Flexibility for Employers in Building Benefit Plans

New DOL 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. Limited wraparound coverage can be provided to help employees who have qualifying individual coverage.

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” is limited benefits provided through a group health plan that wrap around either “eligible individual health insurance”. “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. 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.

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.

While this is still a grey and developing situation, it is clear that employers are beginning to find alternatives to offering traditional group medical insurance and the IRS and DOL are keeping a close eye on how employers are handling the transition. This will not be the last time we address this issue in 2015.

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