How New Final Regulations on Supplemental Insurance Plans and Dollar Limits Will Affect Employees

Any HR pro knows – there's so much more to insurance than major medical coverage. And the Departments of Treasury, Labor, and Health and Human Services (the "Departments") have addressed some of the "extras" of the insurance world in their latest proposed regulations.

On June 10, 2016, the Departments issued proposed regulations to address certain **excepted benefits, lifetime and annual limits, travel insurance, and short-term limited duration insurance**. Recently, the Departments issued their final regulations, which adopt the proposed regulations without significant change for the most part.

Changes or no, employers and plan sponsors should review any benefit plans they currently offer or are considering if they are the kinds of benefit plans addressed in these final regulations. A thorough review will help you determine if you're compliant with all applicable plan requirements that become effective for plan years that begin on and after January 1, 2017.

The Departments intend to address hospital and other fixed indemnity fixed indemnity insurance, as well as expatriate health plans (which were included in the proposed regulations), in future rulemaking.

Supplemental Insurance – An Excepted Benefit

The notion of excepted benefits originated 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 market reform provisions, such as the 90-day waiting period, extension of coverage to age 26 for dependent children, and annual and lifetime dollar limits. The plans also do not pay the Patient Centered Outcomes Research (PCORI) or reinsurance fees imposed on group health plans.

Plans in the excepted benefits category known as "supplemental insurance" have two requirements. The benefits in these plans:

1. Must be provided under a separate policy, certificate or contract of insurance
2. Qualify as Medicare supplemental health insurance (Medigap) plans, TRICARE supplemental programs or "similar supplemental coverage provided to coverage under a group health plan"

Prior regulations issued by the Departments indicated that similar supplemental coverage "must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles." The Departments also provided the following safe harbor conditions for supplemental insurance plans to be considered excepted benefits:

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

The 2016 proposed and final regulations allow supplemental coverage to maintain excepted benefit status, if the policy includes additional benefits not considered essential health benefits ("EHBs") in the state where the coverage is marketed in

addition to filling in coverage gaps. Therefore, any benefit included in the supplemental policy that is either (a) covered under the primary group health plan, or (b) is considered an EHB in the state where the coverage is issued would not be considered a supplemental excepted benefit plan.

Lifetime and Annual Dollar Limits

Individual and small group market plans must provide benefits in all ten of the ACA-mandated EHB categories:

1. Ambulatory patient services
2. Emergency services
3. Mospitalization
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

In contrast, **large group health plans, self-funded group health plans and grandfathered plans (collectively "exempt plans") are not required to** provide EHB benefits. However, these exempt plans may not impose annual and lifetime dollar limits on any EHBs that they cover. In order to determine what benefits are considered EHBs under exempt plans, the plan sponsor must select a "base benchmark plan."

Under the ACA, each state (including the District of Columbia) designates a benchmark plan that all other plans will be measured against in order to define the EHBs in its individual and small group market. EHB exempted plans may choose any state plan or one of the three Federal employees' health benefit plans to be used as the base benchmark to establish the plan's EHBs.

The final regulations clarify that if a state benchmark plan is selected, all EHBs, as well as state benefit mandates enacted before December 31, 2011, must be considered part of the base benchmark plan subject to the annual and lifetime dollar limit prohibitions. Furthermore, if one of the Federal employee benefit plans is selected as the base benchmark plan, it would also need to be supplemented to ensure the inclusion of all 10 required EHBs.

Oftentimes, the carrier for a large insured group health plan will designate a plan in the state where they are headquartered or conduct most of their business as the benchmark plan. A self-funded plan sponsor may have more latitude in selecting a benchmark plan. For example, a self-funded plan that wishes to cover bariatric surgery up to a certain dollar limit would want to find and select a benchmark plan that does not include bariatric surgery as an EHB.

Travel Insurance

The regulators expressed concern that certain travel insurance products also offer limited health benefits. The final regulations adopt the proposed regulations without change and consider travel insurance to be an excepted benefit. Travel insurance is defined as "insurance coverage for personal risks incident to planned travel, which may include, but are not limited to, interruption or cancellation of a trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage." Travel insurance would not include comprehensive medical protection for travelers with trips lasting six months or longer, including expatriates and military personnel being deployed.

Short-Term Limited-Duration Insurance

This type of insurance is generally geared toward individuals transitioning from one job to another. These policies typically provide coverage for a period of less than 12 months with an expiration date specified in the contract. Short-term insurance may contain annual and/or lifetime limits on EHBs, have pre-existing condition limitations, and be medically underwritten.

The need for these types of transitional individual policies were expected to become less prevalent when the ACA Marketplaces opened in 2014. However, in some circumstances, the opposite appears to be happening.

The Departments expressed concern that these short-term limited-duration policies are being purchased by individuals as their primary source of coverage with some insurers extending coverage beyond a 12-month period. For certain consumers, most notably healthier individuals, the combination of a short-term policy and the individual mandate penalty is a more cost-efficient way to have health coverage. The problem is that this strategy can adversely impact the ACA individual market risk-pool, leading to higher costs for plans purchased from the ACA Marketplace.

The final regulations have been adopted without change. They revise the definition of short-term limited-duration insurance to require the coverage be less than three months in duration, taking into account any extensions that may be elected by the policyholder with or without carrier consent. The policy must also include a disclaimer in at least 14-point type indicating the plan does not qualify as minimum essential coverage ("MEC") and that an additional tax payment may be owed. The regulations are effective for policies sold on and after January 1, 2017. Some states may have already approved short-term policies for sale in 2017 based on prior rules. Therefore, the Department of Health and Human Services ("HHS") has indicated that no enforcement action will be taken for the sale of non-compliant products prior to April 1, 2017, provided the coverage ends on or before December 31, 2017. States may also delay enforcement against issuers with respect to such coverage sold before April 1, 2017.

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