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Proposed Expansion of "Excepted Benefits"

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established certain categories of "**excepted benefits**" that generally are not governed by the HIPAA portability regulations. Employee benefits that qualify as excepted benefits under HIPAA are also not subject to the market reforms under the Affordable Care Act (ACA), including the ACA's prohibition on annual limits and preventive care coverage requirement.

On Dec. 20, 2013, the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (Departments) issued **proposed regulations** that would expand excepted benefits. Specifically, the proposed regulations would:

- Allow self-insured plans to cover **dental and vision benefits** as excepted benefits without an extra premium payment;
- Permit **limited group wraparound coverage** of individual coverage as excepted benefits; and
- Recognize certain **employee assistance programs** (EAPs) as excepted benefits.

These proposed regulations would be effective with respect to limited wraparound coverage for plan years starting in 2015. Until final regulations are issued, through at least 2014, the Departments will consider dental and vision benefits and EAP benefits that meet the proposed requirements to qualify as excepted benefits.

CATEGORIES OF EXCEPTED BENEFITS

The current HIPAA regulations establish the following four categories of excepted benefits. The benefits in the first category are excepted in all circumstances. In contrast, the benefits in the second, third and fourth categories are excepted only if certain conditions are met.

1. Benefits that are Generally Not Health Coverage

The first category includes benefits that are generally not health coverage, such as automobile insurance, liability insurance, workers' compensation and accidental death and dismemberment coverage.

2. Limited Excepted Benefits

The second category of excepted benefits is limited excepted benefits, which may include limited-scope vision or dental benefits as well as benefits for long-term care, nursing home care, home health care or community based care. Benefits provided under a health flexible spending arrangement (health FSA) may also qualify as limited excepted benefits in certain circumstances.

3. Non-coordinated Excepted Benefits

The third category of excepted benefits, referred to as "non-coordinated excepted benefits," includes both coverage for only a specified disease or illness (such as cancer-only policies) and hospital indemnity or other fixed indemnity insurance.

4. Supplemental Excepted Benefits

The fourth category of excepted benefits is supplemental excepted benefits. These benefits must be supplemental to Medicare or CHAMPVA/TRICARE coverage (or similar coverage that is supplemental to coverage provided under a group health plan) and provided under a separate policy, certificate or contract of insurance.

OVERVIEW OF THE PROPOSED REGULATIONS

The proposed regulations would amend the second category of excepted benefits—limited excepted benefits. The proposed regulations would expand limited excepted benefits by:

- Allowing self-insured plans to cover **dental and vision benefits** as excepted benefits without an extra premium payment;
- Permitting **limited group wraparound coverage** of individual coverage as excepted benefits; and
- Recognizing certain **EAPs** as excepted benefits.

Dental and Vision Benefits

In 2004, the Departments published final regulations with respect to excepted benefits (the HIPAA regulations). Under the HIPAA 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, respectively) and are either:

1. Provided under a separate policy, certificate or contract of insurance; or
2. Are otherwise not an integral part of a group health plan.

While only insured coverage may qualify under the first test, both insured and self-insured coverage may qualify under the second test. The HIPAA regulations provide that benefits are not an integral part of a plan if participants have the right to elect not to receive coverage for the benefits, and if participants elect to receive coverage for the benefits, they pay an additional premium or contribution for it. Thus, under these regulations, self-insured dental or vision coverage cannot qualify as excepted benefits unless employees pay a separate, at least nominal, premium for the coverage.

In order to level the playing field between insured and self-insured coverage, the proposed regulations would **eliminate the requirement that participants pay an additional premium or contribution** for limited-scope vision or dental benefits to qualify as benefits that are not an integral part of a plan (and thus, as excepted benefits).

Limited Wraparound Coverage

The ACA requires that non-grandfathered health plans in the individual and small group markets cover essential health benefits (EHB), which include items and services in ten statutorily specified categories. Self-insured group health plans and health insurance coverage in the large group market often cover items and services in addition to the types of services included in EHB. Also, some of these group health plans may provide broader provider networks than those often included in the individual and small group market.

If employer-sponsored coverage is considered "unaffordable" (meaning an employee's contribution for single coverage exceeds 9.5 percent of his or her household income), that employee may be eligible to receive federal subsidies for coverage through an Exchange. Although these employees might pay lower premiums for coverage through an Exchange, they might also have less generous coverage in terms of benefits or a different provider network than they would have had in their group health plan.

To address this issue, the proposed regulations would allow employers to supplement Exchange coverage by offering "wraparound" coverage to employees who cannot afford the employer-sponsored coverage. Under this approach, the

proposed regulations would treat certain wraparound coverage provided under a group health plan as excepted benefits when it is offered to individuals who:

- Could receive these benefits through their group health plan if they could afford the premiums; but
- Do not enroll in the employer-sponsored plan because the premium is unaffordable under the ACA.

This approach would allow employers to provide employees with overall coverage that is comparable to the group health plan coverage, taking into account both the wraparound coverage and the Exchange coverage. In the proposed regulations, the Departments note that provision of excepted benefits will *not* satisfy an applicable large employer's responsibilities under the ACA's employer mandate.

Under these proposed regulations, employer-provided wraparound coverage would constitute excepted benefits (limited wraparound coverage), and therefore would not disqualify an employee from eligibility for the premium tax credit and cost-sharing reductions, only if the following five conditions are met:

- ***The coverage can wrap around only certain coverage provided through the individual market***. Specifically, the individual health insurance coverage must be non-grandfathered and cannot consist solely of excepted benefits.
- ***The limited wraparound coverage must be specifically designed to provide benefits beyond those offered by the individual health insurance coverage***. Specifically, the limited wraparound coverage must either provide benefits that are in addition to EHBs or reimburse the cost of health care providers considered out-of-network under the individual health insurance coverage, or both. The limited wraparound coverage may also, but is not required to, provide benefits to reimburse participants' otherwise applicable cost sharing under the individual health insurance policy, but that cannot be its primary purpose.
- ***The limited wraparound coverage must be otherwise not an integral part of a group health plan***. Specifically, the plan sponsor offering the limited wraparound coverage must sponsor another group health plan meeting minimum value (that is, the plan's share of total allowed costs of benefits provided under the plan is at least 60 percent of those costs) for the plan year, referred to as the "primary plan." This primary plan must be affordable for a majority of the employees eligible for the primary plan. Only individuals eligible for this primary plan may be eligible for the limited wraparound coverage.
- ***The limited wraparound coverage must be limited in amount***. Specifically, the total cost of coverage under the limited wraparound coverage must not exceed **15 percent** of the cost of coverage under the primary plan offered to employees eligible for the wraparound coverage. For this purpose, the cost of coverage includes both employer and employee contributions towards coverage and is determined in the same manner as that in which the applicable premium is calculated under a COBRA continuation provision.
- ***The limited wraparound coverage must be nondiscriminatory***. Specifically, the limited wraparound coverage must not differentiate among individuals in eligibility, benefits or premiums based on any health factor of an individual (or any dependent of the individual). In addition, the limited wraparound coverage must not impose any preexisting condition exclusion. Finally, both the primary coverage and the limited wraparound coverage must not discriminate in favor of highly compensated individuals. These limitations are intended to ensure the coverage is available regardless of health status and to prevent employers from shifting employees with high medical costs to an Exchange.

Employee Assistance Programs (EAPs)

Employee assistance programs (EAPs) are typically programs offered by employers that can provide a wide-ranging set of benefits to address circumstances that might otherwise adversely affect employees' work and health. Benefits may include short-term substance use disorder or mental health counseling or referral services, as well as financial counseling and legal services. To the extent an EAP provides benefits for medical care, it would generally be

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considered group health plan coverage, which would generally be subject to the HIPAA and ACA market reform requirements, unless the EAP meets the criteria for being excepted benefits.

The Departments issued guidance on Sept. 13, 2013, that provided transition relief for EAPs. Under this transition relief, until final regulations are issued, 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. For this purpose, employers may use a reasonable, good faith interpretation of whether an EAP provides significant benefits in the nature of medical care or treatment.

The proposed regulations would recognize EAPs as excepted benefits, beginning in 2015, if the following conditions are met:

- The program does not provide significant benefits in the nature of medical care;
- The program's benefits are not coordinated with benefits under another group health plan. The Departments propose the following three conditions to meet this standard:
  - Participants in the separate group health plan must not be required to exhaust benefits under the EAP (making the EAP a "gatekeeper") before an individual is eligible for benefits under the other group health plan;
  - Participant eligibility for benefits under the EAP must not be dependent on participation in another group health plan; and
  - Benefits under the EAP must not be financed by another group health plan;
- No employee premiums or contributions may be required to participate in the EAP; and
- There is no cost sharing under the EAP.

According to the Departments, these criteria are intended to ensure that employers are able to continue offering EAPs as supplemental benefits to other coverage. In addition, the Departments want to ensure that, in circumstances in which an EAP with limited benefits is the only coverage (or the only affordable coverage) provided to an employee, that the coverage does not unreasonably disqualify an employee from otherwise being eligible for the premium tax credit for enrolling in coverage through an Exchange.

COMMENT SOLICITATION, APPLICABILITY DATE AND RELIANCE

The Departments invite comments on these proposed regulations. Comments are due on or before **Feb. 22, 2014**.

Until final regulations or other guidance are issued, through at least 2014, the Departments will consider dental and vision benefits, as well as EAP benefits, meeting the conditions of these proposed regulations to qualify as excepted benefits. To the extent final regulations or other guidance with respect to vision or dental benefits or EAPs is more restrictive on plans and issuers than these proposed regulations, the final regulations or other guidance will not be effective prior to Jan. 1, 2015.

Source: Departments of Labor, Health and Human Services and the Treasury

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