Excepted Benefits – HIPAA and ACA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains rules for group health plans and health insurance issuers regarding portability. The Affordable Care Act (ACA) made extensive changes to HIPAA's portability provisions, including prohibiting pre-existing condition exclusions or annual limits and requiring plans to cover preventive care services.

HIPAA's portability rules broadly apply to group health plans and health insurance issuers offering group health insurance coverage. However, certain categories of coverage—called "excepted benefits"—are not subject to HIPAA's portability rules.

Employee benefits that qualify as excepted benefits under HIPAA are also not subject to the ACA's market reforms, including the ACA's prohibition on annual limits and preventive care coverage requirement.

This Compliance Overview summarizes the categories of benefits that qualify as excepted benefits under HIPAA and the ACA.

Overview of Excepted Benefits

In 2004, the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (Departments) published final regulations on excepted benefits (the HIPAA regulations). The HIPAA regulations established the following four categories of excepted benefits:

1	Benefits that are generally not health coverage
2	Limited excepted benefits
3	Non-coordinated excepted benefits
4	Supplemental excepted benefits

The benefits in the first category are excepted in all circumstances. However, the benefits in the second, third and fourth categories are types of health coverage that are excepted only if certain conditions are met.

Benefits That Are Generally Not Health Coverage

The first category includes benefits that are generally not health coverage, such as:

- Coverage only for accident (including accidental death and dismemberment)
- Disability income coverage
- Workers' compensation or similar coverage
- Liability insurance, including general liability insurance and automobile liability insurance
- Coverage issued as a supplement to liability insurance
- Automobile medical payment insurance
- Credit-only insurance (for example, mortgage insurance)
- Coverage for on-site medical clinics
- Travel insurance

The benefits in this category are excepted in all circumstances.

Limited Excepted Benefits

The second category of excepted benefits is limited excepted benefits, which may include limited-scope vision or dental benefits as well as benefits for long-term care, nursing home care, home health care or community-based care.

Limited-scope dental benefits are benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth). Limited-scope vision benefits are benefits substantially all of which are for treatment of the eye.

Limited benefits qualify as excepted benefits if they are either:

- Provided under a separate policy, certificate or contract of insurance; or
- Otherwise not an integral part of a group health plan, whether insured or self-insured.

While only insured coverage may qualify under the first test, both insured and self-insured coverage may qualify under the second test. To satisfy the requirement that limited-scope vision or dental benefits cannot otherwise be “an integral part of the plan,” (whether they are provided through the primary plan, separately or as the only coverage offered), either:

- Participants must be able to decline coverage; or
- Benefit claims must be administered under a contract separate from claims administration for any other benefits under the plan.

Health Flexible Spending Arrangements (FSAs)

Benefits provided under a health flexible spending arrangement (health FSA) may also qualify as limited excepted benefits if they satisfy the **availability and maximum benefit** requirements.

Availability Requirement—Other non-excepted group health plan coverage (for example, major medical coverage) must be made available for the year to the class of participants by reason of their employment.

Maximum Benefit Requirement—The maximum benefit payable under the health FSA to any participant for a year cannot exceed the greater of:

- Two times the participant’s salary reduction election under the health FSA for the year; or
- The amount of the participant’s salary reduction election for the health FSA for the year, plus $500.

An FAQ issued on May 2, 2014, clarifies that unused carryover amounts remaining at the end of a plan year in a health FSA that satisfy the modified "use-or-lose" rule should not be taken into account when determining if the health FSA satisfies the maximum benefit requirement.

Employee Assistance Programs

Employee assistance programs (EAPs) are typically programs offered by employers that can provide a wide-ranging set of benefits to address circumstances that might otherwise adversely affect employees’ work and health (such as short-term substance use disorder or mental health counseling or referral services, as well as financial counseling and legal services).

To the extent that an EAP provides benefits for medical care, it would generally be considered group health plan coverage, which would generally be subject to the HIPAA and ACA’s market reform requirements, unless the EAP meets the criteria for being excepted benefits.

The Departments final regulations from Oct. 1, 2014, recognize EAPs as a limited excepted benefit in certain circumstances. An EAP is an excepted benefit if four requirements are met:

- The program does not provide significant benefits in the nature of medical care (for this purpose, the amount, scope and duration of covered services are taken into account);
- The EAP’s benefits are not coordinated with benefits under another group health plan. This requirement has two elements:
  - Participants in the separate group health plan must not be required to use and exhaust benefits under the EAP (making the EAP a “gatekeeper”) before an individual is eligible for benefits under the other group health plan; and
  - Participant eligibility for benefits under the EAP must not be dependent on participation in another group health plan;
- No employee premiums or contributions may be required to participate in the EAP; and
- The EAP does not impose any cost-sharing requirements.

Excepted Benefit HRAs

On June 13, 2019, the Departments issued a final rule that expanded the definition of limited excepted benefits to include a new type of health reimbursement arrangement (HRA). Effective for plan years beginning on or after Jan. 1, 2020, employers offering traditional group health plan coverage may offer an excepted benefit HRA of up to $1,800 per year (indexed annually for inflation) to reimburse an employee for eligible medical care expenses, including premiums for:

- Individual health coverage that consists solely of excepted benefits (such as stand-alone vision and dental plans, accident-only coverage, workers' compensation coverage or disability coverage);
- Coverage under a group health plan that consists solely of excepted benefits;
- Short-term, limited-duration insurance plans; and
- COBRA coverage.

However, an excepted benefit HRA cannot reimburse premiums for individual health coverage, coverage under a group health plan (other than COBRA or other group continuation coverage), or Medicare parts B or D.

An excepted benefit HRA must be offered in conjunction with a traditional group health plan, although employees are not required to enroll in the traditional plan to use the excepted benefit HRA. Also, the excepted benefit HRA must be uniformly available to all similarly situated individuals (as defined under HIPAA).

Non-Coordinated Excepted Benefits

The third category of excepted benefits, referred to as "non-coordinated excepted benefits," includes both coverage for only a specified disease or illness (such as cancer-only policies) and hospital indemnity or other fixed indemnity insurance. To qualify as excepted benefits, a hospital indemnity or other fixed indemnity insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness regardless of the amount of expense incurred.

To be exempt as "non-coordinated excepted benefits," benefits must:

- Be provided under a separate policy, certificate or contract of insurance;
- Not contain any coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and
- Be paid with respect to an event, without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

On July 7, 2023, the Departments issued a proposed rule that would create additional requirements for hospital indemnity and fixed indemnity coverage to ensure that consumers can distinguish between this coverage and comprehensive medical coverage. The Departments' proposed rule would clarify the prohibition on coordination between fixed indemnity coverage and any group health plan maintained by the same plan sponsor. The proposed rule would also require plans and issuers to provide a notice to consumers to alert them to the differences between fixed indemnity coverage and comprehensive medical coverage. This guidance is only in proposed form and has not been finalized.

Supplemental Excepted Benefits

The fourth category of excepted benefits is supplemental excepted benefits. These benefits must be supplemental to Medicare or CHAMPVA/TRICARE coverage (or similar coverage that is supplemental to coverage provided under a group health plan, known as "similar supplemental coverage") and provided under a separate policy, certificate or contract of insurance.

Supplemental health insurance will be considered an excepted benefit if it is provided through an insurance policy that is separate from the primary coverage under the plan and meets all of the following requirements (IRS Notice 2008-23):

- The supplemental policy is issued by an entity that does not provide the primary coverage under the plan;
- The supplemental policy is specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles, but does not become secondary or supplemental only under a coordination of benefits provision;
- The cost of the supplemental coverage is 15 percent or less of the cost of primary coverage (determined in the same manner as the applicable premium is calculated under COBRA); and
- The supplemental coverage sold in the group health insurance market does not differentiate among individuals in eligibility, benefits or premiums based upon any health factor of the individual (or any dependents of the individual).

In addition, a final rule from Oct. 31 2016, clarifies that supplemental health insurance coverage that provides benefits for items and services not covered by the primary coverage satisfies the requirement that the coverage be designed "to fill gaps in primary coverage," if none of the benefits provided by the supplemental policy are an essential health benefit (EHB) in the state in which the coverage is issued. Supplemental health insurance products that both fill in cost sharing in the primary coverage, such as coinsurance or deductibles, and cover additional categories of benefits that are not EHB, also are considered supplemental excepted benefits under the final rule, provided all other criteria are met.

LINKS AND RESOURCES

- Final regulations on HIPAA excepted benefits from 2004
- Final regulations from October 2016 regarding similar supplemental coverage
- Proposed regulations from July 2023 on fixed indemnity excepted benefits coverage

This Compliance Overview is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice. ©2015-2020, 2023 Zywave, Inc. All rights reserved.