UBA PPACAAdvisor

Proposed Expansion of Excepted Benefits

On December 26, 2013, the U.S. Department of Health and Human Services (HHS), the Internal Revenue Service (IRS) and the Department of Labor (DOL) published proposed regulations on "excepted benefits." Excepted benefits are health benefits that are limited enough in scope to be exempt from most of the requirements of the Patient Protection and Affordable Care Act (PPACA). Excepted benefits are not considered "minimum essential" coverage. Whether coverage is "minimum essential" is important for several reasons -- large employers must offer minimum essential coverage or pay a penalty, most individuals must have minimum essential coverage or pay a penalty, and a person who has minimum essential coverage is not eligible for a premium subsidy even if his or her income is low. The proposed regulations address three areas: limited scope dental and vision benefits, employee assistance plans (EAPs), and a new type of benefit called a "limited wraparound" plan.

Stand-Alone Dental and Vision Benefits

Dental and vision benefit plans are considered excepted benefits if the benefits offered are limited to care of the mouth or eyes and the benefits either are provided under a separate policy or they are not an "integral" part of the medical plan. Under the current rules, benefits are not considered an integral part of a plan if participants have the right to opt out of coverage and they are required to pay a separate premium or contribution if they elect coverage. The proposed regulations would eliminate the requirement that individuals pay a premium or other contribution in order for the stand-alone/limited scope dental and vision coverage to be an excepted benefit.

Employee Assistance Plans

Employee assistance plans (EAPs) are considered group health plans if they provide significant benefits for medical care. The regulatory agencies have received many requests for clarification of what constitutes "significant benefits" since most EAPs will not be able to meet PPACA's prohibition on annual limits. In addition, if an EAP is considered a group health plan that provides minimum essential coverage, coverage under the EAP would prevent an employee from qualifying for a premium subsidy through the marketplace.

To address these concerns, the proposed regulations provide that an EAP will be considered an excepted benefit if it meets these four criteria:

1. The EAP cannot provide significant benefits in the nature of medical care. "Significant benefits" still is not defined in this proposed regulation, but the agencies have asked for comments 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 in any way with benefits under another group health plan. This means, for example, that participants could not be required to exhaust EAP benefits before being eligible for benefits under the group medical plan and that the EAP must be available whether or not the employee participates in the group medical plan.
3. The EAP cannot require premiums or contributions for participation.
4. The EAP may not require any cost sharing.

Wraparound Coverage

Under PPACA, insured plans in the individual and small group markets must cover essential health benefits (EHBs). However, self-insured group health plans and large group insured plans are not required to offer all of the EHBs, and may offer coverage in addition to the types of services included in the EHBs, such as certain types of orthodontia, adult dental and vision, long-term custodial care, infertility, acupuncture and hospice care. These plans also may have broader networks. To assist employers that provide affordable minimum value coverage to most employees, and who want to provide supplemental coverage that wraps around marketplace coverage for employees who purchase marketplace coverage because the employer-provided coverage is unaffordable, the proposed regulations offer the possibility that employers may be able to provide "wraparound" coverage so that overall coverage is similar for all employees. To try to avoid employers replacing group health coverage with wraparound coverage or structuring their plans so that low income workers receive fewer primary benefits than high income workers, wraparound coverage would only qualify as excepted benefits if five conditions are met:

1. The coverage must wrap around 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, it must provide benefits beyond EHBs or reimbursement for out-of-network services. The wraparound coverage could not simply reimburse deductibles, coinsurance and copays under the individual market plan.
3. The employer's primary group health plan must offer minimum value coverage and be affordable for the majority of employees in that plan. All employees eligible for the wraparound coverage must also be eligible for the primary plan.
4. The total cost of the wraparound coverage could not exceed 15 percent of the cost of coverage under the primary plan.
5. The coverage must not treat employees or dependents differently with respect to eligibility, benefits, or premiums because of a health factor or discriminate in favor of highly compensated individuals.

Effective Date

Through at least 2014, and until final regulations are issued, stand-alone dental and vision coverage and EAP benefits that meet the proposed regulations will qualify as excepted benefits. If adopted, the wraparound option would first be available in 2015.

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