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Health Care Reform: New Rules for “Excepted Benefits”

On December 24, 2013, the Internal Revenue Service (IRS), Department of Labor (DOL), and Department of Health and Human Services (HHS) (collectively, “the Departments”) published a **proposed rule** (Proposed Rule) to amend regulations governing “*excepted benefits*” under the Patient Protection and Affordable Care Act (ACA). The Proposed Rule makes it easier for health plan sponsors to provide coverage for limited-scope vision, dental and employee assistance programs (EAPs) as excepted benefits. The Proposed Rule also creates a new type of excepted benefits called “wraparound coverage.”

What are Excepted Benefits?

Generally, the concept of excepted benefits emerged after enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA excepted benefits are exempt from certain statutory requirements, including many of the insurance market reforms under the ACA.

Background of HIPAA Excepted Benefits

The HIPAA portability rules—which govern special enrollment, pre-existing condition exclusions, certificates of creditable coverage, nondiscrimination based on a health status, and wellness programs—include a list of “excepted benefits” that are exempt from the HIPAA portability rules. These excepted benefits also are exempt from other laws that apply to group health plans through HIPAA, including the Mental Health Parity Equity Act, the Women’s Health and Cancer Rights Act, the Newborn’s and Mother’s Health Protection Act, and Title I of the Genetic Information Nondiscrimination Act. These HIPAA excepted benefits also are exempt from many of the ACA market reform requirements, including: the requirement to provide coverage to age 26, the limit on waiting periods, the prohibition on annual and lifetime limits, the preventive care rules, and the out-of-pocket and deductible limits.

The HIPAA portability statute classifies several sub-categories of HIPAA excepted benefits. These excepted benefits sub-categories have varying compliance rules under both HIPAA and the ACA market reforms.

Excepted Benefits Sub-Category	HIPAA	ACA Market Reforms
<ul style="list-style-type: none"> • Accident insurance • Disability income insurance • Liability and liability supplement insurance • Worker’s compensation • Automobile payment insurance • Credit-only insurance • On-site medical clinics 	Exempt	Exempt
<ul style="list-style-type: none"> • Limited-scope dental plan • Limited-scope vision plan • Long-term care benefits 	Exempt from portability rule Subject to privacy/security rules	Exempt
<ul style="list-style-type: none"> • Medicare supplement coverage • Other supplemental coverage provided under separate policy (i.e., fills “gaps” in group health plan policy) 	Exempt from portability rule Subject to privacy/security rules	Exempt

Significance of Excepted Benefits

Exemption from numerous HIPAA and ACA mandates make excepted benefits easier for an employer to provide to employees. Importantly, excepted benefits have two significant implications under the ACA:

- An employer cannot avoid potential employer shared responsibility (Employer Mandate) penalties under the ACA simply by providing excepted benefits. If an employer is subject to the Employer Mandate (i.e., if an employer generally employs 50 or more full-time equivalent employees), it must still decide whether to offer health plan coverage that provides minimum value and is affordable or else pay a penalty—even if the employer provides excepted benefits coverage to full-time employees.
- From the employees' perspective, excepted benefits coverage does not satisfy the individual coverage mandate. This means the employee who has excepted benefits would also need to obtain “minimum essential coverage” from another source, such as the employer's group health plan or the Health Insurance Marketplace (i.e., “exchanges”). Employees electing excepted benefits coverage may still be eligible for premium tax credit (PTCs) toward coverage purchased through a Marketplace.

ACA Changes to Limited Scope Dental and Vision Benefit Exception

The Proposed Rules would eliminate the requirement that self-insured, limited-scope dental and vision plans impose a separate employee premium or contribution in order to be an excepted benefit. Under the current HIPAA portability rules, limited scope dental and vision benefits are considered excepted benefits if they are: 1) provided under a separate policy, certificate or contract of insurance; or 2) otherwise not “an integral part” of an employer's group health plan. Under the HIPAA standard (before the ACA), dental and vision benefits are considered an “integral part” of a self-insured group health plan unless participants have the right to waive coverage for the benefits and are required to pay an additional premium or contribution (even if a nominal amount) if they elect to receive such benefits.

In a welcome change, the Proposed Rule would make it easier for plans offering self-insured dental and vision coverage to meet the definition of an excepted benefit by not requiring that participants pay an additional premium or contribution for the limited scope dental and vision benefits. This means that plans may now offer no-cost (to participant) dental and vision coverage and still be “excepted benefits,” as long as a separate election or “opt out” option exists for dental and vision coverage. In addition, plans that have “bundled” dental or vision coverage with medical coverage also may meet the excepted benefits standard since the Proposed Rule removes the requirement that participants pay a separate contribution. However, plans with bundled dental/vision must still offer an “opt out” option to qualify as excepted benefits.

The Proposed Rule also appears to provide relief for “limited purpose” health reimbursement arrangements (HRAs, also called “health reimbursement accounts”) that reimburse dental and vision expenses. Eliminating the premium or contribution requirement from the excepted benefit definition should mean that these limited-scope HRAs that reimburse only dental or vision expenses will be considered excepted benefits and are therefore exempt from the ACA's market reforms. Most importantly, these limited-scope HRAs are exempt from the ACA's prohibition on annual limits and the preventive services rule. **Note:** Additional guidance from the Departments would be welcome, including clarification regarding whether a stand-alone HRA used to fund premiums for excepted benefits is itself considered an “excepted benefit.”

EAPs as New Excepted Benefit

The Proposed Rule includes criteria that allow employee assistance programs¹ (EAPs) to be deemed “excepted benefits.” This is important because the status of EAPs has long been ambiguous, yet potential effects of the ACA have given the question of EAPs new urgency.

Earlier guidance from the Departments (*Notice 2013-54*) generally provided that—through 2014—an EAP would constitute an excepted benefit only if the employer determined that the EAP did not provide “significant benefits in the nature of medical care or treatment,” based on reasonable and good faith judgment.

The Proposed Rule issued in December 2013 further refines the guidance and treats an EAP as an excepted benefit if *all* the following conditions apply:

- The EAP does not “provide significant benefits in the nature of medical care”
- The EAP’s benefits are not coordinated with another group health plan
- No employee premiums or contributions are required to participate
- No cost-sharing is involved

Three criteria must exist in order to satisfy the second condition (“not coordinated with group health benefits”) that would allow the EAP to be treated as an excepted benefit: 1) there can be no requirement that a participant exhaust benefits under the EAP before he or she is eligible for benefits such as mental health coverage under the employer’s group health plan (i.e., the EAP cannot be the “gatekeeper” for the group health plan); 2) eligibility for the EAP cannot be dependent on participation in the group health plan; and 3) benefits provided under the EAP cannot be financed by the employer’s group health plan.

New Excepted Benefit for Limited “Wraparound” Coverage

The Proposed Rule creates a HIPAA excepted benefit for a new type of benefit called “wraparound coverage.” The Proposed Rule explains that there may be situations where an employee will choose to obtain coverage on the individual market, such as through the Marketplace, instead of electing to participate in his or her employer’s group health plan. This may be true even though the individual market coverage may be less generous than the coverage available under the group health plan. Adding “limited wraparound coverage” to the list of excepted benefits addresses a predicament employees may face if their employer offers “minimum essential coverage” but they still have to seek coverage in the Marketplace because the employer’s coverage is “unaffordable” under ACA guidelines. In this situation, employers may want to permit individuals to move to Marketplace or other individual coverage. In particular, Marketplace coverage may be preferred if it is less expensive than the employer’s group coverage or if the individual would qualify for a PTC because the employee’s contribution (premium) for group coverage exceeds **9.5%** of his or her household income for self-only coverage. The new wraparound coverage option enables employers to provide extra coverage for these employees who elect more affordable Marketplace coverage (many of whom will also qualify for a PTC).

Under the Marketplace PTC rules, if an individual is enrolled in group health plan coverage that is not an excepted benefit, he or she *would not* qualify for the PTC. The new “limited wraparound coverage” sub-category changes that disqualification. *Now, under the Proposed Rule, employers can provide supplementary coverage (limited wraparound coverage) to these employees without nullifying their eligibility for a PTC.* With limited wraparound coverage considered an “excepted benefit,” these employees may receive overall coverage that is comparable to the group health plan, while still maintaining their PTC eligibility.

¹ EAPs typically provide wide-ranging benefits to address circumstances that might otherwise adversely affect employees’ work and health; including short-term mental health (or substance abuse) counseling or referral services, as well as financial counseling and legal services. EAPs are typically offered by employers at no extra cost to employees/participants.

To qualify as an excepted benefit, the limited wraparound coverage must satisfy five conditions:

1. The coverage must “wrap around” (i.e., be offered only to individuals who have enrolled in) individual market or Marketplace coverage that does not consist solely of excepted benefits. In other words, the individual must have minimum essential health coverage, in addition to the wraparound coverage.
2. The wraparound coverage must provide benefits beyond the benefits offered by the individual market coverage (for example, the wraparound coverage must provide benefits in addition to essential health benefits, cover the cost of out-of-network providers, or both).
3. The employer’s own group health plan must provide “minimum value” (the plan’s share of the total cost of benefits provided to an employee must be at least **60%**) and be “affordable” (the contribution for self-only coverage must not exceed **9.5%** of an employee’s household income) to a majority of its employees. Additionally, wraparound coverage may only be offered to employees eligible to participate in the group health plan.
4. The cost of the wraparound coverage cannot exceed **15%** of the cost of the group health plan, considering both employer and employee contributions.
5. The wraparound coverage must be offered on a nondiscriminatory basis.

The Proposed Rule also clarifies that new exceptions for wraparound coverage and EAPs will be subject to the HIPAA privacy and security rules, but are exempt from most of the HIPAA portability requirements, ACA market reforms and other ACA mandates. Additional guidance on limited wraparound coverage would be welcome, including clarification of employers’ recordkeeping obligations with respect to meeting the applicable conditions of the exception, particularly where employees may select various alternate forms of individual market coverage, as well as application of the nondiscrimination rules in this context.

The Proposed Rule is intended to be effective with respect to limited wraparound coverage for plan years beginning on or after **January 1, 2015**.

UMC Impact

Excepted benefits may be particularly helpful for annual conferences that may have participants who will go to the Marketplaces (“exchanges”) and qualify for a PTC toward coverage. The PTC rules provide that if an individual was enrolled in employer group health plan coverage, he or she may not qualify for such a PTC. Since some plan sponsors automatically cover participants in their EAPs, *the Proposed Rule allows these participants to still qualify for a PTC in the Marketplace if they are otherwise qualified based on their income or other factors*. The same holds for plan sponsors wishing to offer standalone limited scope vision and dental benefits to participants who may seek Marketplace coverage; *such standalone vision/dental benefits would not disqualify the participant from PTC eligibility*. In addition, *the Proposed Rule clearly allows traditional limited EAPs and vision and dental plans to continue without having to meet the ACA mandates, such as preventive care and no annual limits*.

Potential for excepted benefits HRAs for vision and dental benefits is promising. Such HRAs would be exempt from many HIPAA and ACA mandates, are generally easy to administer, and would not interfere with PTCs in the Marketplace for eligible participants. The new wraparound coverage may hold similar promise for plan sponsors that have participants who depart for coverage through the Marketplaces; however, careful review of additional guidance from the Departments in a final rule on this topic would be necessary.

HealthFlex Impact

The General Board will be assessing the impact of the Proposed Rule on the current structure and designs of the HealthFlex vision, dental and EAP benefits. Minor modifications of those benefits for 2015 may be necessary to ensure that they remain excepted benefits. The General Board will also explore the potential of other excepted benefit offerings, such as limited-scope HRAs and wraparound coverage.

More About ACA Requirements

The General Board continues to monitor federal health care reform and provide applicable information for annual conferences, local churches and other UMC employers, as well as information for individuals. We encourage you to check the General Board's [health care reform web page](#) frequently for updates.

Questions and Information

If you have questions or would like additional information, please send your inquiries to healthcarereform@gbophb.org. General information about health care reform is available from the federal government at www.healthcare.gov.

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