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REFORM Update

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Final Regulations Issued On "Excepted" Benefits

On October 1, 2014, the Departments of Labor, Health and Human Services (HHS) and the Treasury released final regulations that address "excepted" benefits. Excepted benefits are generally exempt from many of the market reform requirements of the Affordable Care Act (ACA). The proposed rules on excepted benefits were released in late 2013, and were addressed in our *Reform Update* at http://www.mcgrawwentworth.com/Reform_Update/2014/Reform_Update_79.pdf.

These final rules focus on limited-scope dental and vision plans. They also address employee assistance programs (EAPs). The final rules changed some key aspects of the proposed regulations. The rules are effective on January 1, 2015.

Dental and Vision Benefits

The requirements for limited-scope dental and vision benefits to be considered excepted benefits have changed over time. The proposed regulations stated that dental and vision plans would only be considered excepted benefits if they are:

- Provided under a separate policy, certificate or contract of service *or*
- Not an integral part of a group health plan

If the plans are provided under a separate contract, they are considered excepted. However, the final guidance does not require a limited-scope vision or dental plan to have a separate contract or independent election in order to be considered an excepted benefit. It may still be excepted if it cannot be considered an integral part of the major medical plan. The limited-scope dental or vision coverage will not be considered integral if either of the following criteria is met:

- A participant may decline coverage in the limited-scope dental or vision plan
- Claims for the limited-scope dental or vision benefits are administered under a contract separate from the claims administration for any other benefits under the plan

These final rules make it much easier for employers to consider their limited-scope dental or vision programs excepted.

Employee Assistance Programs (EAPs)

The final rules adopted the proposed rules for EAPs. For an EAP to be considered an excepted benefit, it must meet all of the following requirements:

1. The EAP does not provide significant medical benefits

2. The EAP is not coordinated with the benefits under another group health plan
    a. The EAP benefits do not need to be exhausted before the group health benefits are triggered
    b. The EAP eligibility is not contingent upon participation in the major medical plan
3. The employer does not require a premium or contribution for EAP coverage
4. The EAP does not contain any cost-sharing requirements

The final rules do not specifically define what "significant medical benefits" means. The proposed rules include a discussion about setting potential visit limits in order to ensure that the benefits provided by the EAP are not significant in nature. None of these proposed limits were adopted by the final rule. The final rule allows employers to determine if the benefits provided are significant. Employers should take into account the amount, scope and duration of covered services.

Most EAPs will be considered excepted benefits under the final rules.

Concluding Thoughts

These final rules specifically address limited-scope dental and vision plans and EAPs. This is just a subset of the four categories of benefits considered excepted:

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.
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 health plan
    b. Provided under a separate policy, certificate or contract of insurance

The proposed regulations also included a discussion of new category called "limited wraparound coverage." The final regulations did not address this new category, but noted that this category of benefits will be addressed in future guidance.