HCR ALERT!

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Proposed Guidance Issued Regarding Certain Excepted Benefits

The Departments of Treasury, Labor and Health and Human Services ("the Departments") recently issued proposed rules to amend existing rules regarding excepted benefits, originally defined by the Health Insurance Portability and Accountability Act (HIPAA). Specifically, the proposed rules address certain limited excepted benefits including dental and vision, employee assistance programs (EAPs) and wraparound coverage. The Departments are seeking comments on the proposed rules.

In general, excepted benefits are exempt from most Affordable Care Act (ACA) provisions, such as prohibitions on lifetime and annual dollar limits on essential health benefits, requirement to cover certain preventive care with no cost-sharing, out-of-pocket limit restrictions, 90-day waiting period limitation, summary of benefits and coverage requirement, and patient-centered outcomes research institute (PCORI) and transitional reinsurance program fees. In addition, excepted benefits do not constitute Minimum Essential Coverage (MEC) under the ACA.

Dental and Vision

Under existing regulations, dental and vision benefits are excepted benefits if either a) they are provided under a separate insured policy or b) participants have the right to elect not to receive the coverage and are required to pay an additional contribution if coverage is elected. By this definition, self-insured dental or vision benefits bundled with medical coverage in a single election and single contribution are not excepted benefits.

To level the playing field between insured and self-insured coverage, the proposed rules eliminate the requirement that participants pay an additional contribution for the coverage in order for self-funded dental or vision benefits to qualify as excepted. (However, participants must still have the right to elect/decline self-insured coverage independent of a medical benefit election to be excepted.)

Employee Assistance Programs

In prior guidance, the Departments indicated that, at least through 2014, an EAP would be considered an excepted benefit if the EAP does not provide "significant benefits in the nature of medical care or treatment" and that employers may use a reasonable, good faith interpretation of whether an EAP provides significant benefits in the nature of medical care or treatment. In the newly-proposed rules, beginning in 2015, EAPs must meet the following criteria to qualify as excepted benefits:

- EAP cannot provide significant benefits in the nature of medical care.

- EAP benefits cannot be coordinated with benefits under another group health plan – participants cannot be required to exhaust EAP benefits before being eligible for benefits under another plan and EAP benefits cannot be dependent upon participation in another group health plan or financed by another group health plan.

- Plan sponsor cannot require employee contributions for EAP coverage.

- EAP plan design cannot require participant cost-sharing.

The Departments are seeking comments on how to define "significant" medical care. For example, they ask whether 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, should be considered to provide significant benefits in the nature of medical care.

Until additional guidance is provided regarding the definition of "significant" medical care, employers are left to use a "reasonable, good faith interpretation". Of note, IRS Notice 2004-50 pertaining to health savings accounts includes the following example that references EAP benefits:

> *"Example (1)*. An employer offers a program that provides employees with benefits under an EAP, regardless of enrollment in a health plan. The EAP is specifically designed to assist the employer in improving productivity by helping employees identify and resolve personal and work concerns that affect job performance and the work environment. The benefits consist primarily of free or low-cost confidential short-term counseling to identify an employee's problem that may affect job performance and, when appropriate, referrals to an outside organization, facility or program to assist the employee in resolving the problem. The issues addressed during the short-term counseling include, but are not limited to, substance abuse, alcoholism, mental health or emotional disorders, financial or legal difficulties, and dependent care needs. This EAP is not a "health plan" under section 223(c)(1) because it does not provide significant benefits in the nature of medical care or treatment." (Note: although in this example benefits are primarily "free or low-cost", the new guidance does specific that only EAPs providing benefit at no cost can be considered excepted benefits.)

Limited Wraparound Coverage

Effective for plan years starting in 2015, the proposed rules would add a new category of excepted benefits – limited coverage provided by plan sponsors that "wraps around" an individual market policy. The Departments recognize that self-insured and large market group plans may offer coverage beyond the essential health benefits offered by policies in the individual market, but in cases in which employer plans are unaffordable for some employees, those employees may choose to purchase individual marketplace coverage with a premium tax credit even though they might have less generous coverage than offered by the group plan. Some employers have inquired whether employer-sponsored wraparound coverage could be provided to such

employees to provide overall coverage that is comparable to the group plan coverage, taking into account both the marketplace coverage and wraparound coverage.

Under the proposed rules, wraparound coverage would be treated as excepted benefits if the coverage:

- Is individual health insurance that is non-grandfathered and does not consist solely of excepted benefits.
- Is designed to provide benefits beyond those offered by the individual insurance coverage – benefits beyond EHB or out-of-network services and primary purpose cannot be reimbursement of cost-sharing under individual market plan.
- Is not an integral part of the employer's primary group health plan – the primary plan must offer minimum value and be affordable for the majority of employees and wraparound coverage must only be available to those eligible for the primary plan.
- Is limited in amount, with the total cost of wraparound coverage not exceeding 15% of the cost of coverage (including employer and employee contributions) under the primary plan.
- Does not differentiate in eligibility, benefits or premiums based on a health factor, discriminate in favor of highly compensated individuals, or impose pre-existing condition exclusions.

Offering wraparound coverage is voluntary on the part of plan sponsors. In addition, it does not limit or eliminate employer shared responsibility obligations or potential associated penalties.

ADDITIONAL PPACA REGULATIONS & GUIDANCE ISSUED IN THE LAST 3 MONTHS

Nov. 2013: HHS Announces Transition Policy Regarding Individual Policies Not Complying with ACA Requirements
Nov. 2013: IRS Issues Final Rules on Additional Medicare Tax & FAQ
Nov. 2013: IRS Issues Notice Regarding Procedural Guidance for Carrier Payment of Health Insurance Providers Fee
Nov. 2013: IRS Issues Final Regulations on Health Insurance Providers Fee
Nov. 2013: HHS Issues Proposed Regulations on Transitional Reinsurance Fee and Other Misc. ACA Items and Fact Sheet
Nov. 2013: HHS Announces One-Year Delay of Online SHOP Enrollment
Dec. 2013: HHS Issues Interim Final Rule Extending Exchange Enrollment Deadline for 1/1/13 Coverage
Dec. 2013: Agencies Issue Proposed Regulations on Excepted Benefits
Jan. 2014: Departments Issue FAQs on Preventive Services, Cost-Sharing Limits, Expatriate Plans, Wellness Programs, Fixed Indemnity Insurance and MHPAEA

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