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BENEFITS BRIEF

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New Proposed Regulations on HIPAA Excepted Benefits

On December 24, 2013, the Departments of Health and Human Services, Labor, and Treasury (collectively, the "Departments") released proposed rules ("Proposed Rules") amending the regulations applicable to excepted benefits ("HIPAA Excepted Benefits" or "Excepted Benefits") under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). See 78 Fed. Reg. 77632 (Dec. 24, 2013). The Proposed Rules revise the requirements under the existing limited scope dental and vision exception, add a new exception for certain employee assistance programs ("EAPs"), and add a new exception for a new benefit called "wraparound coverage."

Below, we provide a background of the existing HIPAA Excepted Benefits rules and summarize the new Proposed Rules. Comments on the Proposed Rules are due February 24, 2014.

I. 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 have been placed into the HIPAA portability statute, including the Mental Health Parity & Equity Act, the Women's Health & Cancer Rights Act, the Newborn's & Mother's Health Protection Act, and Title I of the Genetic Information Nondiscrimination Act. These Excepted Benefits also are exempt from many of the ACA requirements. For example, HIPAA Excepted Benefits do not have to comply with the requirement to provide coverage to age 26, the annual and lifetime limit prohibition, the preventive care rules, or the out-of-pocket and deductible limits under the ACA.

The HIPAA portability statute adopted several categories of HIPAA Excepted Benefits, including:

- First Category – Accident insurance, disability income insurance, liability and liability supplement insurance, workers' compensation, automobile medical payment insurance, credit-only insurance, and on-site medical clinics.

- Second Category – Limited scope dental, vision, and long-term care benefits that are provided under a separate insurance policy or otherwise not an integral part of the group health plan (*i.e.,* separate election and separate premium).

- Third Category – Noncoordinated benefits, such as coverage for a specified disease (*e.g.*, cancer-only policies) or hospital or other fixed indemnity insurance, where benefits are provided under a separate insurance policy and not coordinated with other group health plan coverage.

- Fourth Category – Medicare supplement coverage or similar supplemental coverage that is provided under a separate policy and designed to fill in gaps in group health plan coverage.

  It is important to understand under which category a particular benefit may fall, as the various exceptions that incorporate the HIPAA Excepted Benefits rules may not apply to all four categories. For example, the HIPAA privacy rules only exempt the first category – the other three categories still must comply.

II. Changes to Limited Scope Dental and Vision Benefit Exception

The Proposed Rules would eliminate the requirement that a self-insured limited scope dental and/or vision plan impose an 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: (i) provided under a separate policy, certificate, or contract of insurance, or (ii) otherwise not "an integral part" of an employer's group health plan (or a collectively bargained multiemployer plan). The current regulations provide that dental and vision benefits are not considered an "integral part" of a plan unless participants have the right to waive coverage for the benefits, and, if the participants elect to receive the benefits, they are required to pay an additional premium or contribution (even if a nominal amount).

The Proposed Rules make it easier for plans offering self-insured dental and vision coverage to meet the definition of an Excepted Benefit by eliminating the requirement 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 dental and vision coverage and still meet the exception, as long as there is a separate election (or opt out) for dental and vision coverage. In addition, plans that have "bundled" medical and dental or vision coverage also may meet the exception since the Proposed Rules remove the requirement that there be a separate contribution (these plans may still need to offer an opt out though).

This change also appears to provide relief for limited purpose HRAs 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 only reimburse dental or vision expenses should be considered Excepted Benefits and thus excepted from the ACA's market reform provisions. See our earlier discussion of this issue at http://www.groom.com/resources-813.html. However, additional guidance would be welcome, including clarification regarding whether a stand-alone HRA used to fund premiums for Excepted Benefits is considered an Excepted Benefit. Employers and service providers who offer HRAs may want to weigh in regarding their own plan designs.

Plans may rely on the Proposed Rules with respect to limited scope dental and vision benefits until regulations are issued in final form, at least through 2014.

III. New Excepted Benefit for Limited "Wraparound" Coverage

The Proposed Rules added a new HIPAA Excepted Benefit for a new type of benefit called "wraparound coverage." The Preamble to the Proposed Rules explains that there may be situations where an employee will choose to obtain

coverage on the individual market, such as through the Exchange, instead of electing to participate in his or her employer's group health plan, even though the individual market coverage may be less generous than the coverage available under the group health plan. Employers may want to allow the individual to move to this coverage, particularly if it is less expensive or if the individual would qualify for a premium subsidy, and may still want to provide extra coverage for those employees. Under the Exchange premium subsidy rules, if an individual is enrolled in group health plan coverage that is other than an Excepted Benefit, he or she may not qualify for the subsidy. In order to permit employers to provide supplementary coverage to these employees so that they may receive overall coverage comparable to the group health plan, while not disqualifying these employees from eligibility for a premium subsidy or tax credit, the Proposed Rules create a new sub-category of Excepted Benefits referred to as limited wraparound coverage. 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 coverage that is non-grandfathered and does not consist solely of Excepted Benefits (this would include coverage through the Exchange);

(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 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 percent) and be "affordable" (the contribution for self-only coverage must not exceed 9.5 percent of an employee's household income) to a majority of its employees, and 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 percent of the cost of the group health plan, considering both employer and employee contributions; and

(5) the wraparound coverage must be offered on a nondiscriminatory basis.

Additional guidance on limited wraparound coverage would be welcome, including, clarification of employers' documentary and recordkeeping obligations with respect to meeting the applicable conditions of the exception, particularly where employees may select various alternate forms of individual market coverage, and application of the nondiscrimination rules in this context.

The Proposed Rules are intended to be effective with respect to limited wraparound coverage for plan years beginning January 1, 2015.

III. New Excepted Benefit for EAPs

The Proposed Rules also added another new Excepted Benefits provision for certain EAPs that do not provide significant medical care. The agencies had earlier issued Notice 2013-54, which generally provided that, through 2014, an EAP would constitute an excepted benefit only if the employer determined, reasonably and in good faith, that the EAP did not provide significant benefits in the nature of medical care or treatment. See our earlier article on Notice 2013-54 at http://www.groom.com/resources-813.html. The Proposed Rules codified this Q&A guidance and

provide additional requirements for EAPs to be considered Excepted Benefits following the end of the transition period.

The Proposed Rules set forth four conditions that must be met for an EAP to constitute a HIPAA Excepted Benefit:

(1) the EAP cannot provide "significant" benefits in the nature of medical care;

(2) the benefits provided under the EAP cannot be coordinated with benefits under the employer's group health plan;

(3) there can be no employee premiums or contributions required for participation in the EAP; and

(4) there can be no cost-sharing.

In order to satisfy the second condition, (i) there can be no requirement that a participant exhaust benefits under the EAP before he or she is eligible for benefits under the employer's group health plan (*i.e.*, the EAP cannot be the "gatekeeper" for the group health plan), (ii) eligibility for the EAP cannot be dependent on participation in the employer's group health plan, and (iii) the benefits provided under the EAP cannot be financed by the employer's group health plan.

The Departments specifically request comments regarding the definition of "significant" benefits in the nature of medical care. For example, the Departments asks whether a program that provides the following should be considered not "significant": providing less than 10 outpatient visits for mental health or substance abuse disorder counseling, an annual wellness checkup, immunizations, and diabetes counseling with no inpatient care. Employers and service providers who offer EAPs may want to weigh in regarding their own plan designs.

This new Excepted Benefit is particularly helpful for employers who may have employees who will go to the Exchange and qualify for a premium subsidy. The premium subsidy rules provided that if the individual was enrolled in other group health plan coverage, they may not qualify for such a subsidy. Since most employers automatically cover employees in their EAPs, these employees could be precluded from qualifying for a premium subsidy in the Exchange even if they otherwise qualified based on their income or other factors. In addition, this new exception clearly allows traditional limited EAPs to continue without having to meet the ACA mandates, such as preventive care and no annual limits.

We note that the Preamble clarifies that new exceptions for wraparound coverage and EAPs should be considered part of the second category of Excepted Benefits. This means that, while these new Excepted Benefits will be exempt from most of the HIPAA portability and ACA insurance market reforms and other mandates, they still will be subject to the HIPAA privacy and security rules.

Employers may rely on the Proposed Rules with respect to EAPs until regulations are issued in final form, at least through 2014.