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Final Regulations on Wraparound Coverage as an Excepted Benefit

Under a new pilot program, employers will be able to offer "wraparound coverage" that qualifies as an excepted benefit in specified circumstances. The coverage would wrap around individual marketplace coverage, and, as an excepted benefit, would not be subject to certain ACA requirements or jeopardize eligibility for marketplace premium tax subsidies. Employers might consider offering this additional benefit to part-time employees, retirees, and their dependents — but should be aware of the complicated requirements for doing so.

Background

HIPAA imposes portability and nondiscrimination requirements on group health plans. Certain types of benefits that are offered on a limited or ancillary basis, however, are exempt from HIPAA's compliance requirements. These "excepted benefits" are also exempt from other requirements, such as the Affordable Care Act's (ACA) market mandates and insurance reforms.

A number of plan sponsors asked the Departments of Treasury, Labor, and Health & Human Services (departments) whether they could offer "wraparound coverage" as an excepted benefit to part-time employees for whom the employer's primary group health coverage is unaffordable, and who purchase coverage in the individual market. The wraparound coverage would allow employers to supplement the individual market coverage, providing coverage comparable to the employer's primary plan. At the same time, as an excepted benefit, the wraparound coverage would not prevent the individual from obtaining a marketplace premium tax credit. In response to these requests, the departments released two sets of proposed regulations. (See our *For Your Information* publications from December 24, 2013 and January 26, 2015).

Final Regulations

After considering comments on the proposals, the departments recently issued final regulations allowing for wraparound coverage as an excepted benefit. The final regulations generally adopt the approach set out in the proposed rules, requiring coverage that wraps around eligible individual health insurance (including Basic Health Plan

coverage offered in some states to certain low-income individuals) to satisfy the following requirements to constitute an excepted benefit:

Cover Meaningful Benefits

The coverage must provide meaningful benefits beyond cost-sharing, and be a "risk-sharing product that covers a defined package of services." To meet this standard, the coverage cannot simply provide benefits only under a coordination of benefits provision or consist of an account-based reimbursement arrangement. The preamble to the final regulations cites the following examples of coverage that would satisfy this requirement: reimbursement for the full cost of primary care, ten physician visits per year, services that are out-of-network under the primary plan, access to onsite clinics at no cost, benefits targeted at a specific population (such as coverage for specific injuries), home health coverage, and coverage of other benefits that are not essential health benefits under the primary plan.

Limited in Amount

The annual per-employee cost (including both employer and employee contributions) of the wraparound coverage must be limited in amount. It cannot exceed the greater of (1) the maximum annual permitted salary reduction for a health flexible spending account (FSA), which is $2,550 in 2015, and (2) 15% of the cost of coverage under the employer's primary plan.

Nondiscrimination

The coverage may not impose any pre-existing condition exclusion or discriminate against individuals in eligibility, benefits, or premiums based on any health factor. Additionally, neither this coverage nor any other group health plan coverage offered by the employer may discriminate in favor of highly compensated individuals.

> **Comment**. Highlighting a comment that requested the "modernizing" of the rules prohibiting discrimination in favor of highly compensated individuals, the departments said they are considering this suggestion for future guidance.

Plan Eligibility

To be eligible for the wraparound coverage, an individual may not be enrolled in a health flexible spending account (FSA) qualified as an excepted benefit. Beyond that, the wraparound coverage is subject to the following conditions:

- The employer must offer its full-time employees minimum value medical coverage reasonably expected to be affordable and substantially similar to coverage it would need to offer to comply with employer shared responsibility requirements. If an employer does not have full-time employees, but the plan covers retirees or part-time employees, this requirement is considered to be met.

> **Comment.** Responding to comments questioning this requirement, the departments noted that they intend this wraparound coverage to allow employers to offer additional employees coverage comparable to that which the employer already offers — not as a substitute for an offer of primary coverage.

A health FSA is considered an excepted benefit if:

- The maximum benefit payable to a participant is no more than 2x the participant's salary reduction election, or, if greater, the participant's salary reduction election plus $500
- The employer also offers other, non-excepted health coverage (e.g., major medical coverage) to employees eligible for the health FSA

- Eligibility must be limited to non-full-time employees and retirees (and dependents of both groups). "Non-full-time" means working fewer than 30 hours per week, on average, as reasonably determined at the time of enrollment. If an employee later works 30 hours or more per week, however, the coverage can remain an excepted benefit, and the employee will still be eligible for premium tax credits for the rest of the plan year.
- The employer must offer individuals eligible for the wraparound coverage other group health coverage, not limited to excepted benefits — akin to the requirement for a health flexible spending account to be an excepted benefit.

For purposes of this wraparound coverage, "dependent" includes both spouse and children.

Reporting

Sponsors of group health plans (whether insured or self-insured) offering wraparound coverage will report to HHS.

Coverage that Wraps Around a Multi-State Plan

The final regulations also allow for coverage that wraps around multi-state plan (MSP) coverage — insured coverage that the US Office of Personnel Management (OPM) has approved for participation in the marketplace to increase competition among marketplace healthcare plans. Coverage that wraps around MSP coverage is subject to the same general requirements applicable to coverage that wraps around individual marketplace coverage, as well as some additional requirements, including review and approval by OPM. However, coverage that wraps around MSP coverage can also be offered to full-time employees and, therefore, may be useful for small employers not subject to ACA shared responsibility requirements.

Pilot Program

Under this pilot program, coverage must first be offered between than January 1, 2016 and December 31, 2018, and end on the later of (1) three years after the date first offered, or (2) the termination date of the last collective bargaining agreement relating to the wraparound coverage.

In Closing

The wraparound option may be of interest to employers looking to provide valuable benefits for part-time employees or retirees, and their dependents, without disqualifying them from claiming a marketplace premium tax credit. Employers wishing to pursue this option should be mindful, though, of the complicated requirements and restrictions governing this type of coverage.

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