Limited Excepted Benefits under Health Care Reform – What It Means to You?

By Matthew J. Renaud and S. Tony Ling

I. Background

On December 24, 2013, the Department of Labor (DOL), Internal Revenue Service (IRS), and Department of Health & Human Services (HHS) (collectively, “the Departments”) issued proposed rules regarding the definition of “excepted benefits”—those benefits that are not subject to the portability and nondiscrimination provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Patient Protection and Affordable Care Act of 2010 (PPACA).

In general, excepted benefits can be categorized into four groups: (1) benefits that are broadly exempt from HIPAA coverage because they simply do not constitute health coverage, e.g., workers compensation insurance, accidental death & dismemberment coverage, and the like; (2) benefits of a limited scope, such as limited-scope dental or vision benefits, provided that they are either not integral components of a plan or are furnished under an altogether separate insurance arrangement; (3) qualifying non-coordinated benefits, such as cancer-only policies; and (4) supplemental benefits, including but not limited to coverage that is supplemental to Medicare or TRICARE. The proposed rulemaking described in this article pertains only to category (2) described above.

II. Limited-Scope Plans

First, the proposed regulations aim to fix what many plan sponsors and consumer groups alike viewed as a problematic discrepancy between the treatment of insured limited-scope plans and those limited-scope plans that are self-insured. Under the previous regulatory framework, limited-scope dental and vision plans that were self-insured would be forced to satisfy additional conditions not required of their fully-insured counterparts. Namely, for a self-insured plan to qualify as an excepted benefit for HIPAA purposes, that plan would be required to (1) permit participants to opt-out and (2) charge enrollees a separate premium. Under the proposed rulemaking, these additional requirements would be stricken, thereby “level[ing] the playing field between insured and self-insured coverage.”

III. Wraparound Coverage

Furthermore, in the preamble to the proposed rulemaking, the Departments expressly address the likelihood that many employed individuals who purchase coverage from the individual marketplace will have done so because the coverage offered by their employer was unaffordable (as that term is defined by PPACA). Accordingly, the proposed regulations would permit designation of certain wraparound plans as excepted benefits beginning in 2015 provided that the wraparound coverage offered be a “true” wraparound; that is, it must only wrap around coverage provided through the individual marketplace and be purposefully designed as such.

Consistent with principles of general applicability governing the notion of excepted benefits, for a wraparound plan to be an excepted benefit, it must not be an “integral part” of a group health plan. In other words, the plan sponsor offering the wraparound coverage must sponsor a “primary” plan that provides “minimum value”
and that is affordable to a majority of employees eligible to participate therein. Moreover, the wraparound plan must be "limited in amount"; that is, the total cost of coverage thereunder cannot exceed 15% of the coverage offered under the primary plan. This 15% threshold will be familiar to those practitioners who have worked with excepted benefits determinations and the safe harbor rule of 15% in the supplemental insurance context.

Lastly (and also analogous to the supplemental insurance safe harbor rules) for wraparound plans to be limited excepted benefits, the proposed regulations impose nondiscrimination provisions. In short, the limited wraparound coverage must be offered uniformly to all individuals and without regard to any health factor. Not surprisingly, the rules governing preexisting conditions\(^3\) and nondiscrimination\(^4\) are incorporated into the wraparound regulations as well.

IV. Employee Assistance Programs

Finally, the proposed rulemaking articulates the conditions for employee assistance programs (EAPs) to qualify as limited excepted benefits. The criteria are as follows:

1. The EAP may not provide "significant benefits in the nature of medical care";
2. The benefits may not be coordinated with benefits under a group health plan; and
3. The EAP may not require participant contributions, the payment of premiums, or cost sharing.

V. Conclusion

The proposed regulations discussed above are just the most recent example of the extent to which the regulatory environment around healthcare remains dynamic and fluid. Especially given the broad reach of PPACA and the often unanticipated effects its implementation can have on plan sponsors, it is advisable for employers and practitioners alike to closely monitor developments and to consult dedicated benefits counsel to more proactively manage the post-PPACA landscape.


\(^2\) "Minimum value" is defined in §36B of the Internal Revenue Code ("IRC").

\(^3\) ERISA §510

\(^4\) IRC §105(h)
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