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Guidance Issued

Regarding Supplemental Excepted Benefits

Daniel Somma | Capital Insurance Advisors, LLC. | (412) 260-9035 | dsomma@capitalinsuranceadvisors.com

The Departments of Labor ("DOL"), Health and Human Services ("HHS"), and the Treasury (collectively, the "Departments") have become aware of health insurance carriers selling supplemental products that provide a single benefit. At least one carrier is characterizing this type of coverage as an excepted benefit. These carriers 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. The Departments issued an FAQ that provides guidance on whether health insurance coverage that supplements group health coverage by providing additional categories of benefits can be characterized as supplemental excepted benefits.

Background

The Public Health Service Act ("PHSA") does not apply to "excepted benefits" including "supplemental excepted benefits." The PHSA requirements include:

- Dependent coverage for children under age 26;
- Coverage of preventive services;
- Preexisting condition prohibition;
- Lifetime limits on essential benefits prohibition;
- Annual limits on essential benefits restriction;

- Nondiscrimination rule for insured plans; and
- New appeals process.

A supplemental excepted benefit, under a safe harbor, is a separate policy, certificate, or contract of insurance that satisfies all of the following requirements:

1. **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.
2. **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.
3. **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.
4. **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).

Relief Provided by the FAQ

One of the requirements that must be satisfied in order to qualify as a supplemental excepted benefit, as stated above, is the policy must be supplemental for gaps in primary coverage. Regarding this requirement, the Departments will not initiate an enforcement action as long as the coverage that provides coverage of additional categories of benefits are not “essential health benefits” in the applicable state where marketed (as opposed to filling in cost-sharing gaps under the primary plan).

The Departments encourage states that have primary enforcement authority over the provisions of the PHSA, to utilize the same enforcement discretion under such circumstances.