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Final Rules Amending Definition of Excepted Benefits

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The Departments of the Treasury, Labor, and HHS (the Departments) have released final rules that amend regulations regarding the definition of "excepted benefits". The guidance specifically addresses limited-scope dental and vision plans as well as employee assistance programs (EAPs) and what requirements must be met for such plans to be considered excepted benefits exempt from the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Affordable Care Act (ACA). For the most part, the final rules adopt the proposed rules from December 2013. The final rules do not address the rules regarding the ability of an employer to sponsor "wraparound" coverage offered to employees who qualify for subsidized individual coverage through a public Exchange/Marketplace, but promise that further guidance is coming.

Effective Date

These final rules apply to group health plans and group health insurance issuers for plan years beginning on or after January 1, 2015.

Background

In general, excepted benefits are exempt from the HIPAA and ACA market reform requirements. In addition, excepted benefits will not cause an individual to lose eligibility for subsidies for coverage obtained through the public Marketplace (Exchange). These final rules provide clarity specifically related to how limited-scope dental and vision benefits and EAPs qualify as excepted benefits.

Limited-Scope Dental and Vision Benefits

Under existing regulations, dental and vision 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 under the first test (provided under a separate policy, certificate, or contract of insurance)
- Fully insured and self-funded plans may both qualify under the second test (not an integral part of a group health plan).

2nd Test – Not Integral to the Group Health Plan

For employers to meet this second test, originally the requirement was that 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. The proposed rules eliminated the requirement that participants pay an additional contribution for limited-scope dental or vision benefits. Consistent with the proposed rules, the final rules require only that participants be able to decline coverage. This requirement is satisfied if participants may decline coverage or the claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan.

In addition, the final rules clarify that the benefits do not have to be offered in connection with a separate offer of major medical or "primary" group health coverage under the plan in order to satisfy this second test. In other words, limited-scope vision or dental benefits can be provided without connection to a primary plan or offered separately from the major medical or "primary" coverage under the plan to satisfy this requirement.

Employee Assistance Programs

The proposed regulations set forth four criteria for an EAP. The final rules adopted the four criteria with some clarification as to what constitutes "significant benefits in the nature of medical care" and a minor modification to the second criterion eliminating the requirement that EAP benefits cannot be financed by another group health plan in order to qualify as excepted benefits.

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To qualify as excepted benefits beginning in 2015:

1. The program cannot provide significant benefits in the nature of medical care. For this purpose, the amount, scope, and duration of covered services are taken into account. Examples:
    - o Benefits are not significant – EAP provides only limited, short-term outpatient counseling for substance use disorder services (without covering inpatient, residential, partial residential, or intensive outpatient care) without requiring prior authorization or review for medical necessity.
    - o Benefits are considered significant – EAP provides disease management services (such as laboratory testing, counseling, and prescription drugs) for individuals with chronic conditions such as diabetes.
2. The EAP cannot be coordinated with benefits under another group health plan.
    - o Participants in the other group health plan must not be required to use and exhaust benefits under the EAP (making the EAP a "gatekeeper") before an individual is eligible for benefits under the other group health plan; and
    - o Participant eligibility for benefits under the EAP must not be dependent on participation in another group health plan.
3. Employees cannot be required to make a contribution to participate in the EAP.
4. There can be no participant cost sharing (such as a co-pay) under the EAP.

Summary

These final rules adopt much of what was previously provided for guidance in the proposed rules. Most employers of self-funded plans welcome the elimination of the requirement that participants pay an additional contribution for limited-scope dental or vision benefits. To ensure 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. In regard to EAP benefits, further guidance regarding what constitutes significant medical benefits is helpful. The Departments have indicated that additional guidance may be provided in this area as needed.

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

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