Employment, Labor & Benefits

MINTZ LEVIN
Mintz Levin Cohn Ferris Glovsky and Popeo PC

Employment, Labor & Benefits Advisory

FEBRUARY 3, 2014

Departments of Labor, Health and Human Services, and Treasury Issue Proposed Regulations Governing "Excepted Benefits"

BY ALDEN BIANCHI

A handful of recent guidance items that the Departments of Labor, Health and Human Services, and Treasury have issued make some important changes related to the regulation of "excepted benefits." These changes are driven in large part by the insurance market reforms and other provisions of the Affordable Care Act (ACA). Included are helpful new rules governing Employee Assistance Plans (EAPs), some welcome clarifications dealing with stand-alone vision and dental plans, and a new "wrap-around" employee benefit that can supplement public exchange coverage. For the most part, these changes should be welcomed by both employers and employees as they endeavor to comply with the ACA.

Statutory Background

The concept of "excepted benefits" was first introduced in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to designate a set of benefits that was *excluded* from that law's substantive portability and nondiscrimination requirements. HIPAA copied and expanded on a regulatory approach first introduced by the Consolidated Budget Reconciliation Act of 1985 (COBRA) under which three separate laws were amended with essentially similar provisions in order to reach most or all employer-sponsored group health plans, as well as state-licensed carriers that issued group insurance products. Thus, COBRA, HIPAA and subsequent federal laws governing group health plans amended the Public Health Service Act (PHS Act) to reach health insurance issuers or carriers, the Employee Retirement and Income Security Act (ERISA) to reach most private sector group health plans, and the Internal Revenue Code (Code) to reach other group health plans (e.g., church and governmental plans that are not subject to ERISA). The ACA adopted a similar approach in its reforms of the insurance markets, but it went even further by extending substantive insurance market reforms to policies of health insurance sold in the individual market. The regulators established early on that the ACA did not apply to excepted benefits.

Excepted Benefits

HIPAA sets out four discrete categories of excepted benefits:

1. ***Benefits that are generally not health coverage*.**
   These include liability insurance, workers compensation, and accidental death and dismemberment coverage. The benefits in this category are excepted in all circumstances.
2. ***Limited excepted benefits*.**
   This category includes limited scope vision or dental benefits, and benefits for long-term care, nursing home care, home health care, or community-based care. The Secretaries of Labor, Health and Human Services, and Treasury have exercised their power to establish

other, similar limited benefits by regulation to add certain health flexible spending arrangements (health FSAs). To be an excepted benefit under this category, the limited benefits must either:

i. Be provided under a separate policy, certificate, or contract of insurance; or

ii. Otherwise not be an integral part of a group health plan, whether insured or self-insured.

3. ***Non-coordinated excepted benefits*.**
This category includes coverage for only a specified disease or illness (such as cancer-only policies), and hospital indemnity or other fixed indemnity insurance. These benefits are excepted only if:

. The benefits are provided under a separate policy, certificate, or contract of insurance;

i. There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and

ii. The benefits are paid with respect to any event without regard to whether benefits are provided under any group health plan maintained by the same plan sponsor.

4. ***Supplemental excepted benefits*.**
Such benefits must be:

. Coverage supplemental to Medicare, coverage supplemental to the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) or to Tricare, or similar coverage that is supplemental to coverage provided under a group health plan; and

i. Provided under a separate policy, certificate, or contract of insurance.

Employee Assistance Plans

EAPs typically include short-term substance use disorder or mental health counseling or referral services, as well as financial counseling and legal services. They are typically available free of charge to employees and are often provided through third-party vendors. To the extent an EAP provides benefits for medical care, however, it would generally be considered group health plan coverage, which would generally be subject to the HIPAA and ACA market reforms, *unless* the EAP meets the criteria for being excepted benefits.

Since EAP benefits are typically very limited, compliance with the ACA prohibition on annual limits could be difficult if not impossible. EAPs are after all intended to provide benefits in addition to those provided under other group health plans. Conversely, if an EAP with very limited benefits was the only coverage offered to employees, and if the coverage failed to qualify as an excepted benefit, then low- and moderate-income employees covered under a compulsory EAP would be ineligible for premium tax credits through a public exchange.

In Notice 2013-54, the Treasury Department announced its intent to amend the regulations governing excepted benefits to provide that benefits under an EAP are considered to be excepted benefits, but only if the program does not provide "significant benefits in the nature of medical care or treatment."[1] An EAP that satisfied this standard would not be subject to the ACA insurance market reforms, nor would it affect an employee's ability to qualify for subsidized coverage through a public exchange if he or she was otherwise eligible.

In proposed regulations issued December 24, 2013, the regulators made good on their promise to designate certain EAPs as excepted benefits. These proposed regulations set forth the following criteria which, if satisfied, will result in an EAP being treated as an excepted benefit beginning in 2015:

1. The program cannot provide significant benefits in the nature of medical care.

   NOTE: The Departments asked for comments on how to define ‘‘significant.’’ For example, does a program that provides no more than 10 outpatient visits for mental health or substance use disorder counseling, an annual wellness checkup, immunizations, and diabetes counseling, with no inpatient care benefits, provide “significant benefits in the nature of medical care?” (One hopes not.) Benefits cannot be coordinated with benefits under another group health plan. To meet this requirement:

   i. 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;

   ii. Participant eligibility for benefits under the EAP must not be dependent on participation in another group health plan; and

   iii. Benefits under the EAP must not be financed by another group health plan.

2. No employee premiums or contributions may be required to participate in the EAP.

3. There can be no cost sharing under the EAP.

Limited Scope Dental and Vision Benefits

Under prior regulations governing excepted benefits, 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:

i. Provided under a separate policy, certificate, or contract of insurance; or

ii. 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. Also under prior regulations, benefits are deemed to be 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 such benefits, they pay an additional premium or contribution for it. This approach puts self-funded plans at a comparative disadvantage. Where employers’ self-fund their limited scope dental or vision benefits, they must charge participants a nominal contribution for the benefits to qualify as excepted benefits. The proposed regulations level the playing field between insured and self-insured coverage by eliminating 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 therefore qualify as excepted benefits).

Limited Wraparound Coverage

The ACA for the first time introduces a federal requirement that health coverage in the individual and small group market include a standardized set of benefits, referred to as “essential health benefits” or “EHB.” Self-insured group health plans and health insurance coverage in the large group market are not required to provide essential health benefits. These plans do, however, routinely cover many EHB categories of services along with other, additional benefits. For example, items and services that are unlikely to be included in EHB include routine adult vision and dental care, long-term/custodial nursing home care, non-medically necessary pediatric orthodontia, and coverage

that extends beyond an EHB plan's coverage of wellness programs, manipulative treatment, infertility, home health care, private duty nursing, hospice, or certain non-traditional treatments. In addition, self-funded and fully-insured large group plans may also provide broader provider networks (e.g., in terms of the number and types of contracted providers) than those typically encountered in the individual and small group markets.

Concerned that low- and moderate-income employees who choose subsidized coverage under a public exchange instead of unaffordable employer-provided coverage will be unable to get the benefit of the added features of the employer's plan, the proposed regulations provide a new excepted benefit, referred to as "limited wraparound coverage." The preamble to the proposed regulations explain it this way:

"[T]he Departments have developed these proposed regulations to treat certain wraparound coverage provided under a group health plan as excepted benefits when it is offered to individuals who could receive such benefits through their group health plan if they could afford the premiums, but who do not enroll in the employer- sponsored plan because the premium is unaffordable under the law. As excepted benefits, the coverage would generally be exempt from the HIPAA and Affordable Care Act market reform requirements of ERISA, the PHS Act, and the Code."

The proposed regulations impose the following requirements in order for wraparound coverage to qualify as an excepted benefit:

1. Coverage can wrap around only certain coverage provided through the individual market, which must be non-grandfathered and cannot consist solely of excepted benefits;
2. The limited wraparound coverage must be specifically designed to provide benefits beyond those offered by the individual health insurance coverage;
3. The limited wraparound coverage must not be an integral part of a group health plan, i.e., the plan sponsor offering the limited wraparound coverage must sponsor another group health plan that provides "minimum value" (i.e., that meets minimum standards of generosity);
4. The limited wraparound coverage must not exceed 15 percent of the total (employer and employee) cost of coverage under the primary plan offered to employees eligible for the wraparound coverage; and
5. 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), nor may it impose any preexisting condition exclusion.

Frequently Asked Questions Part XVIII — Fixed Indemnity Arrangements

Hospital and fixed indemnity arrangements are not subject to the ACA, if they qualify as excepted benefits. In a set of Frequently Asked Questions issued on January 24, 2013, the Departments clarified their understanding of what policies qualify as hospital indemnity or other fixed indemnity programs[2] as follows:

Q7: What are the circumstances under which fixed indemnity coverage constitutes excepted benefits?

The Departments' regulations provide that a hospital indemnity or other fixed indemnity insurance policy under a group health plan provides excepted benefits only if:

- The benefits are provided under a separate policy, certificate, or contract of insurance;
- There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and
- The benefits are paid with respect to an event without regard to whether benefits are

provided with respect to the event under any group health plan maintained by the same plan sponsor.

The Departments explained that:

"[V]arious situations have come to the attention of the Departments where a health insurance policy is advertised as fixed indemnity coverage, but then covers doctors' visits at $50 per visit, hospitalization at $100 per day, various surgical procedures at different dollar rates per procedure, and/or prescription drugs at $15 per prescription…. When a policy pays on a per-service basis as opposed to on a per-period basis, it is in practice a form of health coverage instead of an income replacement policy. Accordingly, it does not meet the conditions for excepted benefits."

The problem that the Departments describe is not uncommon. Issuers of hospital and fixed indemnity products offer a broad variety of hospital and fixed indemnity policies, many of which include, at a minimum, per diem amounts of doctors' visits and hospitalization, and thus run afoul of the January 2013 FAQ. To the extent that an employer offers a non-compliant policy, the Departments' FAQs have three important potential consequences:

- The offending policies, since they would no longer be viewed as excepted benefits and could not qualify for a waiver, would be subject to — and would certainly fail to satisfy — the ACA's insurance market reforms dealing with annual and lifetime limits and first-dollar preventative care, among others, thereby triggering potentially substantial penalties;
- An employee who purchased coverage under one of the offending policies would (unless they relinquished the policy) be ineligible for premium subsidies from a public insurance exchange by reason of his or her having minimum essential coverage under an eligible employer-sponsored plan; and
- Participants covered under an offending policy would have a potential claim under ERISA to compel payment of benefits in accordance with the Act's insurance market reforms.

An FAQ issued January 9, 2014 appears to offer some solutions, but the extent of the relief is ambiguous. With respect to group market coverage, the FAQ says, simply, that the previously offending coverage "may qualify as supplemental excepted benefits." In the next sentence, the FAQ points to a 2007 Department of Labor Field Assistance Bulletin (FAB 2007-04). The implication (though not clearly stated) is that a group market hospital or fixed indemnity policy will be treated as an excepted benefit if it conforms to the requirements of FAB 2007-04.

Under FAB 2007-04, coverage is treated as supplemental coverage provided to coverage under a group health plan, if it is a separate policy, certificate, or contract of insurance and if it satisfies all of the following requirements:

1. The supplemental policy, certificate, or contract of insurance must be issued by an entity that does not provide the primary coverage under the plan. For this purpose, entities that are part of the same controlled group of corporations or part of the same group of trades or businesses under common control are considered a single entity.
2. The supplemental policy, certificate, or contract of insurance must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles, but does not include a policy, certificate, or contract of insurance that becomes secondary or supplemental only under a coordination-of-benefits provision.
3. The cost of coverage under the supplemental policy, certificate, or contract of insurance must not exceed 15 percent of the COBRA cost of primary coverage.
4. The supplemental policy, certificate, or contract of insurance that is group health insurance 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).

Fixed indemnity coverage offered in the individual market will — once the necessary conforming HHS regulations

are adopted — be treated as excepted benefits if it meets the following conditions:

The coverage is sold only to individuals who have other health coverage that is minimum essential coverage;

ii. There is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage;

iii. The benefits are paid in a fixed dollar amount regardless of the amount of expenses incurred and without regard to the amount of benefits provided with respect to an event or service under any other health coverage; and

iv. A notice is displayed prominently in the plan materials informing policyholders that the coverage does not meet the definition of minimum essential coverage and will not satisfy the ACA's individual responsibility requirements.

* * *

View Mintz Levin's Employment, Labor & Benefits attorneys.

Read and subscribe to *Employment Matters* blog.

Endnotes

[1] IRS Notice 2013-54 is available at: http://www.irs.gov/pub/irs-drop/n-13-54.pdf. The Department of Labor issued a parallel rule in DOL Technical Release 2013-03 (Sept. 13, 2013), available at: http://www.dol.gov/ebsa/newsroom/tr13-03.html. The Department of Health and Human Services is expected to issue guidance with respect to the application of the laws under its jurisdiction consistent with Notice 2013-54 and Tech. Rel. 2013-03.

[2] FAQs about Affordable Care Act Implementation Part XI (Jan. 24, 2013) http://www.dol.gov/ebsa/faqs/faq-aca11.html.