Segal Consulting

update

Compliance News for Multiemployer Plans

June 4, 2015

Final Rule on Limited Wraparound Coverage Under the Affordable Care Act

The final rule on wraparound coverage under the Affordable Care Act[1] issued by the Departments of Treasury, Labor, and Health and Human Services (collectively, the "Departments" responsible for implementing the law) allows plan sponsors to provide limited benefits that supplement (or "wrap around") coverage obtained through certain individual health insurance policies.[2] The final rule describes two kinds of limited wraparound benefits: those available only to part-time employees or pre-Medicare eligible retirees enrolled in individual health insurance policies (such as a plan available through a Marketplace[3]) and those that can be used to supplement multi-state plans offered through the public Marketplace.[4] Such limited "wraparound" benefits are considered "excepted benefits," which means they are not be subject to the Affordable Care Act's group health plan mandates, such as the prohibition on annual dollar limits.

This *Update* discusses limited wraparound coverage. It concludes with a section on the implications for plan sponsors.

Limited Wraparound Coverage Is a Pilot Project

Plan sponsors may only provide limited wraparound benefits under a pilot program, with a sunset date. The limited wraparound coverage must first be offered between January 1, 2016 and December 31, 2018,[5] and must end on the later of the following dates:

- Three years after the date wraparound coverage is first offered; or
- When the last collective bargaining agreement (CBA) relating to the plan, if applicable, terminates after the date wraparound coverage is first offered (determined without regard to any CBA extension agreed to after the date wraparound coverage is first offered).

Health Compliance News:

NEW! On June 25, 2018, the Centers for Medicare & Medicaid Services released a form that sponsors of limited wraparound coverage can use for the reporting that's required in order for the coverage to qualify as an excepted benefit.

[1] The Affordable Care Act is the shorthand name for the Patient Protection and Affordable Care Act (PPACA), Public Law No. 111-48, as modified by the subsequently enacted Health Care and Education Reconciliation Act (HCERA), Public Law No. 111-152.

[2] The final rule was published in the March 18, 2015 *Federal Register*.

[3] "Marketplace" is the federal government's term for what the Affordable Care Act refers to as an "Exchange."

[4] A multi-state plan is a special type of Marketplace plan that insurers offer under contract with the U.S. Office of Personnel Management (OPM).

[5] This is one year later than the Departments had put forth in a proposed rule published last December, which gives plan sponsors more time to design and implement a limited wraparound benefit.

Requirements for any Limited Wraparound Coverage

Either type of limited wraparound benefits must meet the following requirements:

- It must provide "meaningful benefits" beyond coverage of participant cost sharing. The coverage cannot provide benefits only under a coordination-of-benefits provision, and cannot be an account-based reimbursement arrangement, such as a health reimbursement arrangement (HRA). It could provide coverage for health benefits that are not covered under the eligible individual insurance, such as non-formulary drugs.
- The annual cost of coverage per employee (and any covered dependents) may not exceed the greater of the maximum annual salary-reduction contribution toward a health flexible spending arrangement (FSA), which is $2,550 for 2015 (indexed annually) or 15 percent of the cost of coverage under the "primary plan," a term not defined in the final rule but which the Departments are expected to clarify.
- The coverage may not discriminate based on a health risk factor, may not impose any preexisting condition exclusion, and may not discriminate in favor of highly compensated individuals.
- Individuals eligible for limited wraparound coverage cannot be enrolled in a health FSA.

Specific Rules for Limited Wraparound Coverage for Part-Time Employees or Retirees

This type of limited wraparound coverage can only be offered to employees who are *not* full-time employees (and their dependents) or to pre-Medicare retirees (and their dependents). Full-time employees are those who are reasonably expected to work for one employer for at least an average of 30 hours per week. These rules do not affect Medicare-eligible retirees who are already permitted to purchase Medicare supplemental coverage policies.

Limited wraparound coverage for part-time employees or retirees must satisfy the following conditions:

- It must wrap around "eligible individual health insurance," which is a non-grandfathered individual plan, such as one available through a Marketplace.
- For each year for which wraparound coverage is offered, an employer that participates in a multiemployer plan that offers a wraparound plan must offer affordable, minimum value coverage (*i.e.*, provides at least 60 percent actuarial value) to 95 percent of its **full-time employees**, bargained or not. Multiemployer plans offering a wraparound benefit that do not have information on the coverage offered by contributing employers to their full-time employees may rely on reasonable representations by employers about this information, unless the plan has specific knowledge to the contrary.
- The plan sponsor must simultaneously offer to wrap-eligible employees or retirees other group health coverage, not limited to excepted benefits. This other coverage should be designed so that it does not disqualify wrap-eligible employees from receiving a premium assistance tax credit if they would otherwise qualify for one when they buy Marketplace coverage.

Requirements for Limited Wraparound Coverage for Full-Time Employees

Somewhat different rules apply to plans that provide wrap benefits to full-time employees (or to part-time employees or retirees) enrolled in a multi-state plan. Certain requirements are specific to the multi-state wrap, including:

- The wrap benefit must be reviewed and approved by the United States Office of Personnel Management.
- The employer must have offered affordable, minimum value coverage to a substantial portion of its full-time employees in the plan year beginning in 2013 or 2014, and must meet certain requirements regarding the minimum contribution toward coverage for the duration of the pilot program.

The requirement to offer *other* group coverage (discussed in the previous section) does not apply.

Implications for Plan Sponsors

Receiving wraparound coverage would not disqualify an employee or retiree from enrolling in a Marketplace plan and receiving a premium assistance tax credit. As a result, the limited wraparound benefit for non-full-time employees may open a new possibility for multiemployer plans with a significant number of low-wage part-time and seasonal workers, or pre-Medicare retirees.

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If you would like additional information about this news, please contact your Segal consultant or the Segal office nearest you. Segal Consulting can be retained to work with plan sponsors and their fund counsel on compliance issues.

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