

FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART XXIII)

February 13, 2015

Set out below are additional Frequently Asked Questions (FAQs) regarding implementation of the Affordable Care Act. These FAQs have been prepared jointly by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments). Like previously issued FAQs (available at <http://www.dol.gov/ebsa/healthreform/> and <http://www.cms.gov/ccio/resources/fact-sheets-and-faqs/index.html>), these FAQs answer questions from stakeholders to help people understand the new law and benefit from it, as intended.

Excepted Benefits

Most provisions of title XXVII of the Public Health Service Act (PHS Act), part 7 of the Employee Retirement Income Security Act (ERISA) and chapter 100 of the Internal Revenue Service Code (the Code) do not apply to excepted benefits, as defined in section 2791 of the PHS Act, section 733 of ERISA and section 9832 of the Code. One category of excepted benefits under section 2791(c)(4) of the PHS Act, section 733(c)(4) of ERISA, and section 9832(c)(4) of the Code is supplemental excepted benefits. 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 (also known as Medigap), Tricare supplemental programs, or “similar” supplemental coverage provided to coverage under a group health plan. Regulations provide that similar supplemental coverage “must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles.” 29 CFR 2590.732 (c)(5)(i)(C), 26 CFR 54.9831-1(c)(5)(i)(C), and 45 CFR 146.145(b)(5)(i)(C). In 2007 and 2008, the Departments issued guidance on the circumstances under which supplemental health insurance would be considered excepted benefits under 2791(c) of the PHS Act.¹ In addition to the requirement that the coverage be issued as a separate policy, certificate, or contract of insurance, the guidance lists four criteria that the Departments will apply to determine if supplemental coverage is similar to Medigap or TriCare and therefore qualifies as an excepted benefit:

1. The policy, certificate, or contract of insurance must be issued by an entity that does not provide the primary coverage under the plan;
2. The supplemental policy, certificate, or contract of insurance must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles;
3. The cost of the supplemental coverage may not exceed 15 percent of the cost of primary coverage; and

¹ See EBSA Field Assistance Bulletin No. 2007-04 (available at <http://www.dol.gov/ebsa/regs/fab2007-4.html>); CMS Insurance Standards Bulletin 08-01 (available at http://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa_08_01_508.pdf); and IRS Notice 2008-23 (available at http://www.irs.gov/irb/2008-07_IRB/ar09.html).

4. Supplemental coverage sold in the group insurance market must not differentiate among individuals in eligibility, benefits, or premiums based upon any health factor of the individual (or any dependents of the individual).

The Departments have become aware of health insurance issuers selling supplemental products that provide a single benefit. At least one issuer is characterizing this type of coverage as an excepted benefit. These issuers claim that the products meet the criteria for supplemental coverage to qualify as an excepted benefit outlined in the Departments' guidance and are designed to fill in the gaps of primary coverage in the sense that they are providing a benefit that is not covered under the primary group health plan.

Q: Can health insurance coverage that supplements group health coverage by providing additional categories of benefits, be characterized as supplemental excepted benefits?

It depends. The Departments' prior guidance² provided an enforcement safe harbor for supplemental insurance products that are specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. In determining whether insurance coverage sold as a supplement to group health coverage can be considered "similar supplemental coverage" and an excepted benefit, the Departments will continue to apply the applicable regulations and the four criteria indicated in the guidance discussed above. In addition, the Departments intend to propose regulations clarifying the circumstances under which supplemental insurance products that do not fill in cost-sharing under the primary plan are considered to be specifically designed to fill gaps in primary coverage. Specifically, the Departments intend to propose that coverage of additional categories of coverage would be considered to be designed to "fill in the gaps" of the primary coverage only if the benefits covered by the supplemental insurance product are not an essential health benefit (EHB) in the State where it is being marketed. If any benefit in the coverage is an EHB in the State where it is marketed, the insurance coverage would not be an excepted benefit under our intended proposed regulations, and would have to comply with the applicable provisions of title XXVII of PHS Act, part 7 of ERISA, and chapter 100 the Code.

We note that this standard applies to coverage that purports to qualify as an excepted benefit as "similar supplemental coverage provided to coverage under a group health plan" under PHS Act section 2791(c)(4), ERISA section 733(c)(4), and Code section 9832(c)(4). This standard does not apply to other circumstances where the coverage may qualify as another category of excepted benefits, such as limited excepted benefits under section 2791(c)(2), ERISA section 733(c)(2), and Code section 9832(c)(2).

Pending publication and finalization of the above proposed regulations, the Departments will not initiate an enforcement action if an issuer of group or individual health insurance coverage fails to comply with the provisions of the PHS Act, ERISA, and the Code, as amended by the Affordable Care Act, with respect to health insurance coverage that (1) provides coverage of additional categories of benefits that are not EHB in the applicable State (as opposed to filling in cost-sharing gaps under the primary plan); (2) complies with the applicable regulatory requirements and meets all of the criteria in the existing guidance on "similar supplemental coverage"; and (3) has been filed and approved with the State (as may be required under State

² Id.

law). As noted above, for purpose of the second criterion of the existing guidance, coverage would be considered designed to “fill gaps in primary coverage” even if it does not include coverage of cost-sharing under the group health plan, only if the benefits are not covered by the group health plan and are not EHBs in the State. The Departments encourage States that have primary enforcement authority over the provisions of the PHS Act, as amended by the Affordable Care Act, to utilize the same enforcement discretion under such circumstances.