

 WHAT YOU NEED TO KNOW

Wraparound Excepted Benefits: Two Pilot Programs

Health plan sponsors are permitted to offer wraparound coverage to employees purchasing individual health insurance in the private market, including the Marketplace, in limited circumstances, under a [Final Rule](#) issued by the U.S. Department of Labor (DOL) and other federal agencies. The Final Rule, published March 18, 2015, sets forth two narrow pilot programs for the limited wraparound coverage. One pilot program allows wraparound benefits only for multi-state plans (MSPs) in the Health Insurance Marketplace. The second pilot program allows wraparound benefits for part-time workers who enroll in an individual policy or in Basic Health Plan (BHP) coverage for low-income individuals, which was established under the Patient Protection and Affordable Care Act (ACA). The wraparound coverage would be an excepted benefit. Excepted benefits are generally exempt from certain requirements of federal laws, including ERISA, the Internal Revenue Code, and parts of the ACA.

General requirements. To be allowable by either pilot program, the wraparound coverage must be specifically designed to provide meaningful benefits such as: (1) coverage for expanded in-network medical clinics or providers; (2) reimbursement for the full cost of primary care; or (3) coverage of the cost of prescription drugs not on the formulary of the primary plan. The limited wraparound coverage must not provide benefits only under a coordination-of-benefits provision and must not consist of account-based reimbursement arrangements.

The annual cost of coverage per employee (and any covered dependent, defined as any individual who is or may become eligible for coverage under terms of a group health plan because of a relationship to a participant) must not exceed the greater of: (1) the maximum permitted annual salary reduction contribution toward health flexible spending arrangements (FSAs) (\$2,650 for 2018); or (2) 15 percent of the cost of coverage under the primary plan, including both employer and employee contributions toward coverage. The wraparound coverage is also subject to non-discrimination rules that prohibit preexisting condition exclusions, favoring of highly compensated individuals, and discrimination based on health status.

MSP coverage standards. Under the MSP pilot program, which provides for limited coverage that wraps around MSPs, the coverage must be reviewed (but not designed by) and approved by the Office of Personnel Management (OPM), which also has authority to revoke the approval of the wraparound plan. Limited wraparound coverage offered in conjunction with MSPs is intended to be offered by employers that were offering reasonably comprehensive coverage prior to the Final Rule, and wish to offer limited wraparound coverage while still contributing roughly the same total toward their employees' health benefits.

To qualify, the employer must have offered coverage (in a plan that began in either 2013 or 2014) that is substantially similar to the coverage that the employer would have had to offer to its full-time employees in order to avoid play-or-pay shared responsibility penalties. The employer's aggregate annual contributions for both primary and limited wraparound coverage must be substantially similar aggregate contributions for coverage offered to full time employees in 2014. This condition will be met if contributions are at least 80 percent of contributions made in 2013 or 2014, applied on an average, full-time worker basis.

Part-time employee standards. To offer the individual health insurance wraparound option, an employer must offer group health insurance coverage that is not limited to excepted benefits and provides minimum value to the class of participants offered the wraparound coverage by reason of their employment. For practical purposes, this means that the limited wraparound coverage can only be offered to part-time employees that are eligible for group coverage from their employer, but instead have purchased individual insurance. The benefits must wrap around eligible individual health insurance (or a BHP). Eligible individual health insurance cannot be grandfathered, cannot be a transitional individual health insurance plan, and cannot be composed solely of excepted benefits.

The employer must be simultaneously satisfying the employer shared responsibility provisions under the ACA in relation to its full-time employees. The Final Rule is clear that the excepted benefits are intended to offer additional workers health coverage comparable to what is already offered, rather than serve as a substitute for primary coverage. These benefits are limited to part-time employees and their dependents, or retired part-time employees and their dependents. Dependents may include spouses to the extent they are eligible for coverage under the terms of the coverage.

Reporting. Limited wraparound coverage qualification as an excepted benefit is also contingent upon reporting requirements for group health plans and group health insurance issuers as well as group health plan sponsors. A self-insured group health plan, or a health insurance issuer offering or proposing to offer MSP wraparound coverage would report the information the OPM deems reasonable to determine whether the plan or issuer qualifies for such coverage or complies with applicable requirements.

Plan sponsors of any group health plan offering any type of limited wraparound coverage would report to the Department of Health and Human Services (HHS) information necessary to determine whether the exception for limited wraparound coverage is allowing plan sponsors to provide workers with comparable benefits whether enrolled in minimum essential coverage under a group health plan offered by the plan sponsor, or enrolled in eligible individual insurance, BHP coverage, or MSP coverage, with additional limited wraparound coverage offered by the plan sponsor, without causing an "erosion of coverage."

In December 2017, the Centers for Medicare and Medicaid Services (CMS) issued a [notice](#) for comments on the pilot program's possible extension and on a proposed reporting form.

On June 25, 2018, the CMS published its [Reporting Form for Plan Sponsors Offering Limited Wraparound Coverage](#). A plan sponsor of limited wraparound coverage must file the form once, within 60 days of the form's publication (by August 24, 2018), or 60 days after the first day of the first plan year that limited wraparound coverage is first offered.

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Dates. To participate in one of the two pilot programs, the wraparound coverage must be offered no earlier than January 1, 2016, and no later than December 31, 2018. The program ends on the later of: (1) the date that is three years after the wraparound coverage is first offered; or (2) the date on which the last collective bargaining agreement relating to the plan terminates after the date the wraparound coverage is first offered.

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