not offer minimum value coverage, and as previously noted, the provision of excepted benefits will not satisfy an applicable large employer's responsibilities under section 4980H of the Code.

Relatively few employees eligible for employer sponsored minimum value plans will qualify for subsidized individual coverage through a public exchange. However, the wraparound option will allow employers to provide some additional coverage to those who do.

As always, should you have any questions, please contact your Parker, Smith & Feek Benefits Team