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Proposed Rules Issued Regarding Wraparound Coverage

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On December 19, 2014, the Departments of Labor, the Internal Revenue Service and Health and Human Services issued a proposed rule that provides helpful guidance with respect to certain wraparound programs. The concept of the wraparound coverage excepted benefit was first introduced in a proposed rule issued December 24, 2013. According to the DOL, these proposed rules would give employees who otherwise may not be able to get generous employer-based benefits access to high level benefits and would give businesses, including small businesses, new flexibility to meet the unique needs of their workforce.

Background

As background, an employer cannot offer employees cash to reimburse the purchase of an individual policy, whether the employer treats the money as pre-tax or post-tax to the employee. Such arrangements are subject to the market reform provisions of the Affordable Care Act, including prohibition on annual limits and the requirement to provide certain preventive services without cost sharing with which it cannot comply. Such an arrangement may be subject to a $100/day excise tax per applicable employee (which is $36,500 per year, per employee).

Limited Wraparound Coverage

"Limited wraparound coverage" is limited benefits provided through a group health plan that wrap around either "eligible individual health insurance" or coverage under a Multi-State Plan. "Eligible individual health insurance" is individual health insurance coverage that is not a grandfathered health plan, not a transitional individual health insurance market plan, and does not consist solely of excepted benefits (which include certain dental and vision plans, health FSAs, and HRAs). To qualify as excepted benefits, the limited benefits must meet all of the following requirements:

1. **Cover additional benefits.** The limited wraparound coverage provides meaningful benefits beyond coverage of cost sharing under either the eligible individual health insurance or Multi-State Plan coverage. The wraparound coverage must not provide benefits only under a coordination-of-benefits provision and must not merely be an account-based reimbursement arrangement.

2. **Limited in amount.** The annual cost of coverage per employee (and any covered dependents) under the limited wraparound coverage does not exceed the indexed maximum annual salary reduction contributions toward health FSAs ($2,550 for 2015). For this purpose, the cost of coverage includes both employer and employee contributions towards coverage and is determined in the same manner as the applicable premium is calculated under a COBRA continuation provision.

3. **No discrimination.** The limited wraparound coverage (a) does not impose any preexisting condition exclusion; (b) does not discriminate against individuals in eligibility, benefits or premiums based on any health factor of an individual; and (c) does not, nor does any other group health plan coverage offered by the plan sponsor, discriminate in favor of highly compensated individuals.

4. **Plan eligibility.** Individuals eligible for the wraparound coverage cannot be enrolled in excepted benefit coverage that is a health FSA.

5. **Reporting.** The plan sponsor of a group health plan offering wraparound coverage must report to HHS, in a form and manner specified in guidance, information HHS reasonably requires.

When Can Limited Wraparound Coverage be Offered?

The provisions apply to limited wraparound coverage that is first offered no later than December 31, 2017 and that ends on the later of:

- The date that is three years after the date wraparound coverage is first offered; or

- The date on which the last collective bargaining agreement relating to the plan terminates after the date wraparound coverage is first offered (determined without regard to any extension agreed to after the date wraparound coverage is first offered).

Under What Circumstances can Limited Wraparound Coverage be Offered?

Wraparound benefits offered in conjunction with eligible individual health insurance must satisfy all of the following requirements:

- Eligibility for the wraparound coverage is limited to employees who are not full-time employees ("FTEs") and their dependents, including retirees and their dependents.

- For each year for which wraparound coverage is offered, the employer that is the sponsor of the plan offering wraparound coverage, or the employer participating in a plan offering wraparound coverage, offers to its FTEs coverage that is substantially similar to coverage that the employer would need to offer to its FTEs in order not to be subject to a potential assessable payment under the employer penalty, if such provisions were applicable; provides minimum value; and is reasonably expected to be affordable (applying the safe harbor rules). If a plan or issuer providing limited wraparound coverage takes reasonable steps to ensure that employers disclose to the plan or issuer necessary information regarding their coverage offered and affordability information, the plan or issuer is permitted to rely on reasonable representations by employers regarding this information, unless the plan or issuer has specific knowledge to the contrary.

- Other group health plan coverage, not limited to excepted benefits, is offered to the individuals eligible for the wraparound coverage. Only individuals eligible for the other group health plan coverage are eligible for the wraparound coverage.

Limited wraparound coverage offered in conjunction with Multi-State Plan coverage must satisfy all of the following conditions:

- The limited wraparound coverage is specifically designed and approved by the Office of Personnel Management ("OPM") to provide benefits in conjunction with coverage under a Multi-State Plan.

- The employer has offered coverage in the plan year that begins in 2014 that is substantially similar to coverage that the employer would need to have offered to its FTEs in order to not be subject to an assessable payment under the employer penalty provisions, if such provisions had been applicable.

- In the plan year that begins in 2014, the employer has offered coverage to a substantial portion of FTEs that provided minimum value and was affordable (applying the safe harbor rules).

- The employer's annual aggregate contributions for both primary and wraparound coverage are substantially the same as the employer's total contributions for coverage offered to FTEs in 2014.

- A self-funded plan, or a health insurance issuer, offering or proposing to offer Multi-State Plan wraparound coverage reports to the OPM, in a form and manner specified in guidance, information OPM reasonably requires to determine whether the plan or issuer qualifies to offer such coverage or complies with the applicable requirements.