Compliance Alert

Final Regulations on Excepted Benefits Issued

October 31, 2014

Quick Facts:

- On September 26, 2014, federal agencies issued final regulations expanding limited excepted benefits.
- The final regulations address limited-scope vision and dental benefits and employee assistance program (EAP) benefits.
- The final regulations apply to group health plans and group health issuers for plan years beginning on or after January 1, 2015.
- Failure to adhere to the final regulations could subject employers to additional federal mandates as well as penalties for noncompliance.

The Health Insurance Portability and Accountability Act (HIPAA) established certain categories of "excepted benefits" that are exempt from the HIPAA portability regulations and other health plan mandates. "Excepted benefits," as defined under HIPAA, also are exempt from many Affordable Care Act (ACA) requirements, such as the prohibition on annual dollar limits and the nongrandfathered plan preventive care mandate.

On September 26, 2014, federal agencies - the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury - issued final regulations expanding one category of excepted benefits. These regulations finalize provisions in a proposed rule issued in December 2013, to:

- allow self-insured plans to cover dental and vision benefits as excepted benefits without an extra premium payment; and
- recognize certain employee assistance programs (EAPs) as excepted benefits.

The proposed rule had also addressed limited group wraparound coverage, but the final regulations did not address this issue. Guidance regarding wraparound coverage will be issued in the future.

Overview 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. However, 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:*** Automobile insurance, liability insurance, workers' compensation and accidental death and dismemberment coverage, etc.

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2. ***Limited Excepted Benefits:*** Generally 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***: 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.

Regulatory history

Final HIPAA regulations on excepted benefits were issued in 2004. In December 2013, federal officials released proposal regulations on the secondary category of excepted benefits – called limited excepted benefits – to simplify the requirements on certain vision and dental benefits and to address EAPs.

Last month's final regulations generally finalize the proposed 2013 provisions regarding dental and vision coverage and EAPs, without significant changes.

Dental and vision benefits

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 2004 regulations had provided that benefits were not an integral part of a plan if participants had the right to elect not to receive coverage for the benefits, and if participants elected to receive coverage for the benefits, they paid an additional premium or contribution for it. Thus, under the prior regulations, self-insured dental or vision coverage could not qualify as excepted benefits unless employees paid a separate, at least nominal, premium for the coverage.

To achieve greater consistency between insured and self-insured coverage, the new 2014 final regulations eliminate the requirement that participants pay an additional premium or contribution for limited-scope vision or dental benefits to qualify as excepted benefits. Without this change, a self-insured plan would still be required to charge participants a nominal contribution for limited-scope vision and dental benefits to qualify as excepted benefits. In some cases, the administrative cost of collecting the nominal contribution could be greater than the contribution itself.

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In addition, without this modification, accepting employer-sponsored limited-scope vision or dental coverage could make an individual ineligible to receive a premium tax credit if they enroll in qualified health plan (QHP) coverage through the public Marketplace ("Exchange"), even if the employer's primary group health coverage is unaffordable to individuals.

The final regulations clarify 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 regulations provide that either:

- participants must be able to decline coverage; or
- benefit claims must be administered under a contract separate from claims administration for any other benefits under the plan.

While coverage for long-term care benefits is not the focus of the final rule, these benefits are also subject to the "not an integral part of a group health plan" standard in order to be classified as excepted benefits. Accordingly, the revisions in the final rule related to limited-scope vision or dental benefits also apply to coverage of long-term care benefits.

Employee Assistance Programs (EAPs)

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. They are typically free of charge to employees and are often provided through third-party vendors.

To the extent an EAP provides benefits for medical care, it would generally be considered group health plan coverage, which would generally be subject to the HIPAA and ACA requirements, unless the EAP meets the criteria for being excepted benefits.

Following the ACA's enactment, compliance with the prohibition on annual dollar limits could be problematic, since these benefits are typically very limited and EAPs generally are intended to provide benefits in addition to those provided under other employer-sponsored group health plans. Moreover, EAPs with very limited benefits (which may be the only coverage offered to employees) could make the employee ineligible to receive a premium tax credit for QHP coverage through an Exchange.

Also, the federal agencies recognize that no universal definition exists for EAPs, and they want to prevent employers from shifting primary coverage to a separate "EAP plan," exempt from certain existing consumer protection provisions (including the mental health parity provisions).

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In September 2013, the agencies provided transition relief for EAPs which provided that, until final regulations are issued, through at least 2014, an EAP constitutes excepted benefits if it does not provide significant benefits in the nature of medical care or treatment. Employers may use a reasonable, good faith interpretation of whether an EAP provides significant benefits in the nature of medical care or treatment.

Under the final regulations, an EAP will constitute excepted benefits if the following four requirements are met:

1. *The EAP does not provide significant benefits in the nature of medical care*. For this purpose, the amount, scope and duration of covered services are taken into account.
2. *The EAP's benefits are not 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.
3. No employee premiums or contributions are required to participate in the EAP.
4. The EAP does not impose any cost-sharing requirements.

Note: The 2014 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 agencies recognized that the EAP and the group health plan often are financed by a single payment (or otherwise combined), and that this requirement would disrupt existing commercial arrangements. Also, other requirements sufficiently protect against inappropriate coordination of the EAP benefits with benefits of the other group health plan.

Effective date

The final regulations apply to group health plans and group health insurance issuers for plan years beginning on or after January 1, 2015. They do not apply to health insurance issuers offering individual health insurance coverage.

Until the final regulations take effect, dental, vision, and EAP benefits will continue to qualify as excepted benefits if they meet the conditions of either the 2013 proposed regulations or the final regulations issued in September 2014.

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Recommended next steps

Employers that have not yet incorporated the proposed 2013 regulations' changes into their plan designs will want to take the following steps in order to ensure excepted benefits status and avoid additional federal mandates and potential penalties. For example:

- Ensure that employees may decline self-insured dental and/or vision coverage separately from their election for medical coverage.
- Review EAP programs to ensure that benefits have been properly designed and are being administered within the regulatory confines of the final regulations.

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For further information on this or any other topics, please contact your EPIC benefits consulting team.

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