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New Proposed Regulations Address Wraparound Coverage

New proposed regulations, through a series of complicated requirements, would allow certain coverage that wraps around marketplace coverage to qualify as an excepted benefit. The pilot program would allow employers to supplement employees' marketplace coverage while preserving those participants' eligibility for marketplace premium tax subsidies.

Background

Certain benefits that are considered limited, or ancillary to comprehensive group health coverage, are not subject to HIPAA's portability and nondiscrimination requirements. These "excepted benefits" are also exempt from other requirements, such as the mental health parity rules, as well as the Affordable Care Act's (ACA) marketplace mandates and insurance reforms. Thus, designation as an excepted benefit meaningfully decreases the compliance burdens associated with providing the benefit. Commonly offered excepted benefits include limited-scope dental and vision benefits, long-term care benefits, and certain employee assistance programs (EAPs). For a discussion of the recent final regulations for those types of excepted benefits, see our October 8, 2014 *For Your Information*.

Some plan sponsors offer their employees robust benefit packages, but those benefits could require high employee contributions that are "unaffordable," as defined under the ACA, for low-wage workers. (For more information on the affordability test, please see our June 18, 2012 *For Your Information*.) After the ACA was enacted, some plan sponsors asked the Departments of Treasury, Labor, and Health and Human Services (departments) whether they could offer "wraparound coverage" as an excepted benefit to employees (1) for whom the employer's group health coverage that is otherwise offered to them (primary coverage) is unaffordable, and (2) who purchase coverage in the individual market, including through a Health Insurance Marketplace (marketplace). The idea behind this wraparound coverage would be to supplement the individual coverage so that the individual's total coverage would be comparable to coverage under the employer's primary plan. As an excepted benefit,

wraparound coverage would not bar the individual from marketplace premium tax credit eligibility, and the coverage would not be subject to the compliance burdens of the ACA's mandates and insurance reforms.

In response to plan sponsors' requests, in December 2013, the departments first proposed regulations addressing wraparound coverage as an excepted benefit. (See our December 24, 2013 *For Your Information*.)

New Proposed Rule Pilot Program

After considering comments on the 2013 proposed rule, on December 19, 2014, the departments proposed a pilot, time-limited program for wraparound coverage. This program would apply to coverage first offered no later than December 31, 2017 that ends on the later of (1) three years after the date the wraparound coverage is first offered, or (2) the termination date of the last collective bargaining agreement relating to the wraparound coverage. Comments on the proposed regulations were due by January 22.

Eligible Individual Health Insurance

"Eligible individual health insurance" is individual health insurance coverage, including marketplace coverage, that is not a grandfathered health plan or a transitional individual health insurance market plan, and does not consist solely of excepted benefits. A multi-state plan is a plan that the US Office of Personnel Management (OPM) has approved for participation on the marketplace. The purpose of multi-state plans is to increase competition among marketplace healthcare plans.

Requirements for Providing Wraparound Coverage as an Excepted Benefit

Under the new proposed regulations, limited benefits offered through a group health plan could wrap around either "eligible individual health insurance" or coverage under a multi-state plan. Wraparound coverage that satisfies the following conditions would be an excepted benefit:

The coverage provides meaningful benefits beyond cost sharing. For example, the coverage could provide for expanded in-network medical providers or benefits not covered by the individual coverage. An account-based reimbursement program or a coordination-of-benefits provision, however, would not be sufficient. The departments invited comments on possible safe harbors for standardizing the types of benefits that would meet this requirement.

The coverage is limited in amount. The annual cost of coverage per employee and dependents — including both employer and employee contributions toward coverage — could not exceed the maximum annual contribution for health FSAs, as indexed ($2,550 in 2015). The cost of coverage would be determined in the same manner as COBRA premiums.

The coverage meets certain nondiscrimination requirements. The coverage could not impose any pre-existing condition exclusions or discriminate against individuals in eligibility, benefits, or premiums based on any health factor. Neither the wraparound coverage nor any other group health plan coverage offered by the employer may discriminate in favor of highly compensated individuals.

Individuals eligible for the coverage cannot be enrolled in a health FSA.

A plan must comply with one of the following two alternative sets of standards for eligibility and benefits:

> **First alternative: Eligible individual health insurance for non-full-time employees and retirees.** This type of coverage must satisfy three standards:

(1) The employer offers its full-time employees coverage that (a) is substantially similar to coverage the employer would need to offer to avoid an assessable payment if the employer were subject to the employer shared responsibility requirements to at least 95% of full-time employees; (b) provides minimum value; and (c) is reasonably expected to be affordable.
(2) Eligibility is limited to employees who are not full-time (and their dependents) or retirees (and their dependents). For this purpose, "full time" would mean an employee who is reasonably expected to work at least 30 hours per week.
(3) Group health plan coverage other than excepted benefits must be offered to individuals eligible for the wraparound coverage. This means that only individuals eligible for other group health plan coverage could be eligible for the wraparound coverage.

> **Comment.** This alternative could be of interest to employers who want to provide alternative coverage to part-timers and/or early retirees. Employers are not subject to ACA assessments for part-time employees or early retirees who receive subsidized marketplace coverage.

Second Alternative: Multi-state plan coverage. For coverage that wraps around a multi-state plan, the following requirements must be met:

(1) The coverage must be designed and approved by OPM to provide benefits in conjunction with coverage under a multi-state plan.
(2) In the plan year beginning in 2014, the employer must have offered coverage substantially similar to coverage it would need to offer its full-time employees to avoid an assessable payment if subject to the employer shared responsibility requirements. The coverage must be affordable, provide minimum value, and be offered to substantially all full-time employees.
(3) For the duration of the pilot program, the employer's aggregate contributions for both primary and wraparound coverage are substantially similar to total contributions for coverage offered to full-time employees in 2014.

> **Comment:** This alternative can be offered to full-time employees and could be of interest to small employers (under 50 full-time employees) who want to offer wraparound coverage to full-time employees and who are not subject to the employer shared responsibility requirements and assessments.

Reporting

The proposed regulations include reporting requirements designed to determine compliance with the program, evaluate effectiveness of the program, and identify if the program contributes to erosion of employee coverage. A sponsor of a group health plan offering wraparound coverage would report to HHS, and a self-insured plan or health insurance issuer offering coverage that wraps around a multi-state plan would report to OPM. Guidance on the information to be reported and the form and manner of reporting is expected.

In Closing

The pilot program may be of interest to employers who wish to supplement their part-time employees' marketplace coverage by giving them access to high-level benefits without jeopardizing marketplace tax credit eligibility. However, given the complexity of the new proposed rules, it remains to be seen whether many employers are

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interested in offering these benefits. Employers should consider waiting until final regulations are issued before implementing a program.

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