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Introduction

On December 20th, the IRS, DOL and Health and Human Services (the "Agencies") issued a Notice of Proposed Rulemaking regarding certain types of "Excepted Benefits." The Agencies have invited comments on these proposed rules. Final guidance on these issues will be effective no earlier than January 1, 2015. Prior to that date, employers can rely on these proposed rules.

Excepted Benefits Under Consideration

The guidance explains that generally, there are four established categories of "excepted benefits" (those not subject to HIPAA or the ACA): benefits that are generally not health coverage (such as automobile insurance, workers compensation, AD&D, etc.), benefits that are "limited excepted benefits" including limited scope vision or dental benefits, "noncoordinated excepted benefits" which include indemnity plans, and supplemental excepted benefits, which are supplemental to Medicare, CHAMPVA, or Tricare. These proposed regulations ***only*** affect the second category of benefits: "limited excepted benefits."

Changes to Dental and Vision Plans

The proposed rules actually implement a very straightforward change that is aimed at correcting a discrepancy between how insured and self-funded plans are handled. Put simply, prior to these proposed rules, a self-funded limited dental or vision plan would only be considered to be an excepted benefit if they charged a premium contribution to employees, while a fully insured limited dental or vision plan could maintain its excepted status even when an employer covered the entire premium. The proposed rules no longer require self-funded limited dental and vision plans to charge an employee contribution solely to maintain its exempted status.

Wraparound Coverage

The second area addressed by the proposed rules deal with a new type of excepted benefit termed "Limited Wraparound Coverage." Limited Wraparound Coverage, as an excepted benefit, is intended to give plan sponsors, in a certain narrow range of circumstances, the ability to enhance employee's Exchange-based coverage.

In a rather lengthy discourse, the proposed rules explain that while the ACA requires individual and small group health plans to cover "Essential Health Benefits" ("EHB"), a list of ten categories of coverage, the actual EHB packages themselves will vary state to state, as each state has its own set of benchmark plans that actually defined EHB in that particular state. Further, because Exchange plans

might not offer the same level of coverage for benefits not on the EHB list as large group health plans (including self-funded group health plans) do, there could be a scenario where an employee opts out of employer coverage that is unaffordable, purchase subsidized coverage through the Exchange, and end up with coverage that is not as complete as the group plan was. The Wraparound Plan would solve this issue, as it could provide for coverage not offered by the Exchange plan, and could potentially broaden the selection of providers the employee has access to.

In order to qualify as an excepted benefit, the Wraparound Coverage has to meet five different criteria. Specifically, the Wraparound Coverage:

1) Can only "wrap around" certain health plans offered in the individual market,
2) Must be specifically designed to provide benefits beyond those offered by the individual health coverage its "wrapping around",
3) Cannot be an integral part of a group health plan,
4) Must be limited in amount, and
5) Cannot be discriminatory.

Individual Coverage Requirement

For Wraparound Coverage to maintain its excepted status under HIPAA and the ACA, it must only wrap around non-grandfathered individual health insurance, and that insurance plan cannot consist solely of excepted benefits. Conceptually, the Wraparound Coverage is supposed to "fill in the gaps" of coverage that meets the bare-bones requirement of the ACA, but isn't quite on par with more comprehensive major medical plans that are typically offered by an employer. This leads to the second requirement…

Going Beyond

Wraparound Coverage must be specifically designed to provide benefits beyond those offered by the individual coverage its "wrapped around." The rules put it this way: "Specifically, the limited wraparound coverage must provide either benefits that are in addition to EHBs, or reimburse the cost of health care providers considered out-of-network under the individual health insurance coverage, or both."

The rules also allow for the Wraparound Coverage to directly reimburse employees for their cost-sharing requirements under the Individual plan (such as deductibles, co-pays and coinsurance), but that cannot be the primary purpose of the Wraparound Coverage.[1]

Wraparound Coverage Cannot be the Primary Plan

The rules are clear that employers are still subject to their Shared Responsibility requirements – that is, to provide minimum value coverage that is affordable to their full-time employees, and this requirement backs that up by dictating that the Wraparound Coverage cannot be the employer's "primary" plan. Instead, the employer's minimum value coverage will be designated as the Primary Plan, and that coverage must be affordable to the majority of the employer's full-time employees.

This requirement gets to the core purpose for the Wraparound Coverage – the Agencies have received feedback from the public that there will be scenarios where employer coverage will be affordable to most, but not all, an employer's full-time employees. Importantly, the regulations acknowledge that in this scenario, the employer is still subject to the Shared Responsibility requirements which would mean that an employer in this scenario would be subject to a penalty for each employee that enrolls in subsidized coverage through the Exchange because the Primary Plan was unaffordable for that employee. The subsidized coverage may not be as comprehensive as the Primary Plan, and that's where the Wraparound Coverage comes into play – it allows the employer to offer a voluntary benefit that compliments the Exchange coverage in order for all full-time employees to enjoy the same level of comprehensive benefits, regardless of whether they're on the Primary Plan or on a plan offered by the Exchange.

Limited In Amount

As a protection against the Wraparound Coverage becoming the Primary Plan, the rules cap the allowable premium cost for the Wraparound Coverage to be no more than 15% of the cost of coverage under the Primary Plan. In this case, the rules are using the applicable COBRA premium to determine the amounts. For example, assume Individual coverage is $450 per month (which is typically split between the employer and the employee). The maximum amount the Wraparound Coverage can cost is 15% of $450, or $67.50 per month. By enforcing a low premium, the rules are in effect limiting the amount of coverage the Wraparound plan can provide.

[1] This would appear to eliminate the use of a Health Reimbursement Arrangement as Wraparound Coverage, a move consistent with the 2013 guidance in which the Agencies prohibited stand-alone HRAs.

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Nondiscrimination Requirements

Finally, Wraparound Coverage cannot be discriminatory in its benefits. For example, it cannot be priced based on individual health factors, and cannot impose any pre-existing condition exclusions. Further, the combination of the Primary Plan and the Wraparound Coverage cannot result in a plan that discriminates in favor of highly-compensated employees.

Purpose of the Wraparound Rules?

The Wraparound Coverage Rules apparently are a concession to Taft-Hartley/multi-employer plans, though their effectiveness at achieving the desired result – continued participation in the Taft-Hartley plan – is yet to be seen. Multiemployer plans face a problem of members exiting the plan and opting for Exchange coverage, and sponsors of multiemployer plans have been looking for ways to preserve their plans in light of this new market reality – this may be a step in that direction.

Employee Assistance Plans

Lastly, the proposed rules look at EAPs. Generally, EAPs have been considered to be group health plans when they offer benefits for medical care. This is problematic since, as health plans, they would be subject to the ACA's full set of requirements for group health plans, including the elimination of annual and lifetime limits on whichever essential health benefits the EAPs covered. EAPs by their very nature are low cost plans that aren't intended to be group health plans, and the application of the ACA's requirements would for all intents and purposes eliminate EAPs as a viable benefit.

Acknowledging that there is no consistent definition of EAPs, these rules set out four criteria for determining whether an EAP provides significant benefits in the nature of medical care. If they do, they are group health plans, but if they don't, they can still be considered to be excepted benefits. The four criteria are:

1) The EAP cannot provide significant benefits in the nature of medical care – though the Agencies requests help from the public defining "significant". They do provide an example: "For example, the Departments request comments as to whether a program that provides no more than 10 outpatient visits for mental health or substance use disorder counseling, an annual wellness checkup, immunizations, and diabetes counseling, with no inpatient care benefits, should be considered to provide significant benefits in the nature of medical care."
2) The EAP cannot be coordinated with benefits under another group health plan – in essence, the EAP must be a stand-alone program that doesn't require an employee to be enrolled in a group

health plan in order to be eligible for the EAP, nor can the EAP be financed through another group health plan.

3) Employees cannot be required to contribute towards the premium of the EAP in order to participate.
4) The employee cannot be subject to any cost sharing under the EAP – no deductibles, co-pays, etc.

EAPs that meet these guidelines will be considered to be excepted benefits and not subject to the ACA's group health plan requirements.

Conclusion

The proposed rules for the limited dental and vision plans as well as those for EAPs can be relied upon through at least 2014. The rules regarding Wraparound Coverage are effective for 2015 and beyond. It would not be surprising to see final versions of these rules issued in 2014, however in the case of the dental, vision and EAP rules, any final rules that are more restrictive would not be effective until January 1, 2015 at the earliest. The rules can be found at here.