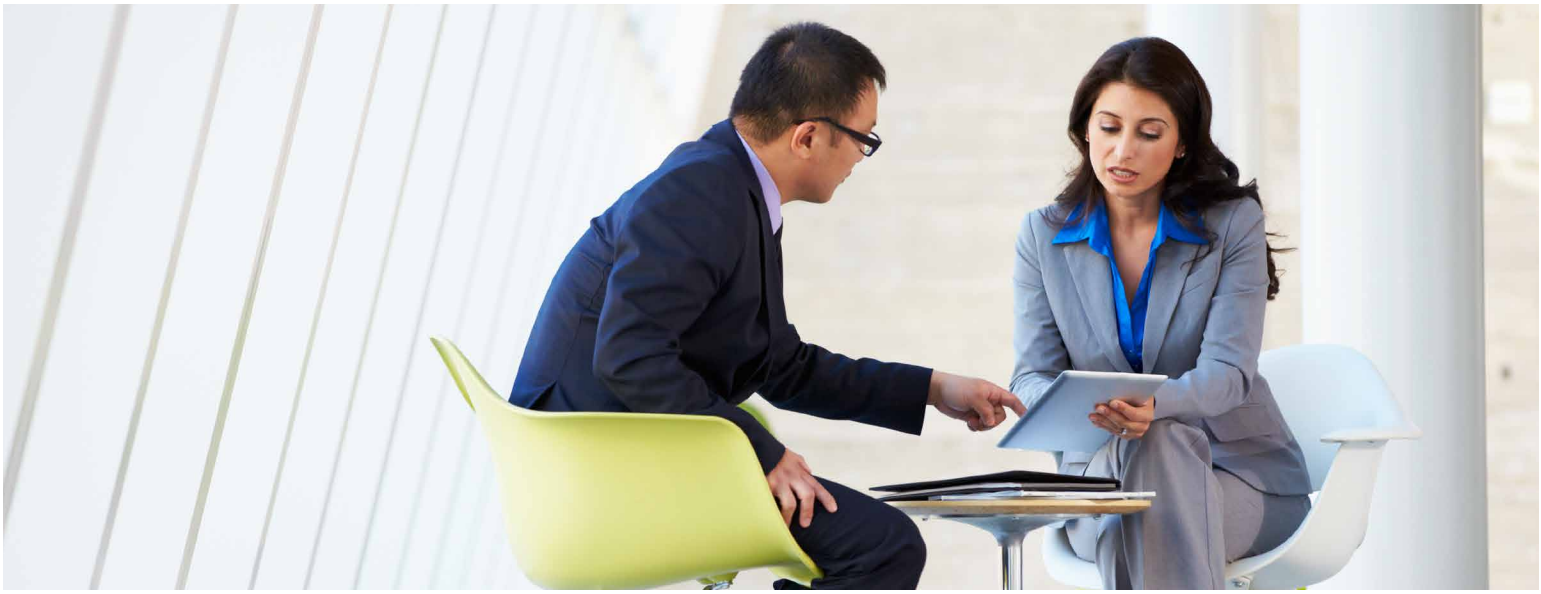
Health Reform

Excepted Benefits

Ed MacConnell | | (215) 355-2121 | edmac@totalbenefitsinc.com



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Relief for Vision, Dental and EAP Benefits and New Wraparound Coverage

The Departments of Labor, Treasury and HHS issued a proposed rule that provides helpful guidance regarding certain excepted benefits, including vision benefits, dental benefits, employee assistance programs (EAPs) and certain wraparound programs.

In essence, the proposed rule:

- Removes the participant contribution requirement for certain limited-scope vision and dental arrangements. Under a revised definition, vision and dental benefits are excepted benefits when offered under a separate policy, contract or certificate of insurance or when the participant has the right to elect not to receive the coverage.
- Establishes four criteria to qualify an EAP as an excepted benefit in 2015.
- Creates a new classification of excepted benefit called a “wraparound program,” subject to specific rules.

Background

Group health plans are subject to various requirements, including new mandates under the Affordable Care Act. However, many of the ACA provisions do not apply to excepted benefits including:

- coverage of children up to age 26;
- no pre-existing condition exclusions;
- no annual or lifetime dollar limits on essential health benefits;
- compliance with out-of-pocket limitations (non-grandfathered plans only);
- W-2 reporting (if applicable); and
- compliance with SBC disclosure rules.

Prior to this proposed rule, self-insured vision and dental arrangements that are 100% employer-paid were considered non-excepted benefits, and subject to the various market reforms. Additionally, vision and dental benefits, and most

EAPs, are considered group health plans under ERISA. To the extent such benefits are not excepted benefits, they may be considered Minimum Essential Coverage. Under the ACA, an individual who has Minimum Essential Coverage is disqualified from subsidies in the Exchange marketplace. Due to these issues, the Departments are providing further guidance to simplify and clarify when these arrangements may qualify as excepted benefits.

Vision and Dental Benefits

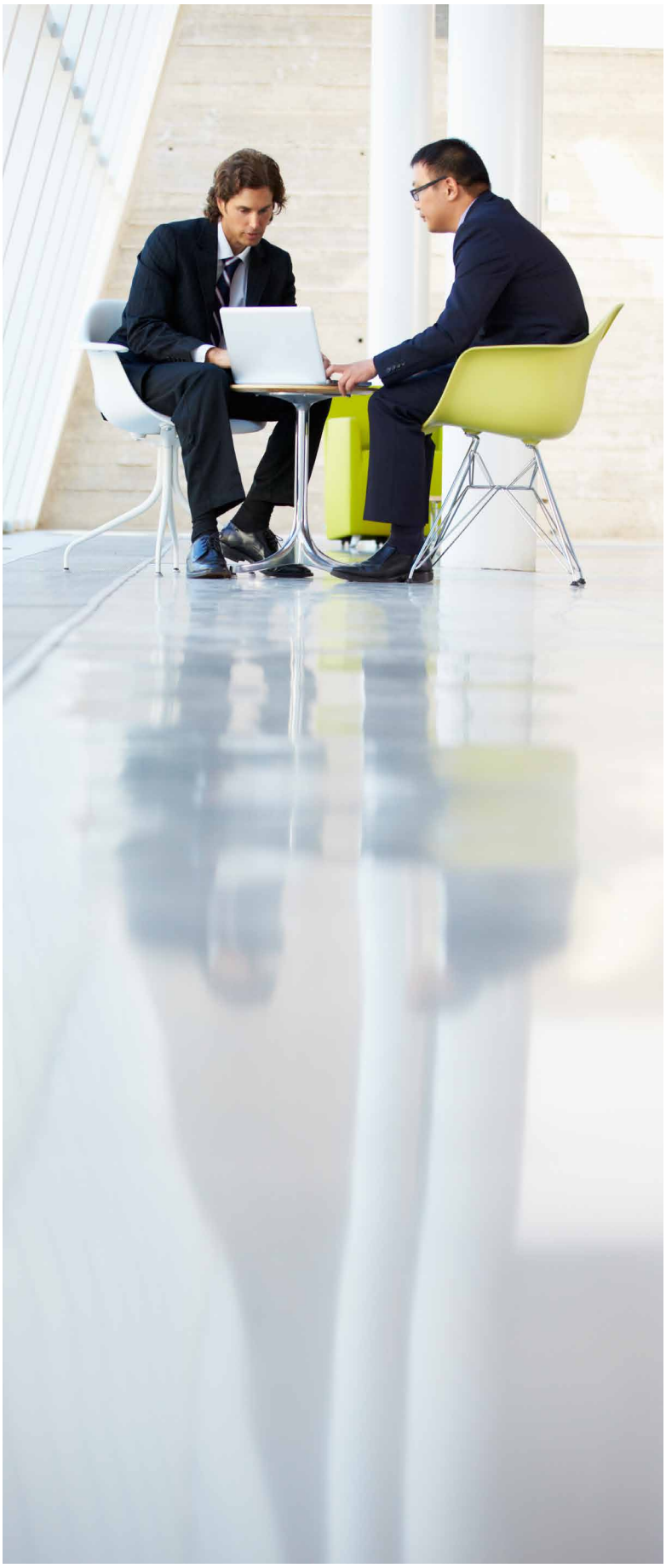
Under current regulations, vision and dental benefits are considered excepted benefits if they are limited in scope (described as benefits, substantially all of which are for treatment of the eyes or mouth respectively) and are:

- provided under a separate policy, certificate or contract of insurance; or
- otherwise not an integral part of a group health plan.

Benefits are not an integral part of a group health plan (whether provided through the same plan or a separate plan) if a participant (1) has the right to elect not to receive coverage for the benefits; and (2) if a participant elects to receive coverage for the benefits, the participant must pay an additional premium or contribution for that coverage (even if that contribution is nominal).

The new proposed regulations eliminate the additional premium or contribution requirement for vision or dental benefits to qualify as excepted benefits. Under this revised definition, vision and dental benefits are excepted benefits if they are limited in scope and are either (1) provided under a separate policy, certificate, or contract of insurance, or (2) the participant has the right to elect not to receive coverage for the benefits. For example, a self-insured dental plan where the participant has the right to decline the dental but if the participants takes the dental, the employer pays 100% of the cost would not be an excepted benefit under the old rule, but would be an excepted benefit under the proposed rule.

Employers and plans may rely on the proposed regulations with respect to vision and dental benefits at least through 2014. If final regulations on this matter are more restrictive than the proposed regulations, such guidance would not be effective prior to January 1, 2015.



Employee Assistance Programs

Earlier guidance provided that through the end of 2014, the Departments will consider an EAP to constitute an excepted benefit only if the EAP does not provide significant benefits in the nature of medical care or treatment. For this purpose, employers may use a reasonable, good faith interpretation of whether an EAP provides significant benefits in the nature of medical care or treatment. Beginning in 2015, the proposed rule lays out new requirements that the EAP will need to satisfy to qualify as an excepted benefit:

- The EAP cannot provide significant benefits in the nature of medical care. The proposed rule seeks comments on how to define the term "significant." The guidance asks whether a program that provides no more than 10 outpatient mental health/substance use disorder counseling sessions, an annual wellness checkup, immunizations, and diabetes counseling with no inpatient benefits should be considered to provided significant benefits in the nature of medical care.
- The EAP cannot coordinate with benefits under another group health plan. To satisfy this requirement, three conditions must be met:
  - Participants cannot be required to exhaust EAP benefits before an individual is eligible for benefits under the group health plan (no EAP "gatekeeper").
  - Eligibility for the EAP cannot be conditioned on participation in another group health plan.
  - The EAP must not be financed by another group health plan.
- No employee premiums or contributions are required to participate in the EAP. The EAP must be 100% employer-paid.
- No cost-sharing under the EAP. Employees are not required to pay anything toward the cost of coverage such as copays.

Wraparound Programs

The proposed rule contemplates a new type of "wraparound" coverage that would constitute an excepted benefit. This coverage is intended to provide additional benefits to certain employees who have unaffordable group health plan coverage offered by an employer and choose to purchase an individual health insurance policy instead of the employer's group health plan. The wraparound plan would provide benefits beyond the essential health benefits offered by the individual policy and may also assist with cost-sharing such as out-of-network costs or other expenses. For example, the wraparound coverage could provide benefits for items and services that cannot be (or are unlikely to be) essential health benefits including routine adult vision and dental care, long-term/custodial nursing home care, non-medically necessary pediatric orthodontia, and coverage that extends beyond the benchmark plan's coverage of wellness programs, manipulative treatment, infertility, home health care, private duty nursing, hospice or certain non-traditional treatments.

To be considered an excepted benefit, the wraparound coverage must satisfy the following five requirements:

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

2. The coverage is specifically designed to provide benefits beyond those offered by the individual health insurance coverage. Specifically, the limited wraparound coverage must provide either benefits that are in addition to essential health benefits or reimburse the cost of health care providers considered out-of-network under the individual health insurance coverage, or both. The coverage may, but is not required to, provide benefits for the participant's otherwise applicable cost-sharing under the individual health insurance policy (however, this cannot be its primary purpose). The wraparound coverage cannot provide benefits solely pursuant to a coordination-of-benefits provision that simply pays benefits whenever the individual health insurance policy does not cover all or part of the expense.

3. The wraparound coverage cannot be an integral part of the group health plan. The plan sponsor must sponsor another group health plan that meets minimum value for the plan year, referred to as the primary plan. This primary plan must be affordable for a majority of the employees who are eligible for the coverage. Future regulations will clarify which of the three IRS affordability safe harbor tests can be used to satisfy the affordability requirement.

4. The wraparound coverage must be limited in amount. Specifically, the total cost of coverage under the limited wraparound coverage must not exceed 15% of the cost of coverage under the primary plan offered to employees eligible for the wraparound coverage. For this purpose, the cost of coverage is the total cost of coverage (inclusive of both employer and employee contributions) and is determined in the same manner as the applicable premium for purposes of COBRA. To the extent an employer sponsors two or more major medical plan options and one does not satisfy the 15% standard but another plan does, the 15% threshold will be met if the average value of the primary plan options meets the 15% standard.

5. There is no discrimination. The limited wraparound coverage must not differentiate among individuals in eligibility, benefits, or premiums based on any health factor of an individual (or any dependent of the individual), and may not impose any pre-existing condition exclusions. In addition, both the primary plan and the limited wraparound coverage must not discriminate in favor of highly compensated individuals under the provisions of PHS Act 2716 and Code Section 105(h). These nondiscrimination rules help ensure that employers will not be able to use wraparound coverage to send excessive numbers of low-wage workers to the Exchange marketplace.

Employers have the option of offering a wraparound plan. This coverage is not intended to replace group coverage for employers who drop coverage or who otherwise do not provide a minimum value plan. Offering this coverage will not satisfy the ACA's employer shared responsibility mandate for applicable large employers. The proposed rule acknowledges that wraparound coverage is targeted to a narrow group of plan sponsors – those that offer a minimum value plan that is affordable to a majority of employees. The Departments are seeking comments as to whether the majority level is appropriate (or whether the primary plan should provide coverage that is affordable to a large or smaller fraction of employees) as the goal is to prevent plan sponsors from shifting employees from the primary plan to the individual market with limited wraparound coverage.

Employer Action

Employers should review vision and dental plans for excepted status. As long as the vision and/or dental coverage is written under a separate policy or contract of insurance, it is an excepted benefit. If the vision or dental benefit is self-insured, under the proposed rule, the plan only needs to allow the participant "choice" (the right not to elect the coverage) in order to retain excepted status. If the dental or vision is a non-excepted benefit, the plan must comply with various ACA mandates, including the market reforms.

EAPs should also be reviewed for excepted status under both the 2014 and 2015 relief; employers should await further guidance.

Employers should also await further guidance and clarification around wraparound programs to understand potential risks and possible benefits to offering this coverage.

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