SEYFARTH SHAW

Health Care Reform Management Alert Series

Agencies Issue Guidance on Wraparound Coverage and Supplemental Insurance Products as Excepted Benefits

Issue 91

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This is the ninety-first issue in our series of alerts for employers on selected topics in health care reform. (Click here to access our general summary of health care reform and other issues in this series). This series of Health Care Reform Management Alerts is designed to provide an in-depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.

As we've previously reported, the Affordable Care Act insurance market reforms (including, but not limited to, the adult child coverage mandate, the preventive service mandate, and the prohibitions on annual and lifetime dollar limits) do not apply to any coverage offerings that would constitute "excepted benefits." Moreover, "excepted benefits" do not constitute minimum essential coverage under the individual mandate; meaning an employee who enrolls in such coverage will not be rendered ineligible for a premium subsidy on the Health Insurance Marketplaces. The IRS, DOL and HHS (collectively, the "agencies") have gradually, but cautiously, expanded the list of "excepted benefits" in an effort to preserve the reach of the insurance market reforms without inadvertently rendering enrolled individuals ineligible for premium subsidies. Recent guidance provides additional clarification on two forms of "excepted benefits" -- supplemental insurance coverage and limited wraparound coverage.

Supplemental Insurance Coverage

HIPAA created a category of excepted benefits that would include supplemental insurance coverage intended to complement and enhance underlying group health coverage. To qualify, the coverage must meet the following requirements:

- The policy, certificate, or contract of insurance must be issued by an entity that does not provide the primary coverage under the plan;
- The supplemental policy, certificate, or contract of insurance must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles;
- The cost of the supplemental coverage may not exceed 15 percent of the cost of primary coverage; and

- Supplemental coverage sold in the group insurance market must not differentiate among individuals in eligibility, benefits, or premiums based upon any health factor of the individual (or any dependents of the individual).

The agencies issued FAQs in February intended to clarify the scope of this category of excepted benefits. Specifically, the agencies are concerned about products that offer additional benefits rather than just provide cost-sharing for benefits covered under the primary insurance policy/plan. The agencies intend to issue regulations to clarify that this excepted benefit category only includes policies covering additional benefits (i.e., those not covered under the primary insurance plan/policy) if the additional benefits are not essential health benefits (EHBs) in the state where the policy is marketed. If any of the additional covered benefits are EHBs, then the supplemental insurance policy would instead be considered a group health plan rendering it subject to the ACA's insurance market reforms.

Plan sponsors should proceed with caution in light of this new guidance, especially with respect to supplemental executive insurance policies, many of which are marketed as meeting the definition of excepted benefits but cover EHBs not covered under the core medical insurance offering.

Limited Wraparound Coverage

On March 18th, the agencies issued final rules regarding a new form of supplemental coverage that would not impact the participating employee's eligibility for a premium tax credit, known as "limited wraparound coverage." Wraparound coverage could be offered by an employer to its part-time employees, retirees, and certain full-time employees (within the limits outlined below). The agencies view wraparound coverage as additional coverage an employer would offer to members of its workforce who are not eligible for the employer's affordable, minimum value coverage (e.g., non-full time employees). This coverage would "wrap" around a primary/core coverage offering, which could be an individual insurance policy, including but not limited to a Marketplace offering and/or a multistate plan option. Of course, premium tax credits are only available to individuals enrolling in Marketplace coverage, multistate coverage, or in a "basic health plan," (a new concept within the ACA that is, to a certain extent, a hybrid between Medicaid and an individual insurance policy).

The wraparound coverage must also meet the following requirements, otherwise the coverage could potentially render the participating employee ineligible for premium tax credits:

1. Meaningful additional benefits

The wraparound coverage must include meaningful benefits beyond cost-sharing. For example, the coverage could offer an expanded provider network or benefits not covered under the primary plan, prescription drugs not on the formulary of the primary plan, ten physician visits per year, services considered to be out-of-network under the primary plan, access to onsite clinics or specific health facilities at no cost, or benefits targeted to a specific population (such as coverage for certain orthopedic injuries). The wraparound coverage cannot be limited to reimbursement for cost-sharing incurred under the individual insurance policy.

2. Limited cost

The value of the coverage (determined on an annual, aggregate, actuarial basis in advance of the plan year) cannot exceed the greater of (a) the inflation-adjusted limits for employee contributions to a health flexible spending account ($2,550 for 2015), or (b) 15% of the cost of the primary coverage (determined in a manner similar to COBRA). This limit applies regardless of whether the coverage is offered at a single or family level.

3. Nondiscrimination

The coverage cannot discriminate in favor of highly compensated employees or against employees based on health status.

4. Eligibility

Wraparound coverage must comply with the following eligibility standards:

- *No Health FSA Coverage*. Individuals eligible for wraparound coverage cannot be enrolled in health FSA coverage. The agencies are concerned that employers would cobble together multiple excepted benefits arrangements to substitute for a primary group health plan, yet still be exempt from the market reforms.
- *Individual Coverage Wrapper*. Eligibility for coverage intended to wrap around an individual policy must be limited to part-time employees (those expected to average less than 30 hours per week) or retirees, and their spouses and dependent children. These individuals must also be eligible for other group health plan coverage sponsored by the employer that does not consist solely of excepted benefits. Also, the employer sponsoring or participating in the wraparound coverage must generally offer its full-time employees coverage sufficient to avoid penalties under the employer mandate, regardless of whether the mandate applies to the employer (for instance, because it is a small employer).
- *Multistate Plan Coverage Wrapper*. Wraparound coverage designed to wrap around a multistate plan must be reviewed and approved by the Office of Personnel Management (OPM) (a Federal governmental agency). A "multistate plan" is a fully-insured offering on the health insurance marketplaces that is featured on the marketplaces of multiple states. OPM will look to the following criteria for purposes of determining whether to approve the plan:
    - The employer offering the wraparound coverage must have offered full-time employees coverage that is substantially similar to coverage the employer would have to offer to avoid the "big penalty" under the employer mandate and must also have offered affordable, minimum value coverage to a "substantial portion" of its full-time employees during the either the 2013 or 2014 plan year (the base year). So under this alternative, certain full-time employees could still participate in the wraparound coverage, if the employer's core coverage offering was unaffordable.
    - The employer must maintain its pre-2015 coverage spend. In other words, the employer's annual aggregate contributions for both primary (core medical) and wraparound coverage in 2015 and beyond must remain substantially the same or greater than the employer's total contributions for coverage offered to full-time employees in the base year. The employer's contribution will be considered to be "substantially the same" if contributions were at least 80% of the level made in the base year, applied on an average, full-time worker basis.

5. Reporting

Employers offering either type of wraparound coverage must report certain elements relating to the coverage to HHS. HHS will use the information to determine whether the availability of the wraparound coverage option encourages abusive practices.

Limited wraparound coverage will be available for a limited time under a *Pilot Program*. To take advantage of the excepted benefit program, limited wraparound coverage must be first offered no earlier than January 1, 2016 and no later than December 31, 2018. The pilot program will end on the later of, three years after the coverage is first offered, or the date on which the last collective bargaining agreement relating to the coverage terminates.

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