SEYFARTH SHAW

Health Care Reform Management Alert Series

Guidance on Excepted Benefits — Issue 74

By Diane Dygert

This is the seventy-fourth issue in our series of alerts for employers on selected topics in health care reform. (Click here to access our general summary of health care reform and other issues in this series) This series of Health Care Reform Management Alerts is designed to provide an in-depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.

On Friday, December 20, 2013, the Departments of Treasury, Health and Human Services and Labor (the "Agencies") jointly announced proposed regulations on "excepted benefits." As we have previously advised in this series, excepted benefits are those benefits plans with such a limited scope as to be exempt from most of the requirements of the Affordable Care Act (ACA). The Agencies issued the proposed guidance and sought comments in three areas: limited scope dental and vision benefits, employee assistance plans (EAPs), and a new creation dubbed a "limited wraparound" plan.

Dental and Vision Benefits

Under 2004 guidance issued by these same Agencies, dental and vision benefit plans are considered excepted benefits if the benefits offered are limited in scope and are either (1) issued under a separate policy, or (2) not otherwise considered integral to the medical 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 guidance provided that benefits are not an integral part of a plan if participants have the right to opt out of coverage, and if they elect coverage, they pay a separate premium or contribution.

Since excepted benefits are generally exempt from the health reform requirements added by the ACA, employers have become concerned as to whether their dental and vision plans meet this last requirement. They have pointed out that insured plans are not required to charge an employee premium, and thus self-funded plans are not on the same footing. For employers to institute a nominal charge just to fit in the exception is administratively burdensome and often costs more than what is being collected. In addition, consumer groups are concerned that if the dental or vision benefits offered by an employer are not excepted benefits but are affordable under the ACA, individuals would be ineligible for the premium tax credit on the Exchanges even if their employer did not offer a traditional group health plan.

Taking these concerns into account, the Agencies propose to eliminate the requirement that individuals must pay a premium or other contribution in order for otherwise limited scope dental and vision coverage to be an excepted benefit.

Employee Assistance Plans

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

The Agencies' position in September 2013 was that EAPs would be group health plans if they offered significant benefits in the nature of medical care or treatment. There has been a clamor for relief on this position due to the difficulty in making EAPs compliant with the ACA's prohibition on annual limits among other concerns. And, again, if an affordable EAP was the only health plan available to an employee, that would prevent him or her from qualifying for a premium tax credit when purchasing a health plan from an Exchange.

In order to provide relief to certain EAPs, the Agencies propose four criteria that must be satisfied in order for an EAP to be an excepted benefit.

1. The EAP cannot provide significant benefits in the nature of medical care. For this purpose, the Agencies request comment on whether an EAP 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 benefits, should be considered to provide significant medical care benefits.

2. The EAP benefits cannot be coordinated with benefits under another group health plan.

    i. Participants cannot be required to exhaust EAP benefits before being eligible for benefits under the other group health plan.

    ii. A participant's eligibility for the EAP must not be dependent on participation in another group health plan.

    iii. EAP benefits must not be financed by another group health plan.

3. The EAP cannot require premiums or contributions for participation.

4. The EAP imposes no cost sharing.

Wraparound Coverage

Under the ACA, insured plans in the individual and small group markets must cover essential health benefits (EHBs). States are to adopt individual benchmark plans that would serve as a reference for EHBs, (*see* issues *36* and *46*.) The Agencies recognize that self-insured group health plans and large group market plans may offer coverage in addition to the types of services included in the benchmark plans' EHBs. As examples, the Agencies list various types of orthodontia, vision, long-term custodial care, infertility and hospice. Further, the Agencies recognize that some employer group health plans may be unaffordable for certain employees and state that Federal law is designed to encourage employers to provide group coverage for their employees.

The idea of "wraparound coverage" has been raised for employees for whom the employer premium is unaffordable and who obtain coverage through an Exchange. Under this approach, employers could provide wraparound coverage to provide overall coverage for these employees that is comparable to the employer-provided group health plan. Two concerns that arise are that wraparound coverage could replace group coverage for employers who do not offer minimum value coverage and/or that employers could structure their plans so that low income workers receive fewer primary benefits than high income workers. Therefore, wraparound coverage would only qualify as excepted benefits if five conditions are met:

1. The coverage is individual health insurance that is non-grandfathered and does not consist solely of excepted benefits.

2. The coverage must be designed to provide benefits beyond those offered by the individual insured coverage. That is, benefits beyond EHBs or reimbursement for out-of-network services. The primary purpose, however, cannot

be the reimbursement of cost-sharing under the individual market plan, which prior guidance has suggested would not work under the ACA.

3. The coverage must not be an integral part of the employer's primary group health plan. The primary plan must offer minimum value coverage and be affordable for the majority of employees in that plan. The wraparound coverage must only be available to those eligible for the primary plan.

4. The coverage must be limited in amount, with the total cost of wraparound coverage not exceeding 15% of the cost of coverage under the primary plan. The cost of coverage includes both the employer and employee contributions and is determined in the same manner as the COBRA premium.

5. The coverage must not differentiate in eligibility, benefits or premiums based on a health factor nor discriminate in favor of highly compensated individuals. Further, the coverage must not impose any preexisting condition exclusion.

Effective Date

Comments on these proposed regulations are due on or before 60 days from date of publication in the Federal Register, which is expected to be December 24, 2013. Until rulemaking is finalized, through at least 2014, the Agencies will consider dental and vision benefits, and EAP benefits, meeting the conditions of these proposed regulations to qualify as excepted benefits. To the extent final regulations or other guidance with respect to vision or dental benefits or EAPs is more restrictive than these proposed regulations, the final regulations or other guidance will not be effective prior to January 1, 2015.

Diane Dygert is a partner in Seyfarth Shaw's Chicago office. If you would like further information, please contact your Seyfarth attorney or Diane Dygert at *ddygert@seyfarth.com*.

Also, follow the Health Care Reform Team on  *@SeyfarthEBLaw*