What Employers Need to Know About New Excepted Benefits Rules

Employers, take note: The rules and definitions for healthcare benefits have changed again.

The Departments of the Treasury, Labor, and Health and Human Services (the "Departments") have issued proposed regulations aimed once again at clarifying a number of healthcare topics, including excepted benefits such as fixed indemnity and hospital indemnity plans.

As a result, the job at hand now for employers and plan sponsors will be to review any excepted benefit plans that are currently offered or being considered for the next plan year to make sure they are compliant with these new proposed regulations.

The guidance is proposed to take effect for plan years that begin on and after January 1, 2017, and employers and plan sponsors may rely on the proposed regulations until the final rules become effective. Comments about the proposed rules may be submitted through August 9, 2016.

So, where did excepted benefits come from and what are the highlights of the proposed regulations?

Excepted Benefits

The concept of excepted benefits started with the Health Insurance Portability and Accountability Act ("HIPAA"). These types of benefits were considered exempt from the HIPAA portability and nondiscrimination requirements. Under the Affordable Care Act ("ACA"), excepted benefits are not subject to many of the market reform provisions that traditional health plans are subject to, such as the 90-day waiting period, extension of coverage to age 26 for dependent children, and annual and lifetime limits. The plans also do not pay the Patient-Centered Outcomes Research Institute ("PCORI") or reinsurance fees imposed on group health plans.

Since the enactment of the ACA, regulators have been looking at different types of excepted benefits to clarify and/or modify the rules regarding these plans. **And this is where it's employers beware. Plans that do not fall under the government's definition of excepted benefits** but that also **do not satisfy ACA market reform provisions** may be subject to **large penalties**, including an IRS excise tax of $100 per day per individual up to $500,000. And that's why it's **so important to review the benefits plans** you want to provide to your employees.

There are four categories of excepted benefits expressly stated in this statute. They are:

(1) Always excepted benefits

These benefits are not considered group health plans and include automobile insurance, liability insurance, workers compensation, and accidental death and disability coverage.

(2) Limited excepted benefits

This category includes limited-scope dental and vision benefits and long-term care benefits. In order to be considered an excepted benefit, these plans must either:

- Be provided under a separate policy, certificate, or contract of insurance (i.e. be an insured arrangement), or
- Not be an "integral part of a group health plan whether insured or self-funded", and the plan must allow employees the right to opt out of the coverage.

Certain health flexible spending accounts ("FSA") also fall under this category. A health FSA may be considered to provide only excepted benefits (and therefore not be subject to ACA market reforms) if:

- Other group health plan coverage (not excepted benefits) is made available for the year to employees, and
- The maximum FSA benefit payable to any participant cannot exceed two times the participant's salary reduction election for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election).

(3) Non-coordinated excepted benefits

Specified disease, critical illness, as well as fixed and hospital indemnity plans, will only be considered excepted benefits if all of the following conditions are satisfied:

- The benefits are provided under a separate policy, certificate, or contract of insurance (i.e. be an insured arrangement);
- There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the plan sponsor; and
- 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.

In addition, earlier guidance (DOL FAQ Part XI) indicated that a group health plan will not be considered an excepted hospital or fixed indemnity benefit if the plan pays benefits in varying amounts based on the type of procedure or service being covered. The plan must only pay a fixed-dollar amount per day (or other time period) to be categorized as an excepted benefit exempt from the ACA market reforms. These proposed regulations enforce this requirement and clearly state that "*hospital indemnity or other fixed indemnity insurance policies that provide benefits for doctors' visits at a fixed amount per visit, for prescription drugs at a fixed amount per drug, or for certain services at a fixed amount per day but in amounts that vary by the type of service…do not meet the condition that benefits be provided on a per day (or per other time period, such as per week) basis*."

The proposed regulations then give three very specific examples of group health plan insurance policies that fail to qualify as excepted benefit indemnity plans.

(i) Policy that provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum of $100 a day.

(ii) Policy that provides benefits for doctors' visits at $50 per visit, hospitalization at $100 per day, various surgical procedures at different dollar rates per procedure, and prescription drugs at $15 per prescription.

(iii) Policy that provides benefits for certain services at a fixed-dollar amount per day, but the dollar amount varies by the type of service.

The proposed regulations go a step further, requiring indemnity plans to inform individuals before enrolling that their plan is a supplement to major medical coverage. They must let individuals know that the plan doesn't count as Minimum Essential Coverage ("MEC"), which could subject them to a tax penalty for failure to satisfy the ACA individual mandate. The proposed regulations even include the disclaimer language that must appear in 14-point type on these policies.

The Departments are requesting comments from employers and the public at large regarding the indemnity plan design limitations for excepted benefit status and the proposed notice requirements. Indemnity plans that fail to satisfy these rules should determine if they may qualify as a "supplemental excepted benefit" as noted in DOL FAQ XVIII.

The proposed regulations also seek comment on whether or not a specified disease policy (such as a cancer policy) will maintain excepted benefit status if more than one disease or critical illness is covered under the same policy. The number one concern of regulators is that consumers may mistakenly confuse multiple disease/illness arrangements for comprehensive coverage, which could leave them without full health coverage and without many of the important consumer protections included in the ACA.

(4) Supplemental excepted benefits

These plans are typically designed to fill gaps in the primary group health plan coverage, such as deductibles, coinsurance or copayments. To qualify as an excepted benefit, the supplemental plan must:

- Be provided under a separate policy, certificate or contract of insurance issued by an entity that does not provide the primary coverage,
- Not pay a benefit as a result of a coordination of benefits feature,
- Cost 15% of or less than the cost of the primary coverage, and
- Not discriminate with regard to eligibility, benefits or premiums based on an individual's health status.

The proposed regulations will also consider a policy to be supplemental coverage if the policy includes additional benefits not considered Essential Health Benefits ("EHB") in the state where coverage is written. States must ensure that any EHB package covers items and services in the 10 benefit categories specified in the ACA, which include:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services as well as chronic disease management
10. Pediatric services including oral and vision care

Takeaway for Employers

Offering additional excepted benefits as perks for your employees is still a great way to attract and keep great talent. However, make sure you **know which of the benefits you offer satisfy ACA requirements**, and make sure you clearly **communicate to employees which plans satisfy the individual mandate of the ACA**. Otherwise, you and your employees can be looking at large tax liabilities at filling time.

If you haven't already, set up an appointment with your legal counselor or benefits broker to see how your benefits plans stack up against the new proposed regulations. Or, reach out to a Cherry Bekaert Benefits team member with your questions. We'll be happy to team you up with one of our best advisors to answer your benefits questions.