XIII. Covered Benefits

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A. Overview of Legal, Tax, and Plan Design Considerations for Covered Benefits

This Section XIII focuses on a self-insured plan sponsor's selection of what items and services will be covered under the plan and any design-based limitations or exclusions that will be imposed on those items and services. Other self-insured health plan design considerations are discussed throughout the manual, including in Sections VI (federal tax treatment), XI (provider networks and other access structures), XII (nondiscrimination rules), XIV (eligibility), and XV (cost-sharing features and participant contributions).

Legislation and Other Guidance Relating to COVID-19. Employer-sponsored group health plans are affected in various ways by government actions relating to the public health emergency caused by the novel coronavirus disease (COVID-19) pandemic, including legislation[*] and agency guidance. Issues relating to group health plan coverage of specified items and services during the COVID-19 emergency are highlighted below in this Section XIII. Employer plan sponsors should monitor new developments, as they may require immediate attention.[†]

* Families First Coronavirus Response Act (FFCRA), Pub. L. No. 116-127 (Mar. 18, 2020); Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. No. 116-136 (Mar. 27, 2020).

† The federal government maintains numerous webpages to assist businesses with COVID-19 response, including the DOL's EBSA Response to COVID-19 webpage, available at https://www.dol.gov/agencies/ebsa/coronavirus (as visited June 9, 2021) and the HHS Coronavirus Disease 2019 (COVID-19) Updates webpage, available at https://www.hhs.gov/about/news/coronavirus/index.html (as visited June 9, 2021).

1. State and Federal Mandates

States have laws regulating insured plans and mandating benefits in areas including well-child care, maternity benefits, cancer treatment, and experimental procedures. These state laws impact benefits provided through insured plans and self-insured health plans sponsored by local and state governments and churches. But due to ERISA preemption, self-insured health plans subject to ERISA are not required to follow state insurance or other state laws with benefits mandates.[1] Other self-insured plans, such as governmental plans and certain church plans, may be subject to state benefit mandates.[1.1]

While relief from state laws still remains a benefit of self-insuring, self-insured health plan sponsors no longer have as much discretion in designing covered benefits as they once had. Various federal laws now prohibit exclusion of benefits for certain conditions or disabilities (such as HIV/AIDS) or require coverage of certain benefits (such as preventive and maternity care). Subsection B includes an at-a-glance checklist of federally mandated benefits, and subsections C through G provide more detailed discussion.

1 For more on ERISA preemption, see Section V. For a detailed discussion of ERISA preemption and other ERISA issues, see *ERISA Compliance for Health & Welfare Plans* (Thomson Reuters/Tax & Accounting, 1992-present, updated quarterly).

1.1 *See, e.g.*, NY Ins § 4709(b) (subjecting self-insured municipal cooperatives to state insurance law regulation); NYS Office of General Counsel Informal Opinion, October 9, 2001 (concluding that self-insured church plans were subject to the requirements of New York insurance law).

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2. Tax Implications

The Internal Revenue Code (and related guidance) significantly influences a self-insured health plan's range of covered benefits. As a general rule, most self-insured health plans cover only benefits that may be offered on a tax-free basis as medical care under Code § 213(d). While a self-insured health plan is not required to cover all Code § 213(d) expenses (and many don't), if a plan covers expenses that do not qualify as Code § 213(d) medical expenses, there will be adverse tax consequences. For more on the tax rules, including details on what qualifies as a Code § 213(d) medical expense, see Section VI.

Employers subject to health care reform's employer shared responsibility provisions will want to consider how their plans' covered benefits will affect potential penalty taxes under Code § 4980H. This is discussed in subsection G.

3. Other Design Implications

In addition to federal and, for non-ERISA plans, state mandates, tax implications, and the cost of providing benefits, a self-insured health plan sponsor's decisions about which items and services to cover are heavily influenced by two other factors: (a) employee expectations that medical treatments for most major and common illnesses (e.g., cancer, heart conditions, flu) will be covered; and (b) the benefits suggested or required by the plan's third-party administrator, pharmacy benefit manager, and provider networks.

Other factors may also influence plan design. In general, private-sector employees tend to have slightly higher salaries than public-sector employees,[1.2] and so a self-insured governmental plan sponsor may opt to bridge the wage gap by providing more comprehensive benefits.[1.3] A self-insured church plan sponsor may be influenced by the church's doctrine and beliefs, and may, for example, opt not to provide domestic partner coverage or coverage for abortions.[1.4]

4. Excepted Benefits and Certain Small Plans

a. Excepted Benefits

The term "excepted benefits" comes from HIPAA and its implementing regulations, which provide that benefits meeting certain requirements are not required to comply with HIPAA's portability rules. Health care reform later invoked this same term to describe certain benefits that are not required to comply with some of the health care reform requirements.[2] Furthermore, certain federal mandates do not apply to group health plans that provide only "excepted benefits."[3]

[1.2] *See Overpaid or UnderPaid? A State -by-State Ranking of Public Employee Compensation* (Apr. 2014), available at https://www.aei.org/wp-content/uploads/2014/04/-biggs-overpaid-or-underpaid-a-statebystate-ranking-of-public-employee-compensation_112536583046.pdf (as visited June 9, 2021).

[1.3] *See Taxpayers fund generous health care plan for state employees, policymakers*, Oklahoma Watch (Aug. 6, 2013) (reporting that state officials defended a generous health insurance package for Oklahoma state employees because it helped offset the wage differential between the public sector and private sector), available at http://newsok.com/article/3869365 (as visited June 9, 2021). One study has shown that in 45 of the 50 states, public-employee health coverage was more valuable relative to wages, as compared to the private sector. *See Overpaid or Under-Paid? A State -by-State Ranking of Public Employee Compensation* (Apr. 2014), available at https://www.aei.org/wp-content/uploads/2014/04/-biggs-overpaid-or-underpaid-a-statebystate-ranking-of-public-employee-compensation_112536583046.pdf (as visited June 9, 2021). Another study found that state governments have not offered high deductible health plans at the same rates as private-sector employees. *See State Employee Health Plan Spending* (Aug. 2014), available at http://www.pewtrusts.org/~/media/assets/2014/08/stateemployeehealthcarereportseptemberupdate.pdf (as visited June 9, 2021).

[1.4] *See, e.g., Crafting Employee Health Plans for Catholic Institutions* (Oct. 1, 2009) (discussing ways in which self-insuring can help the Catholic Church and its institutions avoid state mandates that may be morally objectionable under Catholic teaching), available at https://cardinalnewmansociety.org/crafting-employee-health-plans-catholic-institutions/ (as visited June 9, 2021). See also subsection C and Section XII of *Health Care Reform for Employers and Advisors* (Thomson Reuters/Tax & Accounting, 2010-present) for a discussion of religious objections to covering mandated contraceptive services.

[2] Code §§ 9831(b) and (c), ERISA §§ 732(b) and (c), and PHSA § 2722. For more information, see Section V of *Health Care Reform for Employers and Advisors* (Thomson Reuters/Tax & Accounting, 2010-present).

[3] Group health plans that provide only "excepted benefits" are not required to comply with the following federal mandates, among others: required coverage for dependent students (Michelle's Law); Mental Health Parity and Addiction Equity Act (MHPAEA); Women's Health and Cancer Rights Act (WHCRA); Newborns and Mothers Health Protection Act (NMHPA); and health care reform's requirements for coverage for children under age 26, patient protections, preventive health services, and clinical trials. For details about these federal mandates, see *Group Health Plans: Federal Mandates Other Than COBRA & HIPAA* (Thomson Reuters/Tax & Accounting, 2002-present, updated quarterly).

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Self-insured group health plans providing major medical benefits will not qualify as "excepted benefits." However, health flexible spending arrangements (health FSAs) generally must qualify as excepted benefits (unless they are integrated with another group health plan, under the same rules that apply to HRAs) in order to avoid violating health care reform.[4] Furthermore, certain types of benefits that employers may offer on a self-insured basis, such as limited-scope dental or vision benefits[5] and employee assistance programs (EAPs),[6] may also qualify as excepted benefits. For detailed discussion of the requirements these benefits must satisfy to be considered "excepted benefits," see Section VI of *HIPAA Portability, Privacy & Security* (Thomson Reuters/Tax & Accounting, 1997-present, updated quarterly) and Section V of *Health Care Reform for Employers and Advisors* (Thomson Reuters/Tax & Accounting, 2010-present).

COVID-19 Testing and Vaccines. An excepted-benefit EAP will not be considered to provide benefits that are significant in the nature of medical care solely because it offers benefits for diagnosis and testing for COVID-19 while the applicable COVID-19 emergency declarations are in effect, or for COVID-19 vaccinations and their administration.[*]

* FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 42, Q/A-11 (Apr. 11, 2020), available at https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-42.pdf (as visited June 9, 2021); FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 44, Q/A-12 (Feb. 26, 2021), available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-44.pdf (as visited June 9, 2021). For more information on these coverage mandates, see Section XVI of *Group Health Plans: Federal Mandates Other Than COBRA & HIPAA* (Thomson Reuters/Tax & Accounting, 2002-present, updated quarterly).

b. Plans Covering "Less Than Two" Employees, Including Retiree-Only Plans

Prior to health care reform, a stand-alone retiree medical plan (whether insured or self-insured) that covered no current employees was considered to be exempt from many of HIPAA's portability requirements as a plan that covered "less than two" participants (on the first day of the plan year) who were current employees (this included any health insurance coverage offered in connection with such a plan).[7] (A retiree medical plan that covered two or more participants who were current employees, however, was generally treated as subject to HIPAA's portability requirements.)[8] Federal agencies have confirmed that the exception for small plans (including retiree-only plans) still exists after health care reform, and that it applies for purposes of both HIPAA and the PHSA mandates.[8.1]

While it may seem that determining whether a plan covers only retirees is a simple matter, some categories of participants (e.g., individuals on long-term disability and rehired retirees) and some situations (e.g., covering a dependent who is also an employee) require careful analysis.[9] For a detailed discussion, see Section V of *Health Care Reform for Employers and Advisors* (Thomson Reuters/Tax & Accounting, 2010-present).

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4 *See* Q/A-7 of IRS Notice 2013-54, 2013-40 I.R.B. 287 and DOL Tech. Rel. 2013-03 (Sept. 13, 2013). *See also* Treas. Reg. § 54.9815-2711(d); DOL Reg. § 2590.715-2711(d); HHS Reg. § 147.126(d).

5 Certain self-insured, limited-scope dental or vision benefits may qualify as excepted benefits if they are not an integral part of a group health plan. *See* Amendments to Excepted Benefits, 26 CFR Part 54; 29 CFR Part 2590; 45 CFR Part 146, 79 Fed. Reg. 59130, 59131 (Oct. 1, 2014).

6 *See* Amendments to Excepted Benefits, 26 CFR Part 54; 29 CFR Part 2590; 45 CFR Part 146, 79 Fed. Reg. 59130 (Oct. 1, 2014).

7 Code § 9831(a)(2), ERISA § 732(a), and PHSA § 2721(a) (prior to amendment by ACA).

8 *See, e.g.*, Treas. Reg. § 54.9831-1(c)(5)(ii).

8.1 *See* Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the PPACA, 26 CFR Parts 54 and 602; 29 CFR Part 2590; 45 CFR Part 147, 75 Fed. Reg. 34537, 34539 (June 17, 2010); FAQs About Affordable Care Act Implementation Part III, Q/A-1 (Oct. 12, 2010). *See also King v. Blue Cross and Blue Shield of Ill.*, 2017 WL 3928339 (9th Cir. 2017) (prohibition against lifetime dollar limits does not apply to retiree-only plans).

9 *See, e.g.*, *Carson v. Lake County, Ind.*, 2017 WL 3160702 (7th Cir. 2017) (court rejected age discrimination claims by rehired retirees whose reemployment was terminated to preserve the status of the employer's retiree health plan as a retiree-only excepted benefit and a secondary payer for MSP purposes).

B. Table: Federal Group Health Plan Mandates

This subsection provides an at-a-glance checklist of federal group health plan mandates that apply to self-insured health plans. See the subsections noted in the table for a discussion of each federal mandate.[9.1]

Federal Mandate	Applies to Self-Insured (Major Medical) Health Plans?	Manual Section
Preventive Health Services	Yes. ***Exceptions:*** (1) certain plans with fewer than two participants who are current employees; and (2) plans grandfathered under health care reform.	Subsection C.1
MHPAEA	Yes. ***Exceptions:*** (1) certain plans with fewer than 2 participants who are current employees; (2) plans that incur increased costs of at least 2% in the first year that compliance is required or at least 1% in any subsequent plan year; (3) self-insured non-federal governmental plans electing to opt out (special rules for plans that comply for one full plan year); and (4) plans maintained by employers with fewer than 50 employees in the previous year.	Subsection C.2
WHCRA	Yes. ***Exceptions:*** (1) certain plans with fewer than two participants who are current employees; and (2) self-insured non-federal governmental plans electing to opt out.	Subsection C.3
NMHPA	Yes. ***Exception:*** self-insured non-federal governmental plans electing to opt out.	Subsection C.4
Required Coverage for Certain Pediatric Vaccines	Yes, if plan covered pediatric vaccines as of May 1, 1993.	Subsection C.5
Clinical Trials	Yes. ***Exceptions:*** (1) certain plans with fewer than two participants who are current employees; and (2) plans grandfathered under health care reform.	Subsection C.6
Patient Protections (Original)	Yes. ***Exceptions:*** (1) certain plans with fewer than two participants who are current employees; and (2) plans grandfathered under health care reform.	Subsection C.7

Expanded Patient Protections Beginning in 2022. The Consolidated Appropriations Act, 2021 (CAA, 2021) adds new patient protection provisions addressing surprise medical billing for emergency and non-emergency services, surprise air ambulance billing, and continuity of care, effective for plan years beginning on or after January 1, 2022.* In addition, the CAA, 2021 transfers original patient protections (regarding choice of health care professional) to a new section of the PHSA and makes them applicable to grandfathered plans for plan years beginning on or after January 1, 2022. The new surprise medical billing for emergency and non-emergency services and surprise air ambulance billing provisions are also applicable to grandfathered plans.† The expanded patient protections are discussed in subsections C.8 (surprise medical billing for emergency and non-emergency services), C.9 (surprise air ambulance billing), and C.10 (continuity of care).

* Consolidated Appropriations Act, 2021 (CAA, 2021), Pub. L. No. 116-260, Division BB (2020).

† ACA § 1251(a)(5), 42 U.S.C. 18011(a)(5), as added by CAA, 2021, Pub. L. No. 116-260, Division BB, § 102(d)(2) (2020).

[9.1] The federal group health plan mandates generally apply to group health plans (a term explained in Section III), including self-insured group health plans. See Section III for a discussion of the opt-out election from certain mandates for non-federal governmental plans. See Section V for a discussion of grandfathered health plans. For a discussion of COBRA, see Section XIV; and for a discussion of HIPAA privacy, see Section XXXI. For a detailed discussion of these federal mandates, see *Group Health Plans: Federal Mandates Other Than COBRA & HIPAA* (Thomson Reuters/Tax & Accounting, 2002-present, updated quarterly).

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