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Expanded Definition of Excepted Benefits

A newly released final rule adjusts regulations originally issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regarding dental and vision benefits. The new rule also expands the definition of excepted benefits to include employee assistance programs (EAPs).

Background. Under HIPAA, certain categories of "excepted benefits" are not subject to the HIPAA portability rules. 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 prohibition on annual limits and the preventive care coverage requirement. The current HIPAA rules establish the following four categories of excepted benefits.

1. *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*—May include limited-scope vision or dental benefits as well as benefits for long-term care, nursing home care, home healthcare or community-based care. Benefits provided under a health flexible spending arrangement (health FSA) may also qualify as limited excepted benefits in certain circumstances. Proposed regulations from 2013 provided for simplified requirements for limited-scope vision or dental benefits to qualify as excepted benefits, and also recognized two new forms of limited excepted benefits in certain circumstances—EAPs and coverage that wraps around certain individual health insurance coverage.
3. *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*—Must be supplemental to Medicare or CHAMPVA/ TRICARE coverage (or similar coverage that is supplemental to coverage provided under a group health plan), and must be provided under a separate policy, certificate or contract of insurance.

The Final Rule. The final rule generally finalizes the proposed provisions on limited excepted benefits (see 2 above) regarding dental and vision coverage and EAPs without significant changes, as follows:

- **Vision and Dental.** Under the existing HIPAA rules, 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. Insured vision and dental benefits, as well as self-insured vision and dental coverage that requires employee contributions, qualified as excepted benefits under the existing rules. Under the final rule, vision and dental benefits provided by employers on a self-insured basis now qualify as excepted benefits, even if they do not require contributions from employees. The final rule clarifies that limited-scope vision or dental 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 for these benefits to be "otherwise not an integral part of the plan." To satisfy the criterion that limited-scope vision or dental benefits cannot otherwise be "an integral part of the plan," (whether they are provided through the primary plan, separately or as the only coverage offered) the final rule provides that either (1) participants must be able to decline coverage, or (2) benefit claims must be administered under a contract separate from claims administration for any other benefits under the plan.

- **EAPs.** The final rule treats EAPs meeting certain conditions as excepted benefits. EAPs are typically free programs offered by employers that can provide a wide-range of benefits to address circumstances that might otherwise adversely affect employees' work and health. Examples include short-term substance abuse or mental health counseling or referral services, as well as financial counseling and legal services. Under the final rule, EAPs are considered excepted benefits if the program is free to employees, if the EAP does not impose any cost sharing requirements, and if the EAP does not provide significant benefits in the nature of medical care or treatment. The EAP benefits also must not be coordinated with benefits under another group health plan. This requirement has two elements. 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 they are eligible for benefits under the other group health plan, and eligibility for benefits under the EAP must not be dependent on participation in another group health plan. The final regulations eliminated the proposed requirement that EAP benefits cannot be financed by another group health plan in order to qualify as excepted benefits.

The proposed rule also addressed limited group wraparound coverage, but the final rule did not address this issue. See our Update for more information on the proposed rule. The Departments intend to publish regulations addressing limited wraparound coverage in the future, taking into account the extensive comments received.

Should you have questions about this or any aspect of healthcare reform, contact your Conner Strong & Buckelew account representative toll free at 1-877-861-3220. For a complete list of Legislative Updates issued by Conner Strong & Buckelew, visit our online Resource Center.