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Amendments to Excepted Benefits Regarding Dental Plans, Vision Plans and EAPs Finalized

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On September 26, 2014,[1] the Department of the Treasury, Department of Labor and Department of Health and Human Services jointly finalized the amendments to the "excepted benefit" regulations regarding dental and vision plans and employee assistance programs ("EAPs"). While the amended regulations adopt the original proposed regulation language eliminating the contribution requirement for self-funded dental and vision plans to be "excepted" from Affordable Care Act (the "ACA") compliance and HIPAA's portability and nondiscrimination provisions, they make changes to the "excepted benefit" criteria for an EAP and defer finalizing provisions relating to the exception for limited wraparound coverage.

The final regulations apply to group health plans for plan years beginning on or after January 1, 2015. In the meantime, dental and vision benefits and EAPs may qualify as excepted benefits under the December 24, 2013 proposed regulations (see our January 2014 article for an overview of the proposed regulations).

Self-Insured Dental and Vision Plans

Prior to the issuance of the proposed regulations, a self-insured dental or vision-only plan could be an "excepted benefit" if it is "otherwise not an integral part of a group of a health plan" — meaning:

- Participants have the right to elect not to receive the coverage; and
- If elected, participants must pay an additional premium or contribution (even a nominal amount) for the coverage.

In contrast, an insured dental or vision plan would be an "excepted benefit" simply if it was provided under a separate policy, certificate, or contract of insurance. To mitigate the different treatment of insured and self-insured dental or vision-only plans, the final regulations make the following changes for a self-insured dental or vision-only plan to be "excepted":

[1] The final regulations will be published in the Federal Register on October 1, 2014.

- ***Eliminate the additional contribution requirement.***

  With the change, an individual who is eligible for "unaffordable" group medical coverage may accept "free" self-insured dental or vision-only coverage without losing eligibility for the premium tax credit under Section 36B of the Internal Revenue Code for individual Marketplace/Exchange coverage; and

- Clarify that a dental or vision-only plan is "otherwise not an integral part of the plan" if participants may decline coverage, or if claims are administered under a separate contract from any other benefit claims administration under the plan.

The preamble to the regulations also clarifies that because self-insured long-term care, nursing home care, home care, home health care, and community-based care are also subject to the "not an integral part of a group health plan" standard to be "excepted" benefits, the changes that apply to self-insured dental or vision-only coverage also apply to these benefits.

EAPs

The final regulations set forth the following four criteria that an EAP must satisfy to be an "excepted benefit":

- ***EAP does not provide significant benefits in the nature of medical care:***

  To satisfy this standard, the amount, scope and duration of covered services are considered. The preamble clarifies that an EAP meets this requirement if it provides only limited, short-term outpatient counseling for substance use disorder services without covering inpatient, residential, partial residential or intensive outpatient care without requiring prior authorization or review for medical necessity. However, a disease management program that provides laboratory testing, counseling and prescription drugs for individuals with chronic conditions would not meet this criterion;

- ***EAP benefits cannot be coordinated with the benefits under another group health plan:***

  To meet this standard, (i) participants in the other group health plan may not be required to exhaust benefits under the EAP before becoming eligible for benefits in the plan; and (ii) EAP eligibility cannot depend on participation in another group health plan (note: the final regulations eliminate the proposed regulations' restriction against the financing of the EAP by another group health plan);

- ***EAP coverage must be provided at no cost:***

  A Plan sponsor may not condition employee eligibility on an employee premium or contribution requirement.

- ***EAP may not impose any cost-sharing requirements.***

The preamble also clarifies that a wellness program may not be treated as an "excepted benefit" in order to circumvent the wellness program rewards, discounts or rebates requirements of Public Health Service Act Section 2705(j), simply by including it in an EAP.

While the final regulations provide welcome relief to sponsors of self-funded dental and vision-only plans, plan sponsors may wish to revisit their EAPs to determine if they meet the new "excepted benefit" criteria and amend the EAP as appropriate. Contact the author of this article for questions or for assistance in understanding these new regulations.

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