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Employee Benefits and Executive Compensation Alert

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Proposed Changes to "Excepted Benefits" Regulations

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Proposed regulations issued at the end of December by the U.S. Departments of Treasury, Labor, and Health and Human Services (the Departments) broaden the categories of health coverage that qualify as "excepted benefits." These regulations are significant because excepted benefits are exempt from many of health care reform's requirements, such as its prohibitions on waiting periods of more than 90 days and annual limits. Excepted benefits also do not disqualify an otherwise qualified individual from receiving a subsidy towards individual health coverage obtained on an Affordable Insurance Exchange (also called a Health Insurance Marketplace).[1]

The proposed regulations are particularly important to employers who sponsor self-insured, limited-scope dental and vision plans and employee assistance programs (EAPs). Employers who make any required changes to these offerings can rely on these regulations now, even though they are in proposed form, and can treat these benefits as excepted. The proposed regulations also create a new type of excepted benefit as of January 2015.

Limited-Scope Dental and Vision Benefits

Fully insured dental and vision plans have always qualified as "excepted benefits" if offered under a separate policy, certificate, or contract of insurance. Self-insured dental and vision plans, however, could only qualify as excepted benefits if they were "not an integral part of a group health plan." Under current regulations, these limited-scope dental and vision benefits are "not an integral part of a group health plan" if: (1) participants have the right not to receive coverage for the benefits ***and*** (2) they must pay an additional premium or contribution for it.[2]

These proposed regulations would level the playing field between fully insured and self-insured coverage by eliminating the requirement that participants must pay an additional amount for limited-scope dental or vision benefits to be treated as non-integral coverage. In other words, provided a participant has a right not to receive the coverage – even though it is offered free of charge – it can be treated as an excepted benefit and, therefore, is exempt from many of health care reform's requirements. Further, it will not make an individual ineligible for a subsidy on an Exchange.

The Departments invite comments on this proposed change to the current regulations. Nonetheless, until the rulemaking is finalized and through at least 2014, the Departments will consider limited-scope dental and vision benefits meeting these proposed regulations to qualify as excepted benefits. To the extent that the final regulations are more restrictive, they will not be effective prior to January 1, 2015. Employers that currently charge nominal amounts for limited-scope dental and vision benefits simply in order for them to be treated as excepted benefits may wish to discontinue doing so.

Employee Assistance Programs

The Departments **issued guidance** on September 13, 2013 regarding EAPs. Under that guidance, EAPs that do not provide "significant benefits in the nature of medical care or treatment" may be treated as excepted benefits through at least 2014. It further provides that employers may use a reasonable, good faith interpretation of whether their program provides significant benefits in the nature of medical care or treatment.

The new proposed regulations provide more detail on how an EAP can qualify as an excepted benefit. Specifically, an EAP must meet the following four criteria:

- The EAP cannot provide significant benefits in the nature of medical care. (While these regulations do not define what constitutes "significant benefits in the nature of medical care," the Departments have requested comments.)
- The EAP benefits cannot be coordinated with the benefits of another group health plan. To meet this requirement, three conditions must be met.
  - The participant cannot be required to exhaust benefits under the EAP before accessing benefits

under the other group health plan.

  - The participant cannot be required to be a part of another group health plan in order to be eligible for the EAP. As such, an employer cannot limit EAP coverage to only those employees who are covered by the major medical plan.
  - The benefits under an EAP may not be financed by another group health plan.
- The EAP cannot require participant premiums or contributions.
- The EAP cannot impose cost-sharing requirements.

These proposed regulations on EAPs qualifying as excepted benefits can be relied upon now in the same manner as the proposed regulations on limited-scope dental and vision plans. This may be advantageous in light of the fact that many EAPs have limits on their benefits. It would also avoid the need to produce a Summary of Benefits and Coverage for an EAP.

Wraparound Coverage

These proposed regulations will permit an employer, in certain circumstances, to provide coverage that qualifies as an "excepted benefit" and wraps around individual coverage obtained by employees on the Exchanges. As an excepted benefit, the wraparound coverage does not need to comply with all of health care reform's requirements. In addition, it will not disqualify individuals from obtaining subsidies for individual coverage on the Exchanges.

The wraparound coverage can be used to provide additional benefits or a broader provider network than those offered by the individual policies on the Exchanges. As such, it permits an employer to provide supplemental coverage to employees for whom its major medical plan is unaffordable and who have opted for coverage on the Exchanges.

However, under the proposed regulations, the wraparound coverage needs to meet the following requirements to be an excepted benefit:

- Coverage must be for employees enrolled in non-grandfathered individual health insurance plans and the coverage must not provide benefits that are "essential health benefits"[3] or provide benefits only under a coordination-of-benefits provision. In contrast, it may reimburse the cost of out-of-network providers or pay cost-sharing amounts under the employee's individual coverage.
- The sponsoring employer must provide another group health plan meeting "minimum value"[4] and that plan must be "affordable"[5] for the majority of employees eligible for that plan (the "Primary Plan"). Only individuals eligible for the Primary Plan can be eligible for the wraparound coverage.
- The total cost of the limited wraparound coverage cannot be more than 15% of the cost of coverage of the Primary Plan.
- Lastly, limited wraparound coverage cannot discriminate among individuals based on any health factors. Furthermore, no preexisting condition exclusions may be applied. Primary and limited wraparound coverage cannot discriminate in favor of highly compensated individuals.

These requirements are designed, in part, to prevent employers from shifting employees from employer-sponsored primary coverage to the Exchanges. Moreover, because the wraparound coverage would qualify as an excepted benefit, it would not provide penalty protection under the employer mandate for the sponsoring employer. Unlike the provisions applicable to limited-scope dental and vision benefits and EAPs, this exception for wraparound coverage cannot be relied upon now. It is proposed to be effective as of January 1, 2015.

Next Steps for Employers

Employers who sponsor limited-scope dental and vision plans and EAPs may wish to review their offerings to see if they can take advantage of these exceptions. Unfortunately, the guidance was issued very late in the year, making it difficult for sponsors of calendar year plans to incorporate any necessary changes prior to the January 1, 2015 plan year. Employers who sponsor fiscal year plans, however, may be able to make any necessary changes sooner. Of course, employers can continue to rely on the current regulations governing excepted benefits.

The guidance would also allow a plan sponsor that otherwise offers a group health plan to provide wraparound coverage to employees who purchase coverage on the Exchanges – although this supplemental coverage would not provide the sponsor with penalty protection under the employer mandate.

The attorneys in Venable's **Employee Benefits and Executive Compensation Group** are available to

help plan sponsors and other interested parties planning for and complying with the changes under health care reform.

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1 Most employer sponsored health plans qualify as "minimum essential coverage" and, if offered to the individual, disqualify the individual from a subsidy for individual coverage on the Exchanges. Excepted benefits, however, do not qualify as minimum essential coverage. IRC § 5000A(f)(3).

2 Fully insured limited-scope dental and vision plans can qualify under this exception as well.

3 Essential health benefits are items and services in the ten statutorily specified categories and must be included in non-grandfathered health plans offered on the Exchanges.

4 An employer-sponsored plan provides minimum value if the plan's share of the total allowed cost of benefits provided to an employee (the minimum value percentage) is at least 60%. Prop Reg § 1.36B-6 (a).

5 For these purposes, coverage is deemed "unaffordable" when the cost for individual coverage under the least expensive option is more than 9.5% of the employee's income. Prop Reg § 1.36B-2(c)(3)(v)(A) (1).