Yes, Employers, There Is an Escape Clause!—Christmas Eve Guidance Exempts Some EAPs and Limited Scope Dental and Vision Plans From HIPAA and Affordable Care Act

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On December 24, 2013, the Departments of Labor, Treasury, and Health and Human Services (the Departments) brought good cheer to employers—proposed regulations that would exempt certain plans from parts of HIPAA and the Patient Protection and Affordable Care Act (Affordable Care Act) by expanding the definition of “limited excepted benefits” to include:

- Employee Assistance Plans (EAPs) that do not provide significant benefits in the nature of medical care;
- Self-insured limited scope dental and vision benefits, regardless of whether participants pay a separate contribution; and
- “Wraparound” employer-provided secondary medical coverage for individuals who purchase coverage in the public Exchanges (marketplaces) because the employer’s primary medical coverage is unaffordable for them.

Under the proposed regulations, EAPs, limited scope dental and vision plans, and wraparound coverage that meet the requirements will be exempt from certain requirements under HIPAA and the Affordable Care Act.

Background

Health plans that qualify as limited excepted benefits are exempt from many HIPAA and Affordable Care Act “consumer protections,”¹ as well as the Patient Centered Outcomes Research Institute (PCORI) fee and Form W-2 reporting. Since excepted benefits do not qualify as “minimum essential coverage” under the Affordable Care Act, participation in a plan of excepted benefits will not disqualify an employee from receiving premium tax credits or subsidies in a public exchange.

EAPs

Many employers offer EAP programs to their employees that include such benefits as short-term mental health counseling, legal services, and financial counseling. Often, these benefits are provided free of charge to employees, and all employees are eligible for such benefits, regardless of the number of hours

¹ The “consumer protections” are included in specific sections of ERISA, the Public Health Services Act, and the Internal Revenue Code (the Code) and include (but are not limited to) HIPAA portability, the Mental Health Parity and Addiction Equity Act of 2008, the Women’s Health and Cancer Rights Act, the Children’s Health Insurance Program Reauthorization Act, and the Affordable Care Act group market reforms, which include extension of coverage to adult children to age 26, no lifetime or annual dollar limit on essential health benefits, summary of benefits and coverage disclosure requirements, and if non-grandfathered, additional reforms such as new claims and appeals requirements (including the addition of an independent review organization) and in-network preventive care with no cost sharing.
worked or participation in the medical plan. To the extent such an EAP provides medical care, however, it would generally be a group health plan and therefore subject to the consumer protection requirements applicable to group health plans.

In September 2013, the Departments issued transition relief for these benefits through 2014. The transition relief provided that the Departments would consider an EAP to be an excepted benefit (and therefore not minimum essential coverage and not subject to the consumer protections) if the EAP did not provide "significant benefits in the nature of medical care or treatment." However, the Departments failed to provide any additional guidance on what constitutes significant benefits in the nature of medical care or treatment, leaving it to employers to make a reasonable good faith interpretation of that term.

With the proposed Christmas Eve regulations, the Departments set forth four criteria that an EAP must satisfy to qualify as an excepted benefit beginning in 2015:

1. The EAP cannot provide significant benefits in the nature of medical care—The Departments have specifically asked for comments on how to define "significant." The proposed regulations include an example of a program that provides up to 10 outpatient visits for mental health or substance abuse disorder counseling, an annual wellness checkup, immunizations, and diabetes counseling, with no inpatient care benefits. The proposed regulations specifically ask whether such a plan should be considered to provide significant benefits in the nature of medical care.

2. The benefits provided by the EAP cannot be coordinated with benefits under another group health plan—The EAP cannot serve as "gatekeeper" for accessing benefits under another group health plan, meaning that participants in a separate group health plan must not be required to exhaust benefits under the EAP before becoming eligible for benefits under the other group health plan. In addition, eligibility for benefits under the EAP must not depend on participation in another group health plan, and benefits under the EAP must not be financed by another group health plan.

3. Employers cannot require employee contributions—No employee premiums or contributions may be required to participate in the EAP.

4. Benefits provided under the EAP cannot require any employee cost sharing—EAPs may not require any deductibles or copayments.

The Departments also specifically request comments on whether the criteria that are proposed are sufficient to prevent the potential for abuse and whether additional or different standards should be proposed. Employers who sponsor EAPs should note that, even if the EAP is an excepted benefit and exempt from the consumer protections, an EAP that provides any medical care (e.g., counseling) may still be subject to other legal requirements, such as summary plan description and COBRA requirements.

Limited Scope Vision and Dental Benefits

Under the existing regulations, vision and dental benefits qualify as excepted benefits only if:

- The dental and vision benefits are limited in scope (substantially all benefits are for treatment of the eyes or mouth), and;
- Are either 1) provided under a separate policy, certificate, or contract of insurance or 2) are otherwise not an integral part of a group health plan. Benefits are not an integral part of the group health plan if participants have the right to elect not to receive coverage for the benefits and, if a participant elects to receive coverage for such benefits, the participant must pay an additional premium or contribution.
Many employer-provided dental and vision plans do not meet the current definition of excepted benefits. For example, employers permit employees to elect coverage under self-insured dental and vision benefits, but do not charge employees for such coverage. Since the coverage is free, these self-insured dental and vision benefits would not qualify as excepted benefits and would be subject to consumer protections requirements. Additionally, fully insured limited scope dental or vision benefits have to be offered under a separate policy or contract of insurance in order to meet the definition of excepted benefits.

The proposed regulations eliminate the requirement that self-insured dental and vision benefits must charge an additional premium or contribution in order to qualify as excepted benefits. Thus, employers can offer these plans to employees for free and still meet the definition of excepted benefits, as long as the other requirements are met (e.g., requiring a separate election).

Limited Wraparound Coverage

Some employers are providing wraparound secondary medical coverage to employees for whom the employer medical coverage is unaffordable and who elect medical coverage through the public Exchanges. The proposed regulations allow such wraparound coverage to qualify as excepted benefits if:

- The wraparound coverage is only available for coverage provided in the individual market. The individual coverage cannot be grandfathered and cannot consist solely of excepted benefits.
- The wraparound coverage is designed specifically to provide benefits beyond those offered by the individual health insurance coverage. Specifically, the wraparound coverage must provide benefits that are in addition to essential health benefits (EHBs) and/or reimburse the cost of out-of-network health care providers. The wraparound coverage may, but is not required to, provide benefits that reimburse for participants’ otherwise applicable cost sharing under the individual health insurance policy.
- The wraparound coverage cannot otherwise be an integral part of a group health plan. This means that the plan sponsor offering the wraparound coverage must sponsor a “primary plan”—a group health plan meeting minimum value for the plan year. The primary plan must be affordable for a majority of employees eligible for the primary plan, and only individuals eligible for this primary plan are eligible for the limited wraparound coverage.
- 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.
- The wraparound coverage must not differentiate among individuals in eligibility, benefits, or premiums based on any health factor of an individual (or any dependent) and must not impose any preexisting condition exclusion. The primary plan and the wraparound coverage must not discriminate in favor of highly compensated individuals.

The Departments note that, under the above criteria, the wraparound coverage will not qualify as excepted benefits if the wraparound coverage replaces group coverage (for employers who drop coverage) or if the employer coverage does not qualify as minimum value. The wraparound coverage would only qualify as excepted benefits if it is used to provide additional coverage to individuals and families enrolled in non-grandfathered individual health insurance coverage, and to whom minimum value employer coverage is offered but is unaffordable. The proposed regulations are designed to prevent plan
sponsors from structuring wraparound coverage so that low-income workers receive fewer primary
benefits than high-income workers.

Also, employers should keep in mind that providing wraparound coverage to employees for whom the
employer’s primary coverage is unaffordable does not exempt employers from penalties under Code
Section 4980H(b) for not offering affordable, minimum value coverage to full-time employees. Employers
will still be liable for those penalties, even if they offer limited wraparound coverage and that coverage is
an excepted benefit.

Effective Date and Comments

The proposed regulations clarify that until final regulations are published, and at least through 2014, the
Departments will consider dental and vision benefits and EAP benefits meeting the conditions of the
proposed regulations to qualify as excepted benefits. To the extent final regulations or other guidance
with respect to these benefits is more restrictive on plans than the proposed regulations, such final
regulations or guidance won’t be effective before January 1, 2015.

Comments on the proposed regulations are due on or before February 24, 2014.

Resources

The proposed regulations are available at: http://www.gpo.gov/fdsys/pkg/FR-2013-12-24/pdf/2013-
30553.pdf

The news release is available at: http://www.dol.gov/opa/media/press/ebsa/EBSA20132381.htm

Aon Hewitt’s Regulatory Guidance Under the Affordable Care Act page, which provides links to Aon
Hewitt bulletins on Affordable Care Act guidance and regulations, is available at:
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