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New Rules Broaden Category of "Excepted Benefits"

New proposed rules recently released by the Departments (IRS, DOL, and HHS) broaden the categories of health coverage that qualify as "excepted benefits" for purposes of parts of HIPAA and many healthcare reform requirements. The proposed rules immediately expand the definition of limited-scope vision and dental benefits and set out the conditions under which EAPs qualify as excepted benefits. They also provide criteria by which employers could offer "wraparound" employer-provided secondary medical coverage for certain individuals who purchase coverage in the public Exchanges (effective in 2015). These new rules are significant for employers who sponsor self-insured, limited-scope dental and vision plans and EAPs.

Background

Certain types of benefits that are considered limited or ancillary to comprehensive health coverage are exempt from HIPAA's portability and nondiscrimination requirements. These benefits, which include "limited excepted benefits" are also exempt from many of healthcare reform requirements, such as the PCOR fee, W-2 reporting, and SBCs. Since excepted benefits do not qualify as "minimum essential coverage", participation in a plan of excepted benefits will also not disqualify an otherwise qualified individual from receiving a subsidy towards individual health coverage obtained on an Exchange.

Self-Insured Limited-Scope Dental and Vision Benefits

Fully-insured dental and vision plans have always qualified as "excepted benefits" if offered under a separate policy, certificate, or contract of insurance. Self-insured dental and vision plans, however, only qualify as excepted benefits if they are limited in scope (substantially all benefits are for treatment of the eyes or mouth) and are "not an integral part of a group health plan." Under current regulations, these benefits are "not an integral part of a group health plan" if: (1) participants have the right not to receive coverage for the benefits, and (2) they must pay an additional premium or contribution for it.

The new rules eliminate the second requirement above, that self-insured dental and vision benefits must charge an additional premium or contribution in order to qualify as excepted benefits. Thus, employers can offer these plans to employees for free and still meet the definition of excepted benefits. However, the rule retains the requirement that participants must be given the option to waive the benefit. In other words, a self-insured limited-scope dental and vision benefit is now an excepted benefit and, therefore, is exempt from many of healthcare reform's requirements, as long as participants have the right to waive the coverage (even if it is offered free of charge). Further, participation in this benefit will not make an individual ineligible for a subsidy on an Exchange.

Through at least the remainder of 2014, and until these rules are finalized, benefits meeting these rules will qualify as excepted benefits. Of course, employers can also continue to rely on the current regulations governing excepted benefits.

Employee Assistance Programs

Many employers offer EAP programs and often these benefits are provided free of charge to employees. Typically all employees are eligible for such benefits, regardless of the number of hours worked or participation in the medical plan. To the extent such an EAP provides medical care, however, it would generally be a group health plan and therefore subject to the consumer protection requirements applicable to group health plans. The new rules expand on previous guidance and provide more detail on how an EAP can qualify as an "excepted benefit." To be excepted, an EAP must meet the following four criteria:

- The EAP cannot provide significant benefits in the nature of medical care.
- The EAP benefits cannot be coordinated with the benefits of another group health plan. To meet this requirement, three conditions must be met:
  - The participant cannot be required to exhaust benefits under the EAP before accessing benefits under the other group health plan.
  - The participant cannot be required to be a part of another group health plan in order to be eligible for the EAP (i.e., an employer cannot limit EAP coverage to only those employees who are covered by the major medical plan).
  - The benefits under an EAP may not be financed by another group health plan.
- The EAP cannot require participant premiums or contributions.
- The EAP cannot impose cost-sharing requirements (no deductibles or co-pays).

An EAP that does not meet all of the above criteria may be treated as an excepted benefit at least through 2014, as long as the employer makes a reasonable, good faith determination that the EAP does not provide significant benefits in the nature of medical care or treatment.

Note that even if an EAP is an excepted benefit, an EAP that provides any medical care (e.g., counseling) may still be subject to other legal requirements, such as the SPD and COBRA requirements.

Wraparound Coverage

Some employers are providing wraparound secondary medical coverage to employees for whom the employer medical coverage is unaffordable and who elect medical coverage through the public Exchanges. This wraparound coverage can be used to provide additional benefits or a broader provider network than those offered by the individual policies on the Exchanges. For example, an employer's wraparound coverage could cover services such as private duty nursing and infertility treatments that individual plans might not be required to cover as essential health benefits. The proposed rules allow such wraparound coverage to qualify as excepted benefits if it meets the following requirements:

- The wraparound coverage must be for employees enrolled in non-grandfathered individual health insurance plans
- The individual coverage cannot consist solely of excepted benefits.
- The wraparound coverage must not provide benefits that are "essential health benefits" or provide benefits only under a coordination-of-benefits provision. In contrast, it may reimburse the cost of out-of-network providers or pay cost-sharing amounts under the employee's individual coverage.
- The wraparound coverage must be designed specifically to provide benefits beyond those offered by the individual health insurance coverage.
- The sponsoring employer must provide another group health plan meeting "minimum value" and that plan must be "affordable" for the majority of employees eligible for that plan (the "Primary Plan"). Only individuals eligible for the Primary Plan can be eligible for the wraparound coverage.
- The wraparound coverage must be limited in amount. Specifically, the total cost of coverage (i.e., both the employer and employee contributions) under the limited wraparound coverage must not exceed 15% of the cost of coverage under the Primary Plan offered to employees eligible for the wraparound coverage.
- Primary Plan and limited wraparound coverage cannot discriminate in favor of highly compensated individuals.
- The wraparound coverage must not differentiate among individuals in eligibility, benefits, or premiums based on any health factor of an individual (or any dependent).
- The wraparound coverage must not impose any preexisting condition exclusion.

As an excepted benefit, the wraparound coverage does not need to comply with all healthcare reform requirements and this supplemental coverage would not provide the sponsor with penalty protection under the employer mandate. In addition, it will not disqualify individuals from obtaining subsidies for individual coverage on the Exchanges. Unlike the provisions applicable to limited-scope dental and vision benefits and EAPs, this exception for wraparound coverage cannot be relied upon now. It is proposed to be effective as of January 1, 2015.

Next Steps

Employers who sponsor self-insured limited-scope dental and vision plans and EAPs may wish to review their offerings to see if they can take advantage of these exceptions. Employers that currently charge nominal amounts for limited-scope dental and vision benefits simply for them to be treated as excepted benefits may wish to discontinue doing so. The guidance would also allow a plan sponsor that otherwise offers a group health plan to provide wraparound coverage to employees who purchase coverage on the Exchanges.

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.