HIPAA-Excepted Benefits

The Affordable Care Act (ACA) imposes numerous requirements on health insurance plans and employer-sponsored group health plans. Most ACA requirements do not apply, however, to benefits and plans that meet the definition of "HIPAA-excepted benefits."

Quick Facts:

- ***HIPAA-excepted benefits*** or ***excepted benefits*** refers to categories of benefits that are exempt from most requirements under the Affordable Care Act (ACA).
- Excepted benefits include the following:
  1. Section 125 health flexible spending accounts (HFSA) that have little or no employer contribution and are offered only to employees who also are eligible for an ACA-compliant group health plan.
  2. Limited-scope dental and vision plans that are not bundled with medical coverage.
  3. Certain fixed-indemnity policies and specific-disease or illness policies.
  4. Plans that do not cover medical care (unless the medical care is merely secondary or incidental).
- Plans meeting the definition of excepted benefits avoid the ACA's restrictions on annual benefit limits, pre-existing condition exclusions, waiting periods, and many other items.

Details:

"HIPAA-excepted benefits" refers to categories of health benefits that have been exempt from various requirements of the Health Insurance Portability and Accountability Act (HIPAA) since the 1990s. For instance, stand-alone dental and vision plans are exempt from HIPAA's special enrollment rules. The Affordable Care Act (ACA), enacted in 2010, adopted the same concept of "excepted benefits," which allows certain health plans to avoid the ACA's strict compliance requirements.

Excepted benefits generally fall into four categories:

- Section 125 health flexible spending accounts with little or no employer contribution.
- Limited-scope dental and vision plans that are not bundled with the employee's medical plan election.
- Certain fixed-indemnity and specific-disease or illness policies.
- Non-health plans, unless the medical benefit is merely secondary or incidental (e.g., travel accident insurance).

Health Flexible Spending Account (HFSA)

A health flexible spending account (HFSA) provided through a § 125 cafeteria plan is an excepted benefit if it meets both of the following conditions:

- The HFSA maximum annual benefit does not exceed two times the employee's salary reduction amount (or, if greater, the salary reduction amount plus $500); and
- The HFSA participant (employee) also is eligible — whether or not actually enrolled — for a non-excepted group health plan that meets the ACA's requirements.

Limited-Scope Dental and Vision Benefits

Dental and vision benefits are excepted benefits as follows:

- For insured plans: Dental and/or vision benefits are provided under a contract, policy, or certificate that is separate from the non-excepted medical benefits; or
- For insured or self-funded plans:
  - Employees can elect not to enroll in the dental and/or vision benefits (regardless of whether they enroll in medical benefits, if offered); or
  - Claims for the dental and/or vision benefits are administered under a contract separate from claims administration for other benefits under the plan.

Fixed-Indemnity or Specific-Disease or Illness Policies

Fixed-indemnity policies and specific-disease or illness policies usually are sold as voluntary products in the individual insurance market, although some policies also may be designed as group plans. These policies do not provide comprehensive health coverage and they are "noncoordinated." ***Noncoordinated*** means that the fixed-indemnity or specific-disease or illness policy pays its benefits without regard to any other coverage.

A fixed-indemnity policy typically provides a fixed dollar amount per day or per period, such as $100 per day of hospitalization, regardless of the actual expenses incurred. The claimant may use the benefit for any purpose.

A specific-disease or illness policy typically provides a benefit based on diagnosis of a specific disease, such as cancer, regardless of actual expenses. The claimant may use the benefit for any purpose.

Non-Medical Benefits

Benefits or plans that do not provide medical care are excepted benefits, unless the medical care is only secondary or incidental to the plan. Examples of excepted benefits include:

- Accident and accidental death and dismemberment (AD&D) coverage.
- Disability income protection plans.
- Workers' compensation or similar plans.
- On-site medical clinics (e.g., clinics providing general health promotion and first aid).

Note regarding Employee Assistance Programs (EAPs): An EAP is considered an "excepted benefit" if it meets the following conditions:

- The EAP is offered at no cost and eligibility is not conditioned on participation in another plan;
- The EAP does not require cost-sharing for services (i.e., there are no co-pays, deductibles, or co-insurance);
- The EAP does not coordinate benefits with another plan; and
- The EAP does not provide significant benefits in the nature of medical care.

ACA Requirements that Do Not Apply to Excepted Benefits

Plans and benefits that meet the definition of "excepted benefits" avoid many ACA requirements, such as:

- Prohibition against lifetime and annual dollar limits.
- Prohibition against pre-existing condition exclusions.
- Preventive services coverage requirement.
- Child to age 26 eligibility requirement.

- Maximum 90-day waiting period limit.
- Summary of Benefits and Coverage (SBC).
- Health plan fees (i.e., Patient-Center Outcomes Clinical Research (PCORI) and Transitional Reinsurance Program (TRP)).

Official Guidance:

The federal departments provide regulatory guidance on this topic in the following material:

“Amendments to Excepted Benefits; Final Rule” (79 Fed. Reg. 59130, 10/1/2014): click here.

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Last Reviewed: June 12, 2018