FEDERAL LAW DISTINGUISHES EXCEPTED BENEFITS
FROM COMPREHENSIVE, MAJOR MEDICAL HEALTH INSURANCE COVERAGE

Common Characteristics of Excepted Benefits Coverage. In enacting the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Congress recognized that there are a variety of insurance products that offer benefits that do not provide comprehensive major medical coverage. These types of arrangements instead provide benefits designed primarily to: supplement comprehensive, major medical care arrangements; or to only make cash payments directly to policyholders; or to offer medical benefits that are secondary or incidental to some other form of non-medical insurance coverage.

In so recognizing this distinction, Congress also determined that imposing the same requirements on these types of insurance coverage as those requirements that are aimed at comprehensive types of medical health insurance arrangements was not appropriate. Because the Congress decided that these supplemental or other non-medical expense benefits should not be regulated in the same manner as comprehensive medical plans, HIPAA established a series of exclusions from the 1996 Act's requirements for so-called "excepted benefit" plans.

The 1996 Act imposed requirements that apply to a "health plan", defined generally as any individual or group plan that "provides or pays for the cost of medical care". "Excepted benefit" coverage offered to individuals directly, or through group health plan arrangements was made explicitly exempt from HIPAA's requirements. This exemption for ""excepted benefits"" was included in the provisions of HIPAA at the inception of the 1996 legislation and applies to any combination of "excepted benefits".

NAIC Models and State Law Established Names of Coverage. Because federal law does not include standards for approving the sale and issuance of insurance coverage, this list of the types of insurance coverage that are "excepted benefits" is based upon the specific named types of coverage under state laws. See, *NAIC Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#170).* In addition, state laws list excepted benefit plans as the types of coverage that are not "health insurance" or a "health plan".

Congress specifically listed the named types of health plan arrangements that are not offered, marketed, and sold as comprehensive, health insurance coverage because they do not provide benefits for comprehensive medical coverage. The list of "excepted benefit" plans employed by the Congress are "terms of art" first employed by state insurance regulation.

These "excepted benefit" plans include the following insurance coverage: accident-only; disability income; liability supplement; general liability; automobile liability; workers' compensation; automobile medical payment; credit-only; on-site medical clinics; dental or vision; long-term care; nursing home care; specified disease or illness; hospital indemnity or other fixed indemnity insurance; Medicare supplement, Tricare supplement, and similar group supplemental coverage.

Excepted Benefits Are Not Group "Health Plans". A group "health plan" provides primary medical coverage and may separately offer group "excepted benefits" to its covered employees and their dependents. To be an "excepted benefit" in the context of a group health plan or group health insurance, the "excepted benefits" coverage must be offered separately from the comprehensive medical care benefits of a group health plan or group health insurance arrangement. Policies must not be "integral" to the group health plan.

There are additional conditions that there must be no coordination between the group health plan's comprehensive benefits and any benefit exclusions under the group health plan. Benefits must be paid directly to policyholders without regard to any coverage under the group health plan. The effect of these conditions is to ensure that these insurance products are not a subterfuge for primary benefits provided under comprehensive medical health insurance.

Excepted Benefits Are Not Creditable Coverage. The listed types of health plans classified as "creditable coverage" in HIPAA demonstrates that the intent of the provision is to include types of "primary" health insurance arrangements providing or paying for "medical care." This is a common quality of "primary" insurance listed as "creditable coverage" and typical for: insured and self-insured group health plans; individual major medical health insurance; Medicare; Medicaid; Tricare; FEHBP; Veterans Administration; Indian Health Service; and coverage under a state health benefit risk pool.

In contrast, "excepted benefit" plans are explicitly determined in statutory language to not be "creditable coverage". Congress further clarified the distinction between comprehensive, medical health plans and health insurance coverage, from "excepted benefits" by classifying "primary" comprehensive medical coverage as "creditable coverage." The term "creditable coverage" expressly does not include coverage consisting solely of "excepted benefits".

This is because plans classified as "creditable coverage" provide "primary" health insurance benefits for payment directly to health care providers for the expenses of many medical care items and services they provide to patients. Major medical benefits commonly may include events such as: professional services of physicians and other medical providers; hospitalization; emergency care; physical therapy; routine nursing care; ambulatory surgery; anesthetics; laboratory services; diagnostic x-rays; mammography screening; prescription drugs; ambulance service; durable medical equipment; prosthetic devices; outpatient services; mental health treatment, surgical expense; maternity expense; and prescription drugs.

Excepted benefits may utilize the occurrence of these "events" as the trigger to pay cash benefits directly to the policyholder. Cash benefits are paid regardless of benefits paid to the health care provider by the primary health insurance coverage. This is because these "events" can incur economic costs and consequences that are not covered by major medical insurance such as lost wages of an hourly paid employee, high deductibles, and other out-of-pocket expenses.

Patient Protection Act Amendments. The Patient Protection and Affordable Care Act ("PPACA" or "ACA") builds upon the statutory structure adopted in 1996 and retains the exceptions for "excepted benefit" coverage because the new reforms are intended to apply to comprehensive, major medical health plans and health insurance. As a result "excepted benefit" coverage is exempt from the PPACA market reforms. None of the provisions of Title I of PPACA are intended to apply to ""excepted benefits"" coverage. The "insurance market reforms" amend the existing HIPAA structure and so would retain the exception for "excepted benefits". The Act also explicitly provides that "excepted benefits" are not minimum essential coverage ("MEC").