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DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

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DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

[CMS-9946-F]

45 CFR Part 146

RIN 0938-AS16

Amendments to Excepted Benefits

AGENCY: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Final rules.

SUMMARY: This document contains final regulations that amend the regulations regarding excepted benefits under the Employee Retirement Income Security Act of 1974, the Internal Revenue Code (the Code), and the Public Health Service Act. Excepted benefits are generally exempt from the health reform requirements that were added to those laws by the Health Insurance Portability and Accountability Act and the Patient Protection and Affordable Care Act. In addition, eligibility for excepted benefits does not preclude an individual from eligibility for a premium tax credit under section 36B of the Code if an individual chooses to enroll in coverage under a Qualified Health Plan through an Affordable Insurance Exchange. These regulations finalize some but not all of the proposed rules with minor modifications; additional guidance on limited wraparound coverage is forthcoming.

DATES: *Effective date.* These final regulations are effective on December 1, 2014.

Applicability date. These final regulations apply to group health plans and group health insurance issuers for plan years beginning on or after January 1, 2015.

FOR FURTHER INFORMATION CONTACT:

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Customer Service Information: Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws, may call the EBSA Toll-Free Hotline at 1-866-444-EBSA (3272) or visit the Department of Labor's Web site (<http://www.dol.gov/ebsa>). In addition, information from HHS on private health insurance for consumers can be found on the Centers for Medicare & Medicaid Services (CMS) Web site (www.cms.gov/ccio) and information on health reform can be found at www.HealthCare.gov.

SUPPLEMENTARY INFORMATION:

I. Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, 110 Stat. 1936, added title XXVII of the Public Health Service Act (PHS Act), part 7 of the Employee Retirement Income Security Act of 1974 (ERISA), and chapter 100 of the Internal Revenue Code (the Code), providing portability and nondiscrimination provisions with respect to health coverage. These provisions of the PHS Act, ERISA, and the Code were later augmented by other consumer protection laws, including the Mental Health Parity Act of 1996,¹ the Mental Health Parity and Addiction Equity Act of 2008,² the Newborns' and Mothers' Health Protection Act,³ the Women's Health and Cancer Rights Act,⁴ the Genetic Information Nondiscrimination Act of 2008,⁵ the Children's Health Insurance Program

¹ Public Law 104-204, 110 Stat. 2944 (September 26, 1996).

² Public Law 110-343, 122 Stat. 3881 (October 3, 2008).

³ Public Law 104-204, 110 Stat. 2935 (September 26, 1996).

⁴ Public Law 105-277, 112 Stat. 2681-436 (October 21, 1998).

⁵ Public Law 110-233, 122 Stat. 881 (May 21, 2008).

Reauthorization Act of 2009,⁶ Michelle's Law,⁷ and the Affordable Care Act.⁸

The Affordable Care Act reorganizes, amends, and adds to the provisions of part A of title XXVII of the PHS Act relating to group health plans and health insurance issuers in the group and individual markets. The term "group health plan" includes both insured and self-insured group health plans.⁹ Section 715(a)(1) of ERISA and section 9815(a)(1) of the Code, as added by the Affordable Care Act, incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by these references are sections 2701 through 2728.

Sections 2722 and 2763 of the PHS Act, section 732 of ERISA, and section 9831 of the Code provide that the requirements of title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, respectively, generally do not apply to excepted benefits. Excepted benefits are described in section 2791 of the PHS Act, section 733 of ERISA, and section 9832 of the Code.

The parallel statutory provisions establish four categories of excepted benefits. The first category includes benefits that are generally not health coverage¹⁰ (such as automobile insurance, liability insurance, workers compensation, and accidental death and dismemberment coverage). The benefits in this category are excepted in all circumstances. In contrast, the benefits in the second, third, and fourth categories are types of health coverage but are excepted only if certain conditions are met.

The second category of excepted benefits is limited excepted benefits, which may include limited-scope vision or dental benefits, and benefits for long-term care, nursing home care, home health care, or community-based care.

⁶ Public Law 111-3, 123 Stat. 65 (February 4, 2009).

⁷ Public Law 110-381, 122 Stat. 4081 (October 9, 2008).

⁸ The Patient Protection and Affordable Care Act, Public Law 111-148, was enacted on March 23, 2010, and the Health Care and Education Reconciliation Act, Public Law 111-152, was enacted on March 30, 2010. (These statutes are collectively known as the "Affordable Care Act".)

⁹ The term "group health plan" is used in title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, and is distinct from the term "health plan," as used in other provisions of title I of the Affordable Care Act. The term "health plan" does not include self-insured group health plans.

¹⁰ See 62 FR 16894, 16903 (Apr. 8, 1997), which states that these benefits are generally not health insurance coverage.

Section 2791(c)(2)(C) of the PHS Act, section 733(c)(2)(C) of ERISA, and section 9832(c)(2)(C) of the Code authorize the Secretaries of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Secretaries) to issue regulations establishing other similar limited benefits as excepted benefits. The Secretaries exercised this authority previously with respect to certain health flexible spending arrangements (health FSAs).¹¹ To be excepted under this second category, the statute (specifically, ERISA section 732(c)(1), PHS Act section 2722(c)(1), and section 9831(c)(1) of the Code) provides that limited benefits must either: (1) Be provided under a separate policy, certificate, or contract of insurance; or (2) otherwise not be an integral part of a group health plan, whether insured or self-insured.

The third category of excepted benefits, referred to as “noncoordinated excepted benefits,” includes both coverage for only a specified disease or illness (such as cancer-only policies), and hospital indemnity or other fixed indemnity insurance. In the group market, these benefits are excepted only if all of the following conditions are met: (1) The benefits are provided under a separate policy, certificate, or contract of insurance; (2) there is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and (3) the benefits are paid with respect to any event without regard to whether benefits are provided under any group health plan maintained by the same plan sponsor.¹²

The fourth category of excepted benefits is supplemental excepted benefits. Such benefits must be: (1) Coverage supplemental to Medicare, coverage supplemental to the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) or to Tricare, or similar coverage that is supplemental to coverage provided under a group health plan; and (2) provided under a separate policy, certificate, or contract of insurance.¹³

¹¹ 26 CFR 54.9831-1(c)(3)(v); 29 CFR 2590.732(c)(3)(v); 45 CFR 146.145(b)(3)(v).

¹² 26 CFR 54.9831-1(c)(4); 29 CFR 2590.732(c)(4); 45 CFR 146.145(b)(4). See also Q7 in FAQs about Affordable Care Act Implementation Part XI, available at <http://www.dol.gov/ebsa/faqs/faq-aca11.html>.

¹³ 26 CFR 54.9831-1(c)(5); 29 CFR 2590.732(c)(5); 45 CFR 146.145(b)(5). The Departments issued additional guidance regarding supplemental health insurance coverage as excepted benefits. See EBSA Field Assistance Bulletin No. 2007-04 (available at <http://www.dol.gov/ebsa/pdf/fab2007-4.pdf>); CMS Insurance Standards Bulletin 08-01 (available at

In 2004, the Departments of the Treasury, Labor, and HHS published final regulations with respect to excepted benefits (the HIPAA regulations).¹⁴ (Subsequent references to the “Departments” include all three Departments, unless the headings or context indicate otherwise.) On December 24, 2013, the Departments issued proposed regulations with respect to the second category of excepted benefits, limited excepted benefits (2013 proposed regulations).¹⁵ The 2013 proposed regulations proposed to: (1) Eliminate the requirement that participants pay an additional premium or contribution for limited-scope vision or dental benefits to qualify as benefits that are not an integral part of the plan; (2) set forth the criteria under which employee assistance programs (EAPs) constitute excepted benefits; and (3) allow plan sponsors in limited circumstances to offer, as excepted benefits, coverage that wraps around certain individual health insurance coverage. The Departments stated that, until rulemaking is finalized, through at least 2014, for purposes of enforcing the provisions of title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, the Departments will consider dental and vision benefits and EAP benefits meeting the conditions of the 2013 proposed regulations to qualify as excepted benefits.

After consideration of comments on the 2013 proposed regulations, the Departments are publishing final regulations regarding dental and vision benefits and EAP benefits. The Departments also intend to publish regulations that address limited wraparound coverage in the future, taking into account the extensive comments received on this issue.

II. Overview of the Final Regulations

A. Dental and Vision Benefits

Under the HIPAA regulations, vision and dental benefits are excepted if they are limited in scope (described as benefits, substantially all of which are for treatment of the eyes or mouth, respectively) and are either: (1) Provided under a separate policy, certificate, or contract of insurance; or (2) are otherwise not an integral part of a group health plan. While only insured coverage may qualify under the first test, both insured and self-insured

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).

¹⁴ 69 FR 78720 (Dec. 30, 2004).

¹⁵ 78 FR 77632.

coverage may qualify under the second test. The HIPAA regulations provided that benefits are not an integral part of a plan if participants have the right to elect not to receive coverage for the benefits, and, if participants elect to receive coverage for such benefits, they pay an additional premium or contribution for the coverage. By contrast, health FSA benefits could qualify as excepted benefits without any participant contribution under the HIPAA regulations.¹⁶

As stated in the preamble to the 2013 proposed regulations, following enactment of the Affordable Care Act, various stakeholders asked the Departments to amend the HIPAA regulations in order to remove conditions for limited-scope vision and dental benefits to be treated as excepted benefits. Specifically, some employers represented that, although their vision and dental benefits complied with the pre-Affordable Care Act requirements in title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code (such as the nondiscrimination and preexisting condition exclusion provisions), compliance with certain Affordable Care Act provisions presented additional challenges. These employers argued that, where employers are providing such benefits on a self-insured basis and without a contribution from employees, employers should not be required to charge a nominal contribution from participants simply for the benefits to qualify as excepted benefits. In some cases, the cost of collecting the nominal contribution would be greater than the contribution itself. Moreover, they pointed out that employers providing dental and vision benefits through a separate insurance policy are not required to charge a participant any premium or contribution in order for the dental or vision benefits to be considered excepted benefits. Similarly, consumer groups argued that, if an employer offers primary group health coverage that is treated as unaffordable under the Code, but offers limited-scope vision or dental coverage, such limited-scope vision or dental coverage should qualify as excepted benefits so as not to make such individuals ineligible to receive a premium tax credit under section 36B of the Code if they enroll in

¹⁶ Under the HIPAA regulations, benefits provided under a health FSA are only excepted for a class of participants if other group health coverage, not limited to excepted benefits, is made available for the year to the class of participants; and the arrangement is structured so that the maximum benefit payable to any participant in the class for a year does not exceed an amount specified in the regulations.

coverage under a Qualified Health Plan (QHP) through an Affordable Insurance Exchange, or “Exchange” (also called a Health Insurance Marketplace or Marketplace).

In response to these concerns, and to achieve greater consistency between insured and self-insured coverage, the 2013 proposed regulations proposed eliminating the requirement under the HIPAA regulations that participants pay an additional premium or contribution for limited-scope vision or dental benefits to qualify as benefits that are not an integral part of a plan (and therefore to qualify as excepted benefits).

The Departments invited comments on this approach. Many comments supported the concept of achieving greater consistency regarding the excepted benefits requirements for dental and vision benefits between insured and self-insured plans. One comment argued that the proposal undermined the inclusion of pediatric vision and dental coverage as an essential health benefit. Other comments requested clarification as to whether separately-administered and stand-alone dental and vision benefits offered separate from, or without a connection to, a primary plan could qualify as excepted benefits.

Consistent with the 2013 proposed regulations, these final regulations eliminate the requirement under the HIPAA regulations that participants pay an additional premium or contribution for limited-scope vision or dental benefits to qualify as excepted benefits. As explained in the preamble to the 2013 proposed regulations, without this change, an employer that establishes or maintains a self-insured plan could be required to charge a nominal contribution from participants simply for limited-scope vision and dental benefits to qualify as excepted benefits and, in some cases, the cost of collecting the nominal contribution would be greater than the contribution itself. In addition, if an employer offers primary group health coverage that is unaffordable to individuals, but limited-scope vision or dental coverage, without this modification, accepting the vision or dental coverage could make such individuals ineligible to receive a premium tax credit under section 36B of the Code if they enroll in coverage under a QHP through the Exchange.

In addition, it is the Departments’ view that the final regulations do not undermine the inclusion of pediatric vision or dental coverage as essential health benefits. The requirement that issuers in the small group market offer coverage of essential health benefits is

not changed, and that rule does not apply to large or self-insured plans. Moreover, PHS Act section 2711 (as incorporated into ERISA by section 715 and the Code by section 9815) allows self-insured plans to choose any definition of essential health benefits that is authorized by the Secretary of HHS for purposes of the prohibition on lifetime or annual dollar limits on essential health benefits.¹⁷

These final regulations clarify that limited-scope vision or dental benefits do not have to be offered in connection with a separate offer of major medical or “primary” group health coverage under the plan, in order to meet the statutory criterion that such benefits are “otherwise not an integral part of the plan.” To meet this criterion, limited-scope vision or dental benefits can be provided without connection to a primary plan, or the limited-scope vision or dental benefits can be offered separately from the major medical or “primary” coverage under the plan (as described in these final regulations). Under the 2013 proposed regulations, in order to satisfy the statutory excepted benefits criterion that such benefits cannot otherwise be “an integral part of the plan,” participants must be able to decline coverage. These final regulations provide that this criterion is satisfied if participants may decline coverage or the claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan.

While coverage for long-term care benefits is not the focus of this rule, such benefits are also subject to the “not an integral part of a group health plan” standard in order to be classified as excepted benefits. Accordingly, the revisions discussed in this section of the preamble also apply to coverage of long-term care benefits.

B. Employee Assistance Programs

EAPs are typically programs offered by employers that can provide a wide-ranging set of benefits to address circumstances that might otherwise adversely affect employees’ work and health. Benefits may include referral services and short-term substance use disorder or mental health counseling, as well as financial counseling and legal services. They are typically available free of charge to employees and are often provided through third-party vendors. Benefits for medical care provided through an EAP would

¹⁷ See CMS, Frequently Asked Questions on Essential Health Benefits Bulletin, Q10 (February 17, 2012) <http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf>.

generally be considered group health plan coverage (and, therefore, minimum essential coverage), which would generally be subject to the HIPAA and Affordable Care Act market reform requirements (and could make individuals receiving benefits under an EAP ineligible to receive a premium tax credit under section 36B of the Code if they enroll in coverage under a QHP through the Exchange), unless the EAP meets the criteria for being excepted benefits.

Since enactment of the Affordable Care Act, various stakeholders have asked the Departments to treat EAPs as excepted benefits for reasons analogous to the arguments described above with respect to vision and dental benefits. Specifically, some employers represented that compliance with the prohibition on annual dollar limits could be problematic as such benefits are typically very limited, and that EAPs generally are intended to provide benefits in addition to those provided under other group health plans sponsored by employers. Moreover, consumer groups have represented that EAPs with very limited benefits, which may be the only coverage offered to employees, could make such employees ineligible to receive a premium tax credit under section 36B of the Code if they enroll in coverage under a QHP through the Exchange. At the same time, the Departments recognize that no universal definition exists for EAPs, and are concerned that employers not act to shift primary coverage to a separate “EAP plan,” exempt from the consumer protection provisions of title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, including the mental health parity provisions.¹⁸

In guidance issued on September 13, 2013, the Departments stated their intent to amend the excepted benefits regulations with respect to EAPs.¹⁹ The guidance also provided transition relief, stating, “[u]ntil rulemaking is finalized, through at least 2014, the Departments will consider an employee assistance program or EAP to constitute excepted benefits only if the employee assistance

¹⁸ The mental health parity provisions are included in PHS Act section 2726, ERISA section 712, and Code section 9812. See also final regulations on mental health parity, published at 78 FR 68239 (November 13, 2013).

¹⁹ See IRS Notice 2013-54 (available at <http://www.irs.gov/pub/irs-drop/n-13-54.pdf>) and DOL Technical Release 2013-03 (available at <http://www.dol.gov/ebsa/newsroom/tr13-03.html>), Q&A 9. See also CMS Insurance Standards Bulletin—Application of Affordable Care Act Provisions to Certain Healthcare Arrangements (available at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cms-hra-notice-9-16-2013.pdf>).

program or EAP does not provide significant benefits in the nature of medical care or treatment. For this purpose, employers may use a reasonable, good faith interpretation of whether an employee assistance program or EAP provides significant benefits in the nature of medical care or treatment.”

The 2013 proposed regulations set forth criteria for an EAP to qualify as excepted benefits beginning in 2015. Under the 2013 proposed regulations, benefits provided under EAPs are excepted if four criteria are met. First, the program cannot provide significant benefits in the nature of medical care. The Departments invited comments on how to define “significant.” For example, the Departments requested comments as to whether a program that provides no more than 10 outpatient visits for mental health or substance use disorder counseling, an annual wellness checkup, immunizations, and diabetes counseling, with no inpatient care benefits, should be considered to provide significant benefits in the nature of medical care.²⁰

The second proposed criterion for an EAP to constitute excepted benefits under the 2013 proposed regulations is that its benefits cannot be coordinated with benefits under another group health plan. The Departments outlined three conditions to meet this proposed criterion: (i) participants in the separate group health plan must not be required to exhaust benefits under the EAP (making the EAP a “gatekeeper”) before an individual is eligible for benefits under the other group health plan; (ii) participant eligibility for benefits under the EAP must not be dependent on participation in another group health plan; and (iii) benefits under the EAP must not be financed by another group health plan.

The third proposed criterion for an EAP to constitute excepted benefits under the 2013 proposed regulations is that no employee premiums or

contributions be required to participate in the EAP. The fourth proposed criterion is that there is no cost sharing under the EAP.

The criteria in the 2013 proposed regulations were intended to ensure that employers are able to continue offering EAPs as supplemental benefits to other coverage, and to ensure that in circumstances in which an EAP with limited benefits is the only coverage, or the only affordable coverage provided to an employee, that the coverage does not unreasonably disqualify an employee from potential eligibility to receive a premium tax credit under section 36B of the Code if the employee enrolls in coverage under a QHP through the Exchange. The Departments requested comments on whether the criteria proposed are sufficient to prevent the potential for abuse, including the evasion of compliance with the mental health parity provisions, and whether different or additional standards should be included.

The Departments received a number of comments relating to the treatment of EAPs as excepted benefits. While the comments generally supported treating EAPs as excepted benefits, there were many suggestions for clarifying or modifying the specific requirements in the 2013 proposed regulations for EAPs to constitute excepted benefits. In particular, many comments included suggestions for clarifying what is meant by significant benefits in the nature of medical care. Most of these comments raised concerns about the suggestion in the preamble to propose using numerical limits on the number of visits.

Some comments requested that EAPs be allowed to provide wellness and disease management programs, provided such programs do not provide significant benefits in the nature of medical care. However, treating wellness programs as excepted benefits by including them in an EAP would circumvent consumer protections contained in the statutory standards for wellness programs under section 2705(j) of the PHS Act as enacted by the Affordable Care Act. This suggestion is not adopted in these final regulations.

Several comments opposed the prohibition in the 2013 proposed regulations on an EAP being financed by the other group health plan to qualify as excepted benefits. In particular, the comments noted that often the EAP and the group health plan are financed by a single payment or otherwise combined, and the requirement would result in disruptions of existing commercial arrangements. Moreover, these comments noted, the other requirements

sufficiently protected against inappropriate coordination of the EAP benefits with the benefits of the other group health plan. In addition, there were a number of comments concerning EAPs that were beyond the scope of the 2013 proposed regulations.

After consideration of the comments, the Departments are finalizing the proposal, with one modification related to financing, described below.²¹ As with the 2013 proposed regulations, these final regulations provide that, for an EAP to constitute excepted benefits, the EAP must satisfy four requirements.

The first requirement of the 2013 proposed regulations and these final regulations is that the EAP does not provide significant benefits in the nature of medical care. For this purpose, the amount, scope, and duration of covered services are taken into account. 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. At the same time, 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. The Departments may, through guidance, provide additional clarification in the future regarding when a program provides significant benefits in the nature of medical care.

The second requirement of these final regulations is that for an EAP to constitute excepted benefits, its benefits cannot be coordinated with the benefits under another group health plan. This requirement has two elements: (1)

²¹ In the 2013 proposed regulations, the requirements regarding EAPs were proposed in paragraph (c)(3)(vii) of 26 CFR 54.9831-1, 29 CFR 2590.732, and 45 CFR 146.145. However, HHS regulations published on October 30, 2013 and effective December 30, 2013 redesignated 45 CFR 146.145(c) as paragraph (b) (78 FR at 65092). Additionally, because these regulations are finalizing only the requirements related to dental and vision benefits and EAP benefits, these final regulations have been renumbered so that the requirements regarding EAPs are now contained in paragraph (c)(3)(vi) of 26 CFR 54.9831-1 and 29 CFR 2590.732, and in paragraph (b)(3)(vi) of 45 CFR 146.145. As stated earlier in this preamble, the Departments also intend to publish regulations that address limited wraparound coverage in the future, taking into account the extensive comments received on this issue. Those provisions are intended to be codified in paragraph (c)(3)(vii) of 26 CFR 54.9831-1 and 29 CFR 2590.732, and in paragraph (b)(3)(vii) of 45 CFR 146.145.

²⁰ Other examples of EAPs that do not provide significant benefits in the nature of medical care, discussed in IRS Notice 2004-50 Q&A-10 include (1) an EAP with benefits that consist primarily of free or low-cost confidential short-term counseling (which could address substance abuse, alcoholism, mental health or emotional disorders, financial or legal difficulties, and dependent care needs) to identify an employee's problem that may affect job performance and, when appropriate, referrals to an outside organization, facility or program to assist the employee in resolving the problem; and (2) a wellness program that provides a wide-range of education and fitness services (also including sports and recreation activities, stress management, and health screenings) designed to improve the overall health of the employees and prevent illness, where any costs charged to the individual for participating in the services are separate from the individual's coverage under the health plan.

Participants in the other group health plan must not be required to use and exhaust benefits under the EAP (making the EAP a “gatekeeper”) before an individual is eligible for benefits under the other group health plan; and (2) participant eligibility for benefits under the EAP must not be dependent on participation in another group health plan. In response to comments, these final regulations do not include the requirement set forth in the 2013 proposed regulations that EAP benefits cannot be financed by another group health plan in order to qualify as excepted benefits.

The third requirement of the 2013 proposed regulations and these final regulations for EAPs to constitute excepted benefits is that no employee premiums or contributions may be required as a condition of participation in the EAP. Finally, as with the 2013 proposed regulations, the final regulations provide that an EAP that constitutes excepted benefits may not impose any cost-sharing requirements.

C. Applicability Date and Reliance

In the preamble to the 2013 proposed regulations, the Departments stated that, until rulemaking is finalized, through at least 2014, for purposes of enforcing the provisions of title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, the Departments will consider dental and vision benefits, and EAP benefits, meeting the conditions of the 2013 proposed regulations to qualify as excepted benefits and that, to the extent final regulations or other guidance with respect to vision or dental benefits or EAPs is more restrictive on plans and issuers than the 2013 proposed regulations, the final regulations or other guidance will not be effective prior to January 1, 2015. These final regulations apply to group health plans and group health insurance issuers for plan years beginning on or after January 1, 2015. They do not apply to health insurance issuers offering individual health insurance coverage. Until the applicability date of these final regulations, the Departments will consider dental and vision benefits and EAP benefits meeting the conditions of the 2013 proposed regulations or these final regulations to qualify as excepted benefits.

III. Economic Impact and Paperwork Burden

A. Summary—Department of Labor and Department of Health and Human Services

As stated above, these final regulations eliminate the requirement

under the HIPAA regulations that participants pay an additional premium or contribution for limited-scope vision or dental benefits to qualify as excepted benefits, and set forth four requirements for an EAP to constitute excepted benefits.

B. Executive Order 12866—Department of Labor and Department of Health and Human Services

OMB has determined that this regulatory action is significant within the meaning of section 3(f)(4) of the Executive Order, and the Departments accordingly provide the following assessment of its potential benefits and costs. The Departments expect the impact of these final regulations to be limited.

Specifically, with respect to vision and dental benefits, the final regulations allow group health plans to offer dental and vision benefits to employees without charging a premium or contribution. As stated earlier in the preamble, this eliminates a difference that would otherwise exist between insured and self-insured coverage. With respect to EAPs, the final regulations clarify the conditions that must be satisfied for such benefits to constitute excepted benefits, which are not subject to the group market requirements under the PHS Act, ERISA, and the Code.

Some employers represented to the Departments that compliance with the Affordable Care Act presented challenges for their limited-scope vision and dental benefits and EAPs. The clarifications provided in these final regulations will benefit employees by ensuring continued access to these benefits. The Departments expect these final regulations to have some costs, but these costs will be limited because the Departments expect the primary result of the final regulations will be that employers providing limited-scope dental and vision and EAP benefits will continue to provide such benefits and that the number of employers who will begin providing such benefits for the first time will be small.

C. Regulatory Flexibility Act—Department of Labor and Department of Health and Human Services

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 et seq.) and that are likely to have a significant economic impact on a substantial number of small entities. Unless an agency certifies that a proposed rule is

not likely to have a significant economic impact on a substantial number of small entities, section 603 of RFA requires that the agency present an initial regulatory flexibility analysis at the time of the publication of the notice of proposed rulemaking describing the impact of the rule on small entities and seeking public comment on such impact. Small entities include small businesses, organizations and governmental jurisdictions.

For purposes of the RFA, the Departments continue to consider a small entity to be an employee benefit plan with fewer than 100 participants. The basis for this definition is found in section 104(a)(2) of the act, which permits the Secretary of Labor to prescribe simplified annual reports for pension plans that cover fewer than 100 participants. Pursuant to the authority of section 104(a)(3), the Department of Labor has previously issued at 29 CFR 2520.104–20, 2520.104–21, 2520.104–41, 2520.104–46 and 2520.104b–10 certain simplified reporting provisions and limited exemptions from reporting and disclosure requirements for small plans, including unfunded or insured welfare plans covering fewer than 100 participants and satisfying certain other requirements.

Further, while some large employers may have small plans, in general small employers maintain most small plans. Thus, the Departments believe that assessing the impact of these final regulations on small plans is an appropriate substitute for evaluating the effect on small entities. The definition of small entity considered appropriate for this purpose differs, however, from a definition of small business that is based on size standards promulgated by the Small Business Administration (13 CFR 121.201) pursuant to the Small Business Act (15 U.S.C. 631 et seq.).

As noted above, the Departments expect the costs imposed by these regulations to be limited for those employers that provide dental, vision and EAP benefits, and that they will not affect employers who do not provide such benefits. The final regulations allow employers to decide based on their own costs and benefits what action to take. This is true for large and small plans alike. Accordingly, the Departments believe that these final regulations do not have a significant economic impact on a substantial number of small entities. Accordingly, pursuant to section 605(b) of the RFA, the Departments hereby certify that these final regulations will not have a significant economic impact on a substantial number of small entities.

D. Special Analyses—Department of the Treasury

For purposes of the Department of the Treasury it has been determined that these final regulations are not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these final regulations, and, because these final regulations do not impose a collection of information on small entities, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Pursuant to section 7805(f) of the Code, these final regulations have been submitted to the Small Business Administration for comment on its impact on small business.

E. Unfunded Mandates Reform Act

For purposes of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1501 *et seq.*), as well as Executive Order 12875, these final regulations do not include any Federal mandate that may result in expenditures by State, local, or tribal governments, or the private sector, which may impose an annual burden of \$100 million adjusted for inflation since 1995.

F. Federalism—Department of Labor and Department of Health and Human Services

Executive Order 13132 outlines fundamental principles of federalism. It requires adherence to specific criteria by Federal agencies in formulating and implementing policies that have “substantial direct effects” on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have these federalism implications must consult with State and local officials, and describe the extent of their consultation and the nature of the concerns of State and local officials in the preamble to the final regulation.

In the Departments’ view, the final regulations, by clarifying policy regarding certain excepted benefits options that can be designed by employers to support their employees, would provide more certainty to employers and others in the regulated community as well as States and political subdivisions regarding the treatment of such arrangements under

the PHS Act, ERISA and the Code. Through the regular course of outreach the Departments normally engage in with officials of States (and political subdivisions), the Departments are aware of no special federalism implications presented by these final regulations. The Departments will continue to conduct regular outreach activities with States.

G. Congressional Review Act

These final regulations are subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*), and will be transmitted to the Congress and to the Comptroller General for review in accordance with such provisions.

IV. Statutory Authority

The Department of the Treasury regulations are adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor regulations are adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Public Law 104–191, 110 Stat. 1936; sec. 401(b), Public Law 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Public Law 110–343, 122 Stat. 3765; Public Law 110–460, 122 Stat. 5123; Secretary of Labor’s Order 1–2011, 77 FR 1088 (January 9, 2012).

The Department of Health and Human Services regulations are adopted pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

List of Subjects

26 CFR Part 54

Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

29 CFR Part 2590

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance, Medical child support, Reporting and recordkeeping requirements.

45 CFR Part 146

Health care, Health insurance, Reporting and recordkeeping

requirements, and State regulation of health insurance.

John Dalrymple,

Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Approved: September 25, 2014.

Mark J. Mazur,

Assistant Secretary of the Treasury (Tax Policy).

Signed this 25th day of September, 2014.

Phyllis C. Borzi,

Assistant Secretary, Employee Benefits Security Administration, Department of Labor.

Dated: September 11, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

Dated: September 19, 2014.

Sylvia Burwell,

Secretary, Department of Health and Human Services.

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Accordingly, 26 CFR part 54 is amended as follows:

PART 54—PENSION EXCISE TAXES

■ **Paragraph 1.** The authority citation for part 54 continues to read, in part, as follows:

Authority: 26 U.S.C. 7805. * * *

Section 54.9831–1 is also issued under 26 U.S.C. 9833; * * *

■ **Par. 2.** Section 54.9831–1 is amended by revising paragraphs (c)(3)(i) and (c)(3)(ii), and adding paragraph (c)(3)(vi), to read as follows:

§ 54.9831–1 Special rules relating to group health plans.

* * * * *

(c) * * *
(3) * * *

(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (c)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section. Furthermore, benefits provided under an employee assistance program are excepted benefits if they satisfy the requirements of paragraph (c)(3)(vi) of this section.

(ii) *Not an integral part of a group health plan.* For purposes of this

paragraph (c)(3), benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan, a separate plan, or as the only plan offered to participants) if either paragraph (c)(3)(ii)(A) or (B) are satisfied.

(A) Participants may decline coverage. For example, a participant may decline coverage if the participant can opt out of the coverage upon request, whether or not there is a participant contribution required for the coverage.

(B) Claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan.

* * * * *

(vi) *Employee assistance programs.* Benefits provided under employee assistance programs are excepted if they satisfy all of the requirements of this paragraph (c)(3)(vi).

(A) The program does not provide significant benefits in the nature of medical care. For this purpose, the amount, scope and duration of covered services are taken into account.

(B) The benefits under the employee assistance program are not coordinated with benefits under another group health plan, as follows:

(1) Participants in the other group health plan must not be required to use and exhaust benefits under the employee assistance program (making the employee assistance program a gatekeeper) before an individual is eligible for benefits under the other group health plan; and

(2) Participant eligibility for benefits under the employee assistance program must not be dependent on participation in another group health plan.

(C) No employee premiums or contributions are required as a condition of participation in the employee assistance program.

(D) There is no cost sharing under the employee assistance program.

* * * * *

DEPARTMENT OF LABOR

Employee Benefits Security Administration

For the reasons stated in the preamble, the Department of Labor amends 29 CFR part 2590 as follows:

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

■ 3. The authority citation for part 2590 is revised to read as follows:

Authority: 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1185d, 1191, 1191a,

1191b, and 1191c; sec. 101(g), Pub. L. 104–191, 110 Stat. 1936; sec. 401(b), Pub. L. 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 12(d), Pub. L. 110–343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111–148, 124 Stat. 119, as amended by Pub. L. 111–52, 124 Stat. 1029; Secretary of Labor’s Order 1–2011, 77 FR 1088 (January 9, 2012).

■ 4. Section 2590.732 is amended by revising paragraphs (c)(3)(i) and (c)(3)(ii), and adding paragraph (c)(3)(vi), to read as follows:

§ 2590.732 Special rules relating to group health plans.

* * * * *

(c) * * *

(3) * * *

(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (c)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section. Furthermore, benefits provided under an employee assistance program are excepted benefits if they satisfy the requirements of paragraph (c)(3)(vi) of this section.

(ii) *Not an integral part of a group health plan.* For purposes of this paragraph (c)(3), benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan, a separate plan, or as the only plan offered to participants) if either paragraph (c)(3)(ii)(A) or (B) are satisfied.

(A) Participants may decline coverage. For example, a participant may decline coverage if the participant can opt out of the coverage upon request, whether or not there is a participant contribution required for the coverage.

(B) Claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan.

* * * * *

(vi) *Employee assistance programs.* Benefits provided under employee assistance programs are excepted if they satisfy all of the requirements of this paragraph (c)(3)(vi).

(A) The program does not provide significant benefits in the nature of medical care. For this purpose, the amount, scope and duration of covered services are taken into account.

(B) The benefits under the employee assistance program are not coordinated with benefits under another group health plan, as follows:

(1) Participants in the other group health plan must not be required to use and exhaust benefits under the employee assistance program (making the employee assistance program a gatekeeper) before an individual is eligible for benefits under the other group health plan; and

(2) Participant eligibility for benefits under the employee assistance program must not be dependent on participation in another group health plan.

(C) No employee premiums or contributions are required as a condition of participation in the employee assistance program.

(D) There is no cost sharing under the employee assistance program.

* * * * *

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Subtitle A

For the reasons stated in the preamble, the Department of Health and Human Services amends 45 CFR part 146 as set forth below:

PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

■ 5. The authority citation for part 146 continues to read as follows:

Authority: Secs. 2702 through 2705, 2711 through 2723, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg–1 through 300gg–5, 300gg–11 through 300gg–23, 300gg–91, and 300gg–92).

■ 6. Section 146.145 is amended by revising paragraphs (b)(3)(i) and (b)(3)(ii), and adding paragraph (b)(3)(vi), to read as follows:

§ 146.145 Special rules relating to group health plans.

* * * * *

(b) * * *

(3) * * *

(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (b)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement are excepted benefits if they satisfy the requirements of paragraph (b)(3)(v) of this section. Furthermore, benefits provided under an employee assistance program are excepted benefits if they satisfy the requirements of paragraph (b)(3)(vi) of this section.

(ii) *Not an integral part of a group health plan.* For purposes of this

paragraph (b)(3), benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan, a separate plan, or as the only plan offered to participants) if either paragraph (b)(3)(ii)(A) or (B) are satisfied.

(A) Participants may decline coverage. For example, a participant may decline coverage if the participant can opt out of the coverage upon request, whether or not there is a participant contribution required for the coverage.

(B) Claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan.

* * * * *

(vi) *Employee assistance programs.* Benefits provided under employee assistance programs are excepted if they satisfy all of the requirements of this paragraph (b)(3)(vi).

(A) The program does not provide significant benefits in the nature of medical care. For this purpose, the amount, scope and duration of covered services are taken into account.

(B) The benefits under the employee assistance program are not coordinated with benefits under another group health plan, as follows:

(1) Participants in the other group health plan must not be required to use and exhaust benefits under the employee assistance program (making the employee assistance program a gatekeeper) before an individual is eligible for benefits under the other group health plan; and

(2) Participant eligibility for benefits under the employee assistance program must not be dependent on participation in another group health plan.

(C) No employee premiums or contributions are required as a condition of participation in the employee assistance program.

(D) There is no cost sharing under the employee assistance program.

* * * * *

[FR Doc. 2014-23323 Filed 9-26-14; 4:15 pm]

BILLING CODE 4150-28-P; 4830-01-P; 4510-29-P]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 147 and 155

[CMS-9949-F2]

RIN 0938-AS02

Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Correcting Amendment

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule; correcting amendment.

SUMMARY: In the May 27, 2014 issue of the *Federal Register* (79 FR 30240), we published a final rule which addressed various requirements applicable to health insurance issuers, Affordable Insurance Exchanges (“Exchanges”), Navigators, non-Navigator assistance personnel, and other entities under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act). The effective date of the rule was July 28, 2014, except for amendments to 45 CFR 155.705, which were effective May 27, 2014. This correcting amendment corrects a limited number of technical and typographical errors identified in the “Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond” final rule.

DATES: Effective Date: This correcting amendment is effective on October 1, 2014.

FOR FURTHER INFORMATION CONTACT: Jacob Ackerman, (301) 492-4179.

SUPPLEMENTARY INFORMATION:

I. Background

The Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond final rule (the “Final Rule”), which appeared in the May 27, 2014 *Federal Register* (79 FR 30240), contained a number of technical and typographical errors. Therefore, on July 24, 2014, we published a correction notice in the *Federal Register* (79 FR 42984), to correct some of those errors. The provisions of the correction notice were effective as if they had been included in the May 27, 2014 final rule. Accordingly, those corrections were effective July 28, 2014.

We have identified additional technical and typographical errors that appeared in the May 27, 2014 *Federal Register*. Therefore, we are publishing an additional correcting document to

correct these errors. The provisions of this correcting document are effective October 1, 2014.

II. Summary of Errors in the Regulations Text

On page 30339, we amended the structure of § 147.104(b)(1)(i), removed duplicate regulatory text regarding the Small Business Health Options Program (SHOP), and made other minor revisions. However, when amending paragraph (b)(1)(i)(B) to remove duplicate regulatory text, we inadvertently cross referenced the incorrect regulatory section. The regulation should have referenced the SHOP group participation rules at § 156.285(e), not § 156.1250(c). We are correcting this error in this correcting document.

On page 30348, at § 155.420, we added a new paragraph (b)(2)(iv) to establish coverage effective dates for plan selections made during a special enrollment period, clarifying a consumer’s ability to select a plan 60 days before and after a loss of coverage. However, we inadvertently omitted the amendatory instruction in the regulations text for adding this paragraph. As a result, this paragraph was published in the May 27, 2014 *Federal Register* but was not codified in the Code of Federal Regulations. We also published a subsequent correction notice amending language to this paragraph on July 24, 2014 (79 FR 42984). However, because the original text had not been codified, the change to this paragraph could not be codified. We are correcting this oversight. Specifically, we are adding a new (b)(2)(iv), which reflects the original language we intended to codify in the *Federal Register* as would have been modified by the July 24, 2014 correction notice.

On page 30350, at § 155.705(b)(3), we describe options with respect to employee choice requirements in the Small Business Health Options Program (SHOP). We are removing the comma after the word “may” in § 155.705(b)(3)(vi) to read, “For plan years beginning in 2015 only, the SHOP may elect. . . .” This was a typographical error that should be made for grammatical correctness.

III. Waiver of Proposed Rulemaking and Delay in Effective Date

We ordinarily publish a notice of proposed rulemaking in the *Federal Register* to provide a period for public comment before the provisions of a rule take effect, in accordance with section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)), and section