ACA COMPLIANCE OVERVIEW

Health Plans Subject to the Affordable Care Act

The Affordable Care Act (ACA) made significant changes to the U.S. health care system, including health plan coverage requirements, patient protections and cost limitations. These changes generally apply to **group health plans and health insurance issuers offering group or individual health insurance coverage.**

However, certain categories of coverage—called "excepted benefits"—are not subject to some of the ACA's requirements, including the prohibition on annual limits and preventive care coverage requirement. Excepted benefits include, for example, health flexible spending accounts (FSAs), stand-alone vision and dental plans and disability plans.

Expatriate health plans and short-term limited duration insurance policies are also exempt from some of the ACA's reforms if they satisfy certain requirements.

LINKS AND RESOURCES

- On Oct. 1, 2014, the Departments of Labor (DOL), Health and Human Services (HHS) and Treasury (Departments) published final regulations on HIPAA excepted benefits.
- The Departments confirmed that plans with fewer than two participants who are current employees (including retiree-only plans) are exempt from the ACA's market reforms.
- On April 3, 2024, the Departments published final regulations on short-term, limited-duration insurance.

Overview

- In general, the ACA's market reforms apply to group health plans and health insurance issuers offering group or individual health insurance coverage.
- However, benefits that qualify as "excepted benefits" under HIPAA are not subject to the ACA's market reforms, including the prohibition on annual limits and preventive care coverage requirement.
- In addition, expatriate health plans that meet certain requirements are exempt from some of the ACA's provisions.

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ACA COMPLIANCE OVERVIEW

Group Health Plans and Health Insurance Issuers

In general, the ACA's market reforms apply to group health plans and health insurance issuers offering group or individual health insurance coverage.

Group Health Plan	Health Insurance Issuer	Health Insurance Coverage
Generally, a plan is a "**group health plan**" if it provides health care and is maintained by an employer. Most employer-provided group health arrangements (whether insured or self-funded) are group health plans for purposes of the ACA.	A "**health insurance issuer**" is an insurance company, insurance service or insurance organization—including a health maintenance organization (HMO)—that is licensed to engage in the insurance business in a state and is subject to state insurance law.	"**Health insurance coverage**" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.

Exemption for Group Health Plans with Fewer than Two Current Employees

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes an exemption for plans with fewer than two participants who are current employees (including retiree-only plans that cover fewer than two participants who are current employees). The Departments confirmed that this HIPAA provision also exempts these plans from the ACA's market reforms. Accordingly, group health plans that do not cover at least two employees who are current employees (such as retiree-only plans) are exempt from the ACA's market reforms.

Excepted Benefits

HIPAA established certain categories of "excepted benefits" that generally are not governed by the HIPAA portability regulations. Employee benefits that qualify as excepted benefits under HIPAA are also not subject to the ACA's market reforms, including the prohibition on annual limits and preventive care coverage requirement.

The current HIPAA regulations establish the following **four categories** of excepted benefits. The benefits in the first category are excepted in all circumstances. In contrast, the benefits in the second, third and fourth categories are excepted only if certain conditions are met.

1. Benefits that are Generally Not Health Coverage

The first category includes benefits that are generally not health coverage, such as:

- Coverage only for accident (including accidental death and dismemberment)
- Disability income coverage
- Liability insurance, including general liability insurance and automobile liability insurance
- Coverage issued as a supplement to liability insurance
- Workers' compensation or similar coverage
- Automobile medical payment insurance
- Credit-only insurance (for example, mortgage insurance)
- Coverage for on-site medical clinics
- Travel insurance

2. Limited Excepted Benefits

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

Limited-scope dental benefits are benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth). Limited-scope vision benefits are benefits substantially all of which are for treatment of the eye. These limited benefits qualify as excepted benefits only if they are either:

1. Provided under a separate policy, certificate or contract of insurance; or
2. 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 coverage may qualify under the second test. To satisfy the requirement that limited-scope vision or dental benefits cannot otherwise be "an integral part of the plan," (whether they are provided through the primary plan, separately or as the only coverage offered), either:

- Participants must be able to decline coverage; or
- Benefit claims must be administered under a contract separate from claims administration for any other benefits under the plan.

Health Flexible Spending Arrangements (FSAs)

Benefits provided under a health flexible spending arrangement (health FSA) may also qualify as limited excepted benefits if they satisfy the **availability** AND **maximum benefit** requirements, as follows.

- **Availability Requirement**—Other non-excepted group health plan coverage (for example, coverage under a major medical group health plan) must be made available for the year to the class of participants by reason of their employment.
- **Maximum Benefit Requirement**—The maximum benefit payable under the health FSA to any participant for a year cannot exceed the greater of:
    - Two times the participant's salary reduction election under the health FSA for the year; or
    - The amount of the participant's salary reduction election for the health FSA for the year, plus $500.

An FAQ clarified that unused carryover amounts remaining at the end of a plan year in a health FSA that satisfy the modified "use-or-lose" rule **should not be taken into account** when determining if the health FSA satisfies the "maximum benefit payable limit" prong under the excepted benefits regulations.

Employee Assistance Programs

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 (such as short-term substance use disorder or mental health counseling or referral services, as well as financial counseling and legal services). To the extent that an EAP provides benefits for medical care, it would generally be considered group health plan coverage, which would generally be subject to the HIPAA and ACA's market reform requirements, unless the EAP meets the criteria for being excepted benefits.

The Departments' final regulations from Oct. 1, 2014, recognize EAPs as a limited excepted benefit in certain circumstances. An EAP is an excepted benefit if four requirements are met:

- 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);
- The EAP's benefits are not coordinated with benefits under another group health plan. This requirement has two elements:
    - Participants in the separate 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
    - Participant eligibility for benefits under the EAP must not be dependent on participation in another group health plan;
- No employee premiums or contributions may be required to participate in the EAP; and
- The EAP does not impose any cost-sharing requirements.

Excepted Benefit HRAs

Effective for plan years beginning on or after Jan. 1, 2020, the Departments expanded the definition of limited excepted benefits to include a new type of health reimbursement arrangement (HRA). Employers offering traditional group health plan coverage may offer an excepted benefit HRA of up to $1,800 per year (indexed annually for inflation) to reimburse an employee for eligible medical care expenses, including premiums for:

- Individual health coverage that consists solely of excepted benefits (such as stand-alone vision and dental plans, accident-only coverage, workers' compensation coverage or disability coverage);
- Coverage under a group health plan that consists solely of excepted benefits;
- Short-term, limited-duration insurance plans; and
- COBRA coverage.

However, an excepted benefit HRA cannot reimburse premiums for individual health coverage, coverage under a group health plan (other than COBRA or other group continuation coverage), or Medicare parts B or D.

An excepted benefit HRA must be offered in conjunction with a traditional group health plan, although employees are not required to enroll in the traditional plan to use the excepted benefit HRA. Also, the excepted benefit HRA must be uniformly available to all similarly situated individuals (as defined under HIPAA).

3. Non-coordinated Excepted Benefits

The third category of excepted benefits, referred to as "non-coordinated 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. To qualify as excepted benefits, a hospital indemnity or other fixed indemnity insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness regardless of the amount of expense incurred.

To be exempt under the non-coordinated excepted benefits category, benefits must:

- Be provided under a separate policy, certificate or contract of insurance;

- Not contain any coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and
- Be paid with respect to an event, without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

4. Supplemental Excepted Benefits

The fourth category of excepted benefits is supplemental excepted benefits. These benefits must be supplemental to Medicare or CHAMPVA/TRICARE coverage (or similar coverage that is supplemental to coverage provided under a group health plan, known as "similar supplemental coverage") and provided under a separate policy, certificate or contract of insurance. To qualify as "similar supplemental coverage," the coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. Similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination of benefits provision.

In addition, final regulations from 2016 clarify that, supplemental health insurance coverage that provides benefits for items and services not covered by the primary coverage satisfies the requirement that the coverage be designed "to fill gaps in primary coverage," if none of the benefits provided by the supplemental policy are an essential health benefit (EHB) in the state in which the coverage is issued. Supplemental health insurance products that both fill in cost sharing in the primary coverage, such as coinsurance or deductibles, and cover additional categories of benefits that are not EHB, also are considered supplemental excepted benefits under the final rule, provided all other criteria are met.

Expatriate Health Plans

The Expatriate Health Coverage Clarification Act of 2014 (EHCCA) generally exempts expatriate health plans and expatriate health insurance issuers from the ACA. On June 10, 2016, the Departments issued proposed regulations to implement the rules for expatriate health plans under the EHCCA. These proposed regulations may be relied upon pending the applicability of final regulations.

To be considered an "expatriate health plan" for this purpose, substantially all of the primary enrollees must be "qualified expatriates" that fall into one of the following categories:

- **Employees in the United States—Individuals:**
  - Whose skills, qualifications, job duties or expertise caused his or her employer to temporarily transfer or assign him or her to the United States for a specific purpose or assignment;
  - Who are reasonably determined to require access to health insurance and other related services and support in multiple countries; and
  - Are offered other multinational benefits on a periodic basis (such as tax equalization or compensation for moving or travel expenses);
- **Employees outside of the United States**—Individuals who are working outside of the United States for a period of at least 180 days in a consecutive 12-month period that overlaps with the plan year; or
- **Employees of social welfare organizations**—Members of a group formed for the purpose of traveling or relocating internationally to perform certain non-profit social welfare service (or similarly situated organizations or groups, such as students or religious missionaries), if not formed primarily for the sale of health insurance coverage, and

HHS has determined requires access to health insurance and other related services and support in multiple countries.

In addition to covering qualified expatriates, to qualify for relief under the EHCCA, expatriate health plans must meet the following requirements:

- Provide coverage for inpatient hospital services, outpatient facility services, physician services and emergency services in countries where qualified expatriates work (in the case of employees transferred to the United States, in both the United States and the transferring country);
- Meet the ACA's "minimum value" standard (that is, the plan's share of total allowed costs of benefits provided under the plan is less than 60% of those costs and the plan includes substantial coverage of inpatient hospitalization and physician services);
- If the plan provides dependent coverage of children, make coverage available for adult children up to age 26;
- Ensure that insurers or administrators have international operations and experience; and
- Satisfy HIPAA portability provisions (such as special enrollment rights) in effect before the ACA's enactment.

In addition, the proposed regulations provide that the ACA's PCORI fee does not apply to an expatriate health plan. The ACA limits the application of the fee to policies issued to individuals residing in the United States and exclude coverage from the fee if the plan is designed specifically to cover primarily employees who are working and residing outside the United States. The proposed regulations expand this exclusion to also exclude an expatriate health plan—regardless of whether the plan provides coverage for qualified expatriates residing or working in or outside the United States—if the plan is an expatriate health plan.

However, the EHCCA's exemption for expatriate health plans does not apply for purposes of the ACA's employer shared responsibility rules and related reporting requirements under Internal Revenue Code (Code) Section 6055 and Section 6056.

Short-term, Limited-duration Insurance

Short-term, limited-duration insurance (STLDI) is a type of health insurance coverage that is designed to fill temporary gaps in coverage when an individual is transitioning from one plan or coverage to another plan or coverage. Although STLDI is not an excepted benefit, it is specifically exempt from the definition of "individual health insurance coverage" and, therefore, is not subject to the ACA's market reform requirements.

STLDI was defined as coverage with an initial contract period of less than 12 months and a maximum total duration of up to 36 months, which included renewals and extensions. Effective for coverage periods beginning on or after Sept. 1, 2024, a final rule limits the length of the initial contract period to no more than three months and the maximum coverage period to no more than four months, taking into account any renewals or extensions. However, on Aug. 7, 2025, the Departments announced they do not intend to prioritize enforcement actions related to the current regulatory definition of STLDI.