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***HEALTH LAW ALERT***
***October 1, 2014***

# HHS Finalizes "Excepted Benefits" Definition

## Changes Apply to Vision & Dental Coverage, EAPs

Today, the Departments of Health and Human Services, Labor, and the Treasury (the Regulatory Agencies) formally[1] published final rules amending the definition of "excepted benefits" to address concerns that group dental plans, vision plans, and Employee Assistance Programs (EAPs) would be required to comply with Affordable Care Act requirements that do not make sense for such coverage. For example, without the amendments to the "excepted benefits" definition, dental plans, vision plans, and EAPs could be required to cover preventive health services without out-of-pocket cost-sharing and to publish a uniform summary of benefits and coverage designed for major medical coverage.

The final rules are published at 79 *Federal Register* 59103 (click here). Click here for my compilation of Selected Federal Health Insurance Provisions incorporating the amendments into previously-published rules (*see* first two links under "Compiled Rules") (or see the "Resources" page at tbixbylaw.com). The amended Department of Health and Human Services rule on excepted benefits is 45 C.F.R. § 146.145; the Department of Labor rule is 29 C.F.R. § 2590.732, and the Department of Treasury rule is 26 C.F.R. § 54.9831-1.

### Dental and Vision Benefits

Limited scope[2] dental or vision benefits offered through a group health plan (or by an insurer to a group health plan) qualify as "excepted benefits" when they are "not an integral part of [the] group health plan." Prior to the amendment published today, benefits were not an integral part of a group health plan (and so were excepted benefits) if the benefits were offered through "a separate policy, certificate, or contract of insurance." For self-funded coverage, dental or vision coverage qualified as excepted benefits only if a participant ***both*** (a) had the right to decline coverage ***and*** (b) had to pay additional premium (or contribution) if s/he elected to receive the coverage.

[1] The Department informally published the Rules and released them to the public on September 26 when they were filed with the Office of the Federal Register.

[2] Dental or vision benefits have a "limited scope" when "substantially all" of the benefits offered are for "treatment of the mouth" or "treatment of the eye," respectively.

The revised rules permit self-funded plans to be treated as "excepted benefits" more easily. First, limited scope dental and vision coverage qualifies as "excepted benefits" when the coverage is "administered under a contract separate from claims administration for any other benefits plan." Second, the rules eliminated the requirement that the participant pay additional premium or contribution upon electing coverage under a limited scope dental or vision plan. Thus, limited scope dental or vision coverage is an "excepted benefit" if ***either*** (a) the plan participant is permitted to decline coverage ***or*** (b) the claims administrator for the dental or vision plan has a separate contract with and does not administer any other benefits for the plan sponsor.

**Employee Assistance Programs**

Under the amended rules, an Employee Assistance Program will qualify as "excepted benefits" provided that the benefits offered meet four requirements. First, the EAP must "not provide significant benefits in the nature of medical care." The Regulatory Agencies provide little guidance on what constitutes such benefits. The rules explain that "the amount, scope and duration of covered services [will be] taken into account" in determining whether medical benefits offered by an EAP are "significant." But the only specific guidance the Agencies offer is to contrast a plan with a vague description of minimal benefits—a plan that "provides only limited, short-term outpatient counseling"—with a plan that offers benefits well beyond what most EAPs offer—a plan that "provides disease management services (such as laboratory testing, counseling, and prescription drugs) for individuals with chronic conditions."

Second an EAP cannot be coordinated with benefits under another group health plan. This means that a major medical group health plan cannot require participants to exhaust benefits under the EAP before being eligible for benefits under the major medical coverage. Thus, for example, a major medical group health plan cannot require a participant to participate in three counseling sessions offered by the EAP before covering mental health benefits. In addition, participation in the EAP cannot be contingent upon an individual being a participant in another group health plan.

The third and fourth requirements for an EAP to qualify as excepted benefits relate to financial contributions by participants: participants cannot be required to pay premiums (or make contributions to self-funded coverage) for EAP coverage and they cannot be required to pay any out-of-pocket cost-sharing, such as copays or deductibles.

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