

# State Health Reform Assistance Network

## Charting the Road to Coverage

ISSUE BRIEF

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## Short-term, Limited-duration Insurance and Excepted Benefits

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As technical assistance professionals with the Robert Wood Johnson Foundation's *State Health Reform Assistance Network*, the Georgetown team fields questions on a variety of topics from *State Network* states. Recent questions have indicated that some confusion exists about which insurance products qualify as "excepted benefits" and are therefore exempt from several requirements of the Affordable Care Act (ACA), such as coverage for preventive health services, a prohibition on lifetime limits, and minimum value requirements. This brief provides a framework of the federal law governing requirements for identifying both "short-term, limited-duration" insurance and "excepted benefits."

### I. Short-term, limited-duration insurance

Short-term, limited-duration insurance is health insurance "provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is less than 12 months after the original effective date of the contract."<sup>1</sup>

Short-term, limited-duration plans are not "excepted benefits," but rather, are excluded from the definition of "individual health insurance coverage,"<sup>2</sup> which is subject to many of the requirements of the Public Health Service Act (PHS Act), as amended by the ACA.<sup>3</sup> Therefore, short-term, limited-duration plans are not subject to the Public Health Service Act requirements applicable to "individual health insurance coverage."

<sup>1</sup> 45 C.F.R. 144.103.

<sup>2</sup> *Id.*; 42 U.S.C. § 300gg-91(b)(5).

<sup>3</sup> The Affordable Care Act subjects a "group health plan and a health insurance issuer offering group or individual health insurance coverage" to several requirements including prohibitions on preexisting condition exclusions (42 U.S.C. § 300gg-3), prohibitions on health status-based discrimination (42 U.S.C. § 300gg-4), prohibitions on lifetime or annual limits (42 U.S.C. § 300gg-11), prohibitions on rescissions (42 U.S.C. § 300gg-12), coverage of preventive health services (42 U.S.C. § 300gg-13), extension of dependent coverage (42 U.S.C. § 300gg-14), the provision of summary of benefits and coverage explanation (42 U.S.C. § 300gg-15), quality of care reporting requirements (42 U.S.C. § 300gg-17), minimum value requirements (42 U.S.C. § 300gg-18), and an effective appeals process (42 U.S.C. § 300gg-19). The Act also imposes requirements on health insurance issuers for coverage "in the individual or small group market," including prohibitions on discriminatory rates (42 U.S.C. § 300gg), guaranteed issue (42 U.S.C. § 300gg-1), guaranteed renewability (42 U.S.C. § 300gg-2), and coverage for essential health benefits (42 U.S.C. § 300gg-6).

#### ABOUT STATE NETWORK

State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit [www.statenetwork.org](http://www.statenetwork.org).

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## II. Excepted benefits

Insurance coverage that qualifies as “excepted benefits” is not subject to many ACA requirements.<sup>4</sup> Excepted benefits are divided into four categories: benefits that are not health coverage (even if they incidentally cover medical care), limited-scope benefits, non-coordinated benefits, and supplemental benefits.<sup>5</sup>

### A. NON-HEALTH INSURANCE TYPES OF COVERAGE

Several categories of benefits that are not considered health insurance coverage, though they may incidentally cover medical costs, are considered “excepted benefits” and are not required to meet additional requirements, like being offered under a separate policy. Under the statute, those types of coverage are accident and disability income insurance, liability insurance and insurance supplemental to liability insurance, workers’ compensation, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, and other similar types of coverage, to be specified in regulations, under which medical benefits are incidental to other insurance benefits.<sup>6</sup> The regulations provide that “coverage only for accident” includes accidental death and dismemberment, and provides mortgage insurance as an example of “credit-only insurance,” but otherwise leaves the statutory definition unchanged.<sup>7</sup>

### B. LIMITED-SCOPE BENEFITS<sup>8</sup>

Limited-scope benefits include certain types of medical care, particularly dental and vision benefits, long-term care, nursing home care, home health care, community-based care benefits, and other similar limited-scope benefits provided in the regulations.<sup>9</sup> Limited-scope benefits are excepted from ACA requirements if they are offered separately.<sup>10</sup> In the individual market, these plans are considered excepted benefits if they “are provided under a separate policy, certificate, or contract of insurance.”<sup>11</sup>

For group health insurance, the regulation provides that limited-scope benefits are excepted if they are “provided under a separate policy, certificate, or contract of insurance” or “are otherwise not an integral part of a group health plan[.]”<sup>12</sup> Only fully insured plans can qualify under the first test, as “[p]rovided under a separate policy, certificate, or contract of insurance.”<sup>13</sup> However, both fully insured and self-insured coverage can qualify as excepted benefits under the second test, “otherwise not an integral part of a group health plan.”<sup>14</sup> Under the Health Insurance Portability and Accountability Act (HIPAA) regulations, benefits are “not an integral part of a group health plan” only if participants “have the right to elect not to receive coverage for the benefits” and “[i]f a participant elects to receive coverage, the participant must pay an additional premium or contribution for that coverage.”<sup>15</sup>

A recently released rule clarifies what is meant by “not an integral part of a group health plan” and eliminates the requirement that participants pay an additional premium for limited-scope dental or vision benefits to be considered excepted.<sup>16</sup> Furthermore, the final regulations clarify that limited-scope vision or dental benefits do not have to be offered in connection with major medical group health coverage to meet the requirement that the benefits are otherwise not an integral part of the plan.<sup>17</sup> To qualify as excepted benefits, limited-scope vision or dental plans can either be offered without connection to a major medical plan or can be offered separately from the major medical coverage.<sup>18</sup> Finally, the test that benefits are not an integral

<sup>4</sup> Excepted benefits were initially labeled as such in the Health Insurance Portability and Accountability Act (HIPAA), because the requirements under HIPAA did not apply to such benefits (29 U.S.C. 1191a(b)). Under the Affordable Care Act, in the individual market, excepted benefits are not subject to the “Individual Market Rules,” per 42 U.S.C. ch. 6A, subch. XXV, pt. B. 42 U.S.C. § 300gg–63. In both the group and individual markets, excepted benefits are not subject to “Individual and Group Market Reforms,” per 42 U.S.C. ch. 6A, subch. XXV, pt. A, subpt. I&II. 42 U.S.C. § 300gg–21.

<sup>5</sup> 42 U.S.C. § 300gg–91(c).

<sup>6</sup> *Id.* § 300gg–91(c)(1).

<sup>7</sup> 45 C.F.R. 146.145(c)(2); 45 C.F.R. 148.220(a).

<sup>8</sup> Final regulations affecting limited-scope benefits are effective January 1, 2015, and any limited-scope plan or Employee Assistance Program (EAP) meeting the conditions of the 2013 proposed rules qualifies as excepted benefits until plan years beginning on or after January 1, 2015. Amendments to Excepted Benefits, 79 Fed. Reg. 59130, 59134 (Oct. 1, 2014).

<sup>9</sup> 42 U.S.C. § 300gg–91(c)(2).

<sup>10</sup> *Id.*

<sup>11</sup> 45 C.F.R. 148.220(b).

<sup>12</sup> *Id.* at 146.145(c)(3)(i).

<sup>13</sup> 79 Fed. Reg. at 59131.

<sup>14</sup> *Id.*

<sup>15</sup> 45 C.F.R. 146.145(c)(3)(ii).

<sup>16</sup> 79 Fed. Reg. at 59132.

<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

part of the plan is “satisfied if participants may decline coverage or claims for the benefits are administered under a contract separate from claims administration for other benefits under the plan.”<sup>19</sup> The final rule also clarifies that the revisions apply to the coverage of long-term care benefits, in addition to limited-scope dental and vision.<sup>20</sup>

### **i. Health Flexible Spending Arrangements**

A health Flexible Spending Arrangement (FSA) is a benefit created to reimburse employees for medical expenses, other than premiums, incurred by the employee and the employee’s spouse, dependents, or children under age 27.<sup>21</sup> Contributions to a health FSA do not count as employee gross income.<sup>22</sup> Employees electing health FSA coverage typically also enter into a salary reduction agreement; however, some employers may provide additional FSA benefits.<sup>23</sup> The amount of the salary reduction is capped, but additional employer contributions are not limited.<sup>24</sup> A health FSA may be considered to be an excepted benefit if it satisfies two requirements. First, other group health coverage, not limited to excepted benefits, must be made available to participants by reason of their employment.<sup>25</sup> Second, the arrangement must be structured such that the maximum benefit payable to any participant cannot exceed twice the participant’s salary reduction election for the arrangement for the year (or, if greater, cannot exceed \$500 plus the amount of the participant’s salary reduction election).<sup>26</sup>

### **ii. Employee Assistance Programs (EAPs)**

EAPs are typically available free of charge to employees from employers and are often provided by third-party vendors.<sup>27</sup> These programs frequently include short-term substance abuse disorder or mental health counseling services, financial counseling, and legal services.<sup>28</sup>

EAPs will only be excepted if they meet four requirements. First, “[t]he program does not provide significant benefits in the nature of medical care.”<sup>29</sup> The “amount, scope, and duration” of services are to be considered in that determination.<sup>30</sup> Second, the benefits are not coordinated with the benefits under another group health plan. This has two elements: the participants in the other group plan must not be required to first exhaust EAP benefits before using the benefits under the other group health plan (with the EAP as a “gatekeeper”), and eligibility for benefits under the EAP must not depend upon participation in another group health plan.<sup>31</sup> Third, no premiums or employee contributions may be required for participation in the Employee Assistance Program.<sup>32</sup> Finally, there is no cost-sharing for the EAP.<sup>33</sup>

### **iii. Wraparounds**

Under a newly finalized rule, in the circumstance where an employer offers group insurance, but that coverage is unaffordable for an employee, the employee may seek insurance in the individual market, either within or outside of the Marketplace.<sup>34</sup> However, such individual market coverage may be less comprehensive than the plan offered by the employer. In those situations, the employer may seek to offer “wraparound coverage” to provide those employees with overall coverage that is comparable to the group health plan coverage, taking into account both the wraparound coverage and the individual market coverage.<sup>35</sup>

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

<sup>21</sup> Department of Labor, Application of Market Reform and Other Provisions of the Affordable Care Act to HRAs, Health FSAs, and Certain Other Employer Healthcare Arrangements, Technical Release No. 2013-03 (SEPT. 13, 2013), <http://www.dol.gov/ebsa/newsroom/tr13-03.html>.

<sup>22</sup> *Id.*

<sup>23</sup> *Id.*

<sup>24</sup> *Id.*

<sup>25</sup> 45 C.F.R. 146.145(c)(3)(v)(A).

<sup>26</sup> *Id.* at 146.145(c)(3)(v)(B).

<sup>27</sup> 79 Fed. Reg. at 59132.

<sup>28</sup> *Id.*

<sup>29</sup> *Id.* at 59133.

<sup>30</sup> *Id.*

<sup>31</sup> *Id.* at 59134. The proposed rule included the requirement that the Employee Assistance Program benefits must not be financed by another group health plan. Amendments to Excepted Benefits, Proposed Rule, 78 Fed. Reg. 77632, 77642 (Dec. 24, 2013). This was removed from the final rule.

<sup>32</sup> 79 Fed. Reg. at 59134.

<sup>33</sup> *Id.*

<sup>34</sup> Amendments to Excepted Benefits, Final Rule, 80 Fed. Reg. 13995, 13996 (Mar. 18, 2015).

<sup>35</sup> *Id.*

The rule advances a pilot program that would permit employers to offer this wraparound coverage until a sunset date,<sup>36</sup> and defines wraparound coverage as coverage that either wraps around: (i) “eligible individual insurance,” defined as individual coverage that is not a grandfathered health plan, a transitional individual market plan, and does not consist solely of excepted benefits, or (ii) a Multi-State Plan. The final rule clarifies that Basic Health Program coverage will be treated as eligible individual insurance.<sup>37</sup> Such coverage must meet the following five requirements. First, it would have to specifically wrap around individual health insurance (as defined above), by “provid[ing] meaningful benefits beyond coverage of cost-sharing under the eligible individual health insurance.” Some examples provided include coverage for drugs not on the formulary of the primary plan, coverage for services that are out-of-network, and coverage for benefits that are not EHB and are not covered by the individual insurance policy.<sup>38</sup> Second, the wraparound coverage would have to be limited in amount.<sup>39</sup> The annual cost of the wraparound coverage could not exceed the maximum annual contribution for health FSAs (\$2,550 in 2015) or 15 percent of the cost of the plan sponsor’s primary coverage.<sup>40</sup> Third, the plan would have to meet three non-discrimination requirements.<sup>41</sup> The wraparound coverage could not differentiate based on health status or impose preexisting condition exclusions, and neither the primary nor wraparound coverage could discriminate in favor of highly compensated employees.<sup>42</sup>

The fourth requirement relates to plan eligibility. For wraparound coverage to qualify as excepted benefits, individuals eligible for the wraparound could not be enrolled in a health FSA that is excepted benefits. Additionally, plans would have to meet one of two alternative requirements depending on whether the wraparound is offered in conjunction with eligible individual insurance for part-time employees or is a Multi-State Plan. Coverage that wraps around eligible individual insurance could be offered to a part-time employee if three requirements were met. First, the employer would have to offer coverage that is substantially similar to the employer mandate to at least 95 percent of full-time employees. The coverage must provide minimum value, and must be reasonably expected to be affordable. If an employer has no full-time employees, but the plan covers retirees or part-time employees, then these requirements are satisfied. Second, only employees who are not full-time and their dependents, and retirees and their dependents, could be eligible for the wraparound coverage. Third, other group coverage, not limited to excepted benefits, would have to be offered to individuals eligible for wraparound coverage.<sup>43</sup>

For wraparound coverage associated with a Multi-State Plan, four eligibility requirements would have to be met for the wraparound coverage to qualify as excepted benefits. First, the wraparound must be approved by the Office of Personnel Management (OPM). Second and third, the employer must have offered coverage that is substantially similar to the employer mandate, and must have offered coverage that meets minimum value and is affordable to a substantial portion of full-time employees in the plan year that began in either 2013 or 2014. Fourth, the employer’s contributions for both primary and limited wraparound coverage must be substantially the same (at least 80 percent) as contributions for coverage offered to full-time employees.<sup>44</sup>

The fifth requirement is a reporting mandate, either to OPM or HHS (depending on the plan type), to determine whether the plan complies with these rules.<sup>45</sup>

#### iv. Employer Payment Plans

A group health plan that reimburses employees for their individual insurance policy premiums *does not* qualify as excepted benefits and must comply with group health plan market reforms.<sup>46</sup> An employer payment plan is a group health plan under which an employer reimburses employees’ premiums for an individual health insurance policy, or the employer uses its funds to directly pay the premiums incurred for an individual health insurance policy.<sup>47</sup>

<sup>36</sup> *Id.* at 14001. The wraparound coverage described in the rule would be considered excepted benefits if offered no earlier than January 1, 2016 and no later than December 31, 2018 and ending within three years after the date the coverage is first offered or the date on which the collective bargaining agreement relating to the plan terminates after the date wraparound coverage is offered.

<sup>37</sup> *Id.* at 13996.

<sup>38</sup> *Id.* at 13997.

<sup>39</sup> *Id.*

<sup>40</sup> *Id.*

<sup>41</sup> *Id.* at 13998.

<sup>42</sup> *Id.*

<sup>43</sup> *Id.* at 13998-99.

<sup>44</sup> *Id.* at 13999-14001.

<sup>45</sup> *Id.* at 14001.

<sup>46</sup> Department of Labor, *supra* note 21.

<sup>47</sup> *Id.*

## C. NON-COORDINATED BENEFITS

Non-coordinated benefits include “coverage only for a specified disease or illness,” such as hospital indemnity or fixed indemnity insurance.<sup>48</sup> Non-coordinated benefits (“[c]overage for only a specified disease or illness,” such as cancer-only policies, or “hospital indemnity or other fixed indemnity insurance”)<sup>49</sup> are only excepted if “the benefits are provided under a separate policy, certificate, or contract of insurance,” “there is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor,” and benefits are paid for a medical event, regardless of whether benefits are provided under a group health plan from the same sponsor.<sup>50</sup>

### i. Fixed Indemnity Insurance

An amendment to the individual market excepted benefits regulation, published in May 2014, clarifies when a fixed indemnity plan in the individual market is an excepted benefit.<sup>51</sup> Fixed indemnity plans in the individual market qualify as excepted benefits if “[t]he benefits are provided only to individuals who attest, in their fixed indemnity insurance application, that they have other health coverage that is minimum essential coverage within the meaning of section 5000A(f) of the Internal Revenue Code, or that they are treated as having minimum essential coverage due to their status as a bona fide resident of any possession of the United States pursuant to Code section 5000A(f)(4)(B).”<sup>52</sup> Additionally, for a fixed indemnity plan to be excepted, there must be “no coordination between the provision of benefits and an exclusion of benefits under any other health coverage,” benefits are paid in fixed amounts per period and/or per service, and a notice is provided in the application for fixed indemnity insurance, stating that the fixed indemnity coverage is a supplement and not a substitute for major medical coverage (for policy years starting on or after January 2015).<sup>53</sup>

In the group health insurance market, to be “hospital indemnity or other fixed indemnity insurance,” the policy “must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, \$100/day) regardless of the amount of expenses incurred.”<sup>54</sup> Therefore, a policy in the group health market that pays a percentage of expenses, even up to a fixed maximum, would not qualify as excepted benefits.<sup>55</sup> However, the Center for Consumer Information & Insurance Oversight (CCIIO) has issued additional guidance on fixed indemnity insurance in a series of frequently asked questions (FAQs) addressing individual market products labeled as fixed indemnity insurance that provides benefits other than on a per period basis.<sup>56</sup> The FAQs provide that group health insurance that does not otherwise qualify as fixed indemnity “may, nonetheless, qualify as supplemental excepted benefits under sections 2722(c)(3) and 2791(c)(4) of the PHS Act, sections 732(c)(3) and 733(c)(4) of the Employee Retirement Income Security Act (ERISA), and sections 9831(c)(3) and 9832(c)(4) of the Code.”<sup>57</sup>

## D. SUPPLEMENTAL HEALTH INSURANCE

The final category of excepted benefits, supplemental plans, generally includes Medicare supplemental health insurance, TRICARE supplemental coverage, and similar coverage supplemental to group health plans.<sup>58</sup> Supplemental benefits qualify as excepted benefits where they are offered as a separate insurance policy.<sup>59</sup> The term “similar supplemental coverage” is not fully defined.<sup>60</sup> However, “similar supplemental coverage” “must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles” and “does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision.”<sup>61</sup>

<sup>48</sup> 42 U.S.C. § 300gg–91(c)(3).

<sup>49</sup> 45 C.F.R. 146.145(c)(4)(i); 45 C.F.R. 148.220(b)(3).

<sup>50</sup> *Id.* at 146.145(c)(4)(ii); 148.220(b)(3).

<sup>51</sup> Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond, Final Rule, 79 Fed. Reg. 30240 (May 27, 2014).

<sup>52</sup> *Id.* at 30341.

<sup>53</sup> *Id.*

<sup>54</sup> 45 C.F.R. 146.145(c)(4)(i).

<sup>55</sup> *Id.* at 146.145(c)(4)(iii).

<sup>56</sup> CCIIO, Affordable Care Act Implementation FAQs – Set 18, [http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca\\_implementation\\_faqs18.html](http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.html).

<sup>57</sup> *Id.*

<sup>58</sup> 42 U.S.C. § 300gg–91(c)(4).

<sup>59</sup> *Id.*

<sup>60</sup> EBSA, Field Assistance Bulletin No. 2007-04 (DEC. 7, 2007), <http://www.dol.gov/ebsa/pdf/fab2007-4.pdf>.

<sup>61</sup> 45 C.F.R. 146.145(c)(5)(i)(C).

An Employee Benefits Security Administration bulletin released in 2007 outlines the requirements a plan must meet to qualify for a safe harbor from ERISA's health reforms as similar supplemental coverage.<sup>62</sup> Some federal guidance suggests that supplemental plans may be drawn more broadly than supplemental retirement plans: an FAQ provides that “[w]ith respect to group health insurance coverage that does not meet the definition of fixed indemnity excepted benefits, coverage that supplements other group health plan coverage may, nonetheless, qualify as supplemental excepted benefits under sections 2722(c)(3) and 2791(c)(4) of the PHS Act, sections 732(c)(3) and 733(c)(4) of ERISA, and sections 9831(c)(3) and 9832(c)(4) of the Code.”<sup>63</sup>

There does not seem to be any available guidance that more definitively describes “[s]imilar supplemental coverage provided to coverage under a group health plan.” Therefore, without further federal guidance on what types of supplemental plans qualify as excepted benefits, the state likely has flexibility in regulating these types of plans.

## Conclusion

The new final rule loosens restrictions on dental, vision, and long-term care benefits by eliminating the requirement that participants pay an additional premium for benefits to be considered excepted, perhaps encouraging employers to continue offering these benefits to employees.<sup>64</sup> Similarly, the rule does not include the requirement that EAP benefits cannot be financed by another group health plan to be excepted, making it easier for employers to offer these benefits and for them to remain excepted from ACA requirements.<sup>65</sup>

Determining whether a particular product qualifies as an excepted benefits product requires a thorough and critical analysis to determine if it meets the many and varied requirements for the relevant product type. Additional regulations and guidance should help to make those determinations less complicated and more straightforward.

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<sup>62</sup> See EBSA, *supra* note 60. Coverage that is offered as a separate policy, certificate, or contract of insurance and is “issued by an entity that does not provide the primary coverage under the plan,” “specifically designed to fill gaps in primary coverage,” “but does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision,” the cost of which does “not exceed 15 percent of the cost of primary coverage,” and does “not differentiate among individuals in eligibility, benefits, or premiums based on any health factor of an individual” is within the enforcement safe harbor.

<sup>63</sup> CCIO, *supra* note 56.

<sup>64</sup> 79 Fed. Reg. at 59132.

<sup>65</sup> *Id.* at 59134.