MARSH & McLENNAN AGENCY

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REFORM UPDATE

Proposed rules to amend the Health Insurance Portability and Accountability Act

The Departments of Treasury, Labor (DOL) and Health and Human Services (HHS) recently issued proposed rules to amend the excepted benefits regulations of the Health Insurance Portability and Accountability Act (HIPAA). Many requirements of the Affordable Care Act (ACA) do not apply to these excepted benefits. The Departments are seeking comments on the proposed regulations.

Excepted benefits are not required to comply with a number of regulations. In general, excepted benefits are exempt from the market reform and other requirements included in the ACA. These include the rules prohibiting annual and lifetime dollar limits on essential benefits, the 90-day maximum waiting period for benefits eligibility, and the requirement to cover certain preventive care services with no cost-sharing. Excepted benefits are also exempt from the ACA's transitional reinsurance program and Patient-Centered Outcomes Research Institute (PCORI) fees.

There are currently four categories of excepted benefits:

1. Benefits that are generally not considered health coverage. This includes automobile insurance, liability insurance, workers' compensation and accidental death and dismemberment coverage.

2. Benefits for medical coverage that are considered limited in scope, such as limited-scope dental and vision plans. This also includes benefits for long-term care, nursing home care, home health care and community-based care. In addition, medical flexible spending accounts that meet certain requirements fall into the limited-scope category.

3. "Non-coordinated" benefits. This includes coverage for a specified disease or illness, cancer-only policies, hospital indemnity, and other fixed indemnity insurance. All of the following must apply for these benefits to be considered excepted:

   a) The benefits are provided under a separate policy, certificate or contract of insurance.

   b) There is no coordination between the provision of these benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

   c) The benefits are paid, with respect to any event, without regard to whether benefits are provided under any group health plan maintained by the same plan sponsor.

4. Supplemental benefits. To be considered excepted, these types of plans must be:

   a) Supplemental to Medicare, veterans' coverage, TRICARE or similar coverage provided by a group health plan

   b) Provided under a separate policy, certificate or contract of insurance

This is only a summary of the categories of excepted benefits. Certain categories have more detailed requirements.

Limited-Scope Benefits

Under the current HIPAA rules, dental and vision benefits are considered limited in scope if they are either:

a) Provided under a separate policy, certificate or contract of service

b) Not an integral part of a group health plan

Benefits are not an integral part of a health plan if:

a) Participants have the right to elect not to receive coverage, which means the coverage is elected independently of the medical election.

b) If participants have an independent right to elect coverage, they must pay an additional premium or contribution for this coverage.

The new regulations propose changes to the requirements for limited-scope benefits. Self-funded employers providing dental and vision benefits to employees at no cost expressed concern. If they do not require employee contributions, they will have a difficult time complying with the 90-day maximum waiting period for coverage and the prohibition on annual dollar limits. Self-funded employers noted that fully-insured plans are not required to charge employee contributions. Finally, employers expressed concern that if dental or vision coverage is not excepted, it could affect an employee's eligibility for premium tax credits in the Health Insurance Marketplace.

As a result of these concerns, the proposed regulations eliminate the requirement that a participant pay an additional premium for a limited-scope dental or vision plan that is not considered an integral part of the group health plan.

Wraparound Coverage

Because the penalties associated with the employer mandate go into effect in 2015, the government recognizes that most employers will offer coverage meeting the 60 percent minimum value threshold. Some employers may have employees who fail the affordability test, because they would be required to pay more than 9.5 percent of their household income for single health plan coverage. If those individuals enroll for coverage in the Marketplace and qualify for a premium subsidy, the employer will be assessed a $3,000 annual penalty for that employee. Although an employee may get help with premium payments, the coverage through the Marketplace may not resemble that of the employer plan.

The wraparound coverage proposed in these rules is intended to allow a plan sponsor to offer a comparable level of benefits to both high-income and low-income workers. The plan sponsor would offer wraparound coverage to supplement individual coverage purchased in the Marketplace. This coverage can be offered only if it qualifies as an excepted benefit. As an excepted benefit, the plan is not subject to most of the requirements of the ACA and would therefore be permitted to "wrap around" individual coverage.

This means that if these requirements are met, small group plans can be renewed for 2014 that do not include, among other things:

Five requirements must be met for the plan's wraparound coverage to be considered an excepted benefit:

1. Coverage can wrap around only certain plans provided through the individual market. The coverage must be non-grandfathered and not consist solely of excepted benefits.

2. The limited wraparound coverage must be designed to provide benefits beyond those offered by the individual health insurance plan. Specifically, the plan must provide benefits that are in addition to essential health benefits, or which reimburse the cost of out-of-network health care providers, or both. The plan can also provide benefits to reimburse cost-sharing under the individual plan, but that cannot be the primary purpose of the wraparound coverage. The wraparound plan cannot exist solely for coordination of benefits with the individual plan.

3. The coverage cannot be an integral part of the group health plan. The plan sponsor must offer another group health plan that meets the minimum value requirements, which will be referred to as the primary plan. The primary plan must be affordable for the majority of employees who are eligible for it. Only the individuals eligible for the primary plan would be eligible for the wraparound plan. The Departments are seeking comments on whether this eligibility provision is appropriate, recognizing that the Departments' goal is to prevent plan sponsors from shifting participants into the individual market. The Departments are also seeking feedback on whether the W-2 safe harbor should be used to determine affordability.

4. The wraparound coverage must be limited in cost. The total cost of coverage must not exceed 15 percent of the cost of the primary coverage offered to employees who are eligible for the wraparound plan. The cost of coverage should be determined as calculated for COBRA, less the 2% administrative fee.

5. The wraparound coverage must not differentiate among individuals in terms of eligibility, benefits or premiums based on any health factor of an individual or dependent. It must not impose pre-existing condition limitations. Finally, both the wraparound and primary plans must not discriminate in favor of highly compensated employees. Comments are requested on whether additional nondiscrimination standards are needed in order to prevent cost shifting and abuse.

Employers will be permitted to offer these limited wraparound plans for plan years starting in 2015. However, even if wraparound coverage is offered, employers will still be assessed the penalty for failing to offer affordable, minimum-value coverage for any employees securing subsidized individual coverage in the Marketplace.

Employee Assistance Programs (EAPs)

Many employers offer EAPs, which include a wide range of benefits to help employees resolve issues at home and work. Benefits may include short-term mental health counseling or referral services, as well as financial counseling and legal referral services. An EAP would generally be considered group health plan coverage, to the extent that it provides benefits for medical care. This means an EAP would be subject to HIPAA and the requirements of the ACA. The only way to exclude EAPs from these requirements would be to designate them as an excepted benefit.

The proposed regulations include four criteria that EAPs must meet in 2015 in order to be considered an excepted benefit:

1. The program cannot provide significant benefits in the nature of medical care. Comments are requested on what "significant" means. The Departments suggested a limit of 10 outpatient visits, which could be for mental and substance abuse, annual wellness, immunizations or diabetes counseling. No inpatient benefits could be provided.

2. Benefits cannot be coordinated with benefits available under another group health plan. Participants cannot be required to exhaust benefits under an EAP before becoming eligible for benefits under the group health plan. Similarly, eligibility for benefits under the EAP must not be dependent upon participation in another group health plan. Finally, benefits under the EAP cannot be financed by another group health plan.

3. No employee premiums or contributions can be required for EAP participation.

4. The EAP cannot require participant cost-sharing.

Most employers' EAPs will easily meet these requirements.

Concluding Thoughts

The Departments expect to issue final guidance after reviewing stakeholder comments. The final guidance will not be effective before January 1, 2015.