Excepted Benefits

Excepted benefits are benefit products that are designed to supplement comprehensive medical coverage. They often provide certain types of medical benefits on a limited or ancillary basis. These benefits are exempt from the Health Insurance Portability and Accountability Act (HIPAA) portability rules.

Excepted benefits also are exempt from other laws that have been placed into the HIPAA portability statute, including the Mental Health Parity & Equity Act, the Women's Health & Cancer Rights Act, the Newborn's & Mother's Health Protection Act, and Title I of the Genetic Information Nondiscrimination Act. In addition, excepted benefits are exempt from many of the ACA requirements.

Please note that just because a benefit is an excepted benefit for purposes of HIPAA's portability requirements does not mean it is exempt from all aspects of HIPAA. For example, some excepted benefits are still subject to HIPAA's administrative simplification requirements (including its privacy and security requirements).

The following material identifies several categories or types of excepted benefits and their exemptions. Please note that this designation by "type" is not found in HIPAA itself, but will assist in the discussion of its application.

TYPE A: NON-COORDINATED EXCEPTED BENEFITS

Type A benefits consist of coverage limited to specified disease coverage and hospital indemnity or other fixed indemnity insurance. Hospital or fixed indemnity insurance is insurance that pays a fixed dollar amount per day (or other period) of hospitalization or illness. Policies that do not pay on a per-period basis but rather pay a fixed amount based on the type of procedure performed or drug prescribed are not considered fixed indemnity insurance and therefore will not qualify as an excepted benefit. In order to qualify as a Type A benefit:

- The coverage is provided under a separate policy, certificate, or contract of insurance.
- There can be no coordination between the provision of such benefits and any exclusion under any plan maintained by that employer.
- Benefits must be payable regardless of whether benefits are provided for the same event under any group health plan maintained by the same plan sponsor.

Note: *Type A benefits are not exempt from the HIPAA privacy and security rules. In addition, the status of Type A benefits for purposes of HIPAA privacy and security is unclear when provided through an employer under an insurance policy for which employees pay 100% of the premium.*

The following requirements do not apply to Type A benefits:

- HIPAA Non-Discrimination requirements
- HIPAA Portability requirements
- Requirements under the Affordable Care Act (ACA)

Important: This information is intended only as an overview. Other requirements, exceptions, or special rules may apply. It is not legal advice and should not be constructed as legal advice. Employers should seek the services of a competent legal or tax professional to determine their or their health plan's obligations under HIPAA.

TYPE B: LIMITED EXCEPTED BENEFITS

Type B excepted benefits consist of the following benefits if they qualify as limited scope benefits:

- Limited-scope dental benefits
- Limited-scope vision benefits
- Benefits for long-term care, nursing-home care, home care, or community-based care
- Employee assistance plans
- Certain health FSAs
- Other similar, limited benefits specified in the regulations.

In order to qualify as limited scope benefits they must:

- not be an integral part of the plan; or
- be provided under a separate policy, contract or certificate of insurance.

Benefits will be viewed as not integral to a plan (even if they are not separate from the medical coverage) if:

- the participant has the right to elect not to receive the coverage (whether or not there is a participant charge); or
- claims for benefits are administered under a separate contract from claims for other benefits under the plan

In addition, dental and vision must consist of benefits substantially all of which are for treatment of the mouth or eye respectively.

An EAP is considered an excepted benefit if it meets all of the following criteria:

It must not provide "significant benefits in the nature of medical care.

- For example: An EAP that 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 does not provide significant benefits in the nature of medical care.
- In contrast, a program that provides disease management services (such as laboratory testing, counseling, and prescription drugs) for individuals with chronic conditions, such as diabetes, does provide significant benefits in the nature of medical care.

An EAP cannot be "coordinated with benefits under another group health plan" This means that:

- Participants in the other group health plan must not be required to use or exhaust benefits under the EAP (making the EAP a "gatekeeper") before an individual is eligible for benefits under the other group health plan.
- 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 as a condition of participation in the EAP.

The EAP may not impose any cost-sharing requirements.

Type B benefits include Health FSAs if they meet the following criteria:

- the maximum benefit payable under the health FSA to any participant cannot exceed two times the employee's salary reduction election under the health FSA for the year (or, if greater, the amount of the employee's salary reduction election for the health FSA for the year, plus $500); and
- the employer offers other group health plan coverage that is not an excepted benefit.

The following requirements do not apply to Type B benefits:

- HIPAA Non-Discrimination requirements
- HIPAA Portability requirements
- Requirements under the Affordable Care Act (ACA)

Note: *Type B benefits are not exempt from the HIPAA privacy and security rules simply because they are excepted benefits. A fixed indemnity nursing home policy, however, is not subject to HIPAA's privacy and security rules.*

TYPE C: SUPPLEMENTAL EXCEPTED BENEFITS

Type C excepted benefits consist of certain supplemental coverage. Benefits are supplemental excepted benefits only if they are provided under a separate policy, certificate, or contract of insurance and are either Medicare supplemental health insurance, TRICARE supplemental programs, or similar supplemental coverage added to coverage under a group health plan.

The Department of Labor has issued a memorandum providing safe harbor requirements for "similar supplemental coverage." In order to fall within the safe harbor, the benefits must be provided under a separate policy, certificate, or contract of insurance that satisfies all of the following requirements:

- **Independent of Primary Coverage**

  The supplemental policy, certificate, or contract of insurance must be issued by an entity that does not provide the primary coverage under the plan. For this purpose, entities that are part of the same controlled group of corporations or part of the same group of trades or businesses under common control, within the meaning of section 52(a) or (b) of the Code, are considered a single entity.

- **Supplemental for Gaps in Primary Coverage**

  The supplemental policy, certificate, or contract of insurance must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles, but does not include a policy, certificate, or contract of insurance that becomes secondary or supplemental only under a coordination-of-benefits provision. Supplemental coverage may also meet this requirement by providing benefits not provided under the primary coverage (as distinct from filling gaps in cost sharing) but only if the benefits are not essential health benefits.

- **Supplemental in Value of Coverage**

  The cost of coverage under the supplemental policy, certificate, or contract of insurance must not exceed 15% of the cost of primary coverage. Cost is determined in the same manner as the applicable premium is calculated under a COBRA continuation provision.

- **Similar to Medicare Supplemental Coverage**

  The supplemental policy, certificate, or contract of insurance that is group health insurance coverage must not differentiate among individuals in eligibility, benefits, or premiums based on any health factor of an individual (or any dependent of the individual).

The following requirements do not apply to Type C benefits:

- HIPAA Non-Discrimination requirements
- HIPAA Portability requirements
- Requirements under the Affordable Care Act (ACA)

Note: *Type C benefits are not exempt from the HIPAA privacy and security rules.*

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TYPE D: NON-HEALTH EXCEPTED BENEFITS

Type D excepted benefits consist of the following:

- Coverage only for accidents (including accidental death and dismemberment coverage)
- Disability income coverage
- Liability insurance, including general liability and auto liability insurance
- Coverage issued as a supplement to liability insurance
- Workers' compensation or similar coverage
- Automobile medical payment insurance
- Credit-only insurance
- Coverage for on-site medical clinics
- Other similar coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits

The following requirements do not apply to Type D benefits:

- HIPAA Non-Discrimination requirements
- HIPAA Portability requirements
- HIPAA Privacy and Security requirements
- Requirements under the Affordable Care Act (ACA)

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