Labor and Employment Alert: Dental and Vision Coverage as an Excepted Benefit and Other Employee Benefit News

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Summary: ACA mandates don't apply to health plans classified as "excepted benefits." The government has proposed regulations expanding the definition of excepted benefits to include self-insured dental and vision coverage even if that coverage is provided without employee contributions.

Excepted benefits = benefits not subject to ACA mandates

Affordable Care Act (ACA) mandates apply to health plans – except for those health plans that are classified as excepted benefits.

Dental and vision coverage as an excepted benefit: the old rule

Up until now, dental or vision coverage was classified as an excepted benefit if (and only if):

1. the dental or vision coverage was insured and the insurance policy did not also include medical coverage; or
2. employees could elect whether to receive the dental or vision coverage (separate from an election of medical coverage) and, if an employee received dental or vision coverage, he or she would have to make contributions for the dental or vision coverage (separate from and in addition to employee contributions for medical coverage).

The old rule was a problem for some employers with self-insured dental and/or vision coverage. A number of employers offered self-insured dental and/or vision coverage as a package with medical coverage, with no separate employee contribution for dental or vision coverage. Up until now, that sort of structure made the dental or vision coverage subject to ACA mandates such as the prohibition on dollar limits on essential health benefits. Since pediatric dental and vision care are essential health benefits, non-excepted self-insured dental and vision coverage could not have dollar limits on pediatric dental and vision care!

Dental and vision coverage as an excepted benefit: the new rule

On December 20, 2013, the government published proposed regulations expanding the class of excepted benefits. Under the proposed rule, dental or vision coverage will be classified as an excepted benefit if:

1. the dental or vision coverage was insured and the insurance policy did not also include medical coverage (same as the old rule); or
2. employees could elect whether to receive the dental or vision coverage (separate from an election of medical coverage) – *even if employees electing dental or vision coverage don't have to make an additional contribution* (a change from the old rule).

In other words, as long as the employer gives employees the opportunity to waive or opt-out of dental or vision coverage, the dental or vision coverage will be an excepted benefit *even if the waiver has no impact on employee contributions.* And, as long as dental or vision coverage is classified as an excepted benefit, dollar limits on pediatric dental and vision care are permissible. Note that this opens the door to dental and vision health reimbursement arrangements.

Employers have the option to apply the new rule through 2014. What happens after 2014 depends on whether the government decides to finalize the new rule as proposed.

EAPs as an excepted benefit

The proposed regulations affirm the common sense conclusion that an employee assistance plan (EAP) is classified as an excepted benefit. An EAP's status as an excepted benefit is subject to the following conditions (easily met by typical EAPs):

1. The EAP does not provide "significant" medical care benefits.
2. Employees don't make contributions for EAP coverage.
3. EAP benefits are not subject to employee cost-sharing (i.e., no copays or coinsurance).
4. Eligibility for the EAP is not contingent on an employee enrolling in another health plan.

Individual health insurance plus employer-sponsored limited wraparound coverage

Is your health plan affordable for your full-time employees? A health plan is deemed to be affordable if the employee contribution for single coverage does not exceed 9.5% of an employee's gross income (or a safe harbor approximating that amount). If your health plan is unaffordable for an employee and that employee buys individual health insurance through the Marketplace with federal premium assistance, you may be subject to a penalty of $3,000 per year ($250 per month) starting in 2015.

You may have run the numbers and are concerned that, despite the penalty for offering unaffordable coverage, it will not be feasible to reduce employee contributions. The government is now considering whether to allow employers to supplement individual health insurance purchased by employees who are eligible for, but waive the employer's health coverage. This supplemental coverage (a new type of excepted benefit to be known as limited wraparound coverage) could be offered subject to the following conditions:

1. The employee must be enrolled in non-grandfathered individual health insurance (typically, through the Marketplace). This would exclude employees enrolled in Medicaid.
2. The wraparound coverage must be designed to pay for benefits not covered by the individual health insurance such as non-essential health benefits and/or services of out-of-network providers. The wraparound coverage may reimburse employee cost sharing under the individual health insurance but that cannot be its "primary purpose."
3. The employer must sponsor a separate medical plan that provides minimum value (i.e., is expected to cover at least 60% of covered medical expenses). That medical plan must be affordable for a "majority" of eligible employees. In addition, only those employees who are eligible for the medical plan may be offered the wraparound coverage.
4. The cost of the wraparound coverage cannot exceed 15% of the cost of the medical plan.
5. The wraparound coverage must meet nondiscrimination standards.

Note that limited wraparound coverage is not yet permissible. The soonest limited wraparound coverage will be permitted is 2015 (and may then be subject to different conditions).

OTHER EMPLOYEE BENEFIT NEWS

Another expansion of preventive care

Non-grandfathered health plans must cover the preventive services and supplies recommended by the U.S. Preventive Services Task Force (USPSTF) on a first-dollar basis (no participant cost sharing). When the USPSTF makes a new recommendation, non-grandfathered health plans must start covering the newly recommended service or supply no later than the first day of the second plan year starting after the publication of the new recommendation.

On September 24, 2013, the USPSTF recommended that health care providers "engage in shared, informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene." Department of Labor FAQs http://www.dol.gov/ebsa/faqs/faq-aca18.html published January 9, 2014 make clear that health plans must provide first-dollar coverage of both the counseling and the medications. So, if your health plan is non-grandfathered, make sure your insurer or third party administrator adds this to the list of preventive care as of the first plan year starting on or after September 24, 2014 (January 1, 2015 for calendar year plans).

Same-gender marriage in Ohio

In December, the Southern District Court of Ohio held that Ohio must recognize same-gender marriages on death certificates. *Obergefell v. Wymyslo*, No. 1:13-cv-00501 (S.D. Ohio 12/23/2013). Although the decision in the case was confined to the recognition of same-gender marriage on death certificates, the rationale in the decision had much broader implications. That decision is being appealed to the Sixth Circuit Court of Appeals. Meanwhile, the Ohio Department of Taxation published Information Release EW 2013-1 (Nov. 14, 2013) (available at http://1.usa.gov/1mIY8tT) which provides that employers must "treat benefits provided to

the same-gender spouses of employees and the dependent children of those spouses as imputed income for Ohio income and school district income tax employer withholding purposes." Note that the instructions in the Information Release may – or may not – be impacted by the ultimate outcome of the Obergefell case.

Recent employee benefit litigation

Surprising $3.8 million award in LTD denial case

A three-judge panel of the Sixth Circuit Court of Appeals surprised the employee benefits community by awarding $3.8 million to the estate of an individual whose claim for long-term disability benefits was denied by the Life Insurance Company of North America (LINA). *Rochow v. Life Insurance Company of North America*, __ F.3d ___ (6th Cir. December 6, 2013).

In January 2002, Daniel Rochow's employment was terminated because he was no longer able to perform his job due to memory loss and other symptoms (problems that had started in 2001). In February 2002, Mr. Rochow was diagnosed with a debilitating brain infection. Mr. Rochow filed a claim for long-term disability benefits in December 2002 which LINA denied on the basis that that claim was filed after employment had terminated. Subsequent appeals were also denied. The suit (now maintained after Mr. Rochow's death by his estate) asked for long-term disability benefits plus equitable relief. The equitable relief awarded by the Court was $3.8 million disgorgement of what the Court found to be LINA's profit on the benefits it had failed to pay Mr. Rochow.

A petition for a rehearing before the full Court has been filed so there may be further developments.

Deadline for filing suit for employee benefits

A plan participant has the right to file suit if a claim for benefits is denied, he or she appeals the denial and the appeal is also denied. Do your employee benefit plans specify a deadline for filing suit after the denial of an appeal? If not, that is a provision you will want to add.

In *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 2013 WL 6569594 (U.S. 2013), the Supreme Court held that the deadline for filing suit for benefits under a long-term disability plan was enforceable as stated in the insurance policy. Since the plaintiff missed the stated deadline, the plaintiff was not entitled to judicial review of the denial of benefits. Of course, the deadline must be reasonable. The deadline under the LTD policy in question was (consistent with state insurance law) three years after proof of loss was due. Where state insurance law is not a factor, we typically recommend a simpler deadline (e.g., one year after the final denial of an appeal).

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This alert is a summary and cannot include all details that may be relevant to your situation. As always, please contact us if you want more information on these developments or other employee benefits matters.