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DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

[TD 9714]

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DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

RIN 1210-AB70

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 146

[CMS-9946-F2]

RIN 0938-AS52

Amendments to Excepted Benefits

AGENCIES: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Final rules.

SUMMARY: This document contains final regulations that amend the regulations regarding excepted benefits under the Employee Retirement Income Security Act of 1974, the Internal

Revenue Code, and the Public Health Service Act to specify requirements for limited wraparound coverage to qualify as an excepted benefit. Excepted benefits are generally exempt from the requirements that were added to those laws by the Health Insurance Portability and Accountability Act and the Affordable Care Act.

DATES: These final regulations are effective on **[INSERT DATE 60 DAYS AFTER PUBLICATION IN THE FEDERAL REGISTER]**.

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Customer Service Information**:** Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws, may call the EBSA Toll-Free Hotline at 1-866-444-EBSA (3272) or visit the Department of Labor's website (http://www.dol.gov/ebsa). In addition, information from HHS on private health insurance for consumers can be found on the Centers for Medicare & Medicaid Services (CMS) website (www.cms.gov/cciio) and information on health reform can be found at www.HealthCare.gov.

SUPPLEMENTARY INFORMATION:

I. Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, 110 Stat. 1936 added title XXVII of the Public Health Service Act (PHS Act), part 7 of the Employee Retirement Income Security Act of 1974 (ERISA), and chapter 100 of the Internal Revenue Code (the Code), providing portability and nondiscrimination provisions with respect to

health coverage. These provisions of the PHS Act, ERISA, and the Code were later augmented by other consumer protection laws, including the Mental Health Parity Act of 1996,[1] the Mental Health Parity and Addiction Equity Act of 2008,[2] the Newborns' and Mothers' Health Protection Act,[3] the Women's Health and Cancer Rights Act,[4] the Genetic Information Nondiscrimination Act of 2008,[5] the Children's Health Insurance Program Reauthorization Act of 2009,[6] Michelle's Law,[7] and the Affordable Care Act.[8]

The Affordable Care Act reorganizes, amends, and adds to the provisions of part A of title XXVII of the PHS Act relating to group health plans and health insurance issuers in the group and individual markets. The term "group health plan" includes both insured and self-insured group health plans.[9] Section 715(a)(1) of ERISA and section 9815(a)(1) of the Code, as added by the Affordable Care Act, incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by these references are sections 2701 through 2728.

Sections 2722 and 2763 of the PHS Act, section 732 of ERISA, and section 9831 of the Code provide that the requirements of title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, respectively, generally do not apply to excepted benefits. Excepted benefits are described in section 2791 of the PHS Act, section 733 of ERISA, and section 9832 of the Code.

[1] Pub. L. 104-204, 110 Stat. 2944 (September 26, 1996).
[2] Pub. L. 110-343, 122 Stat. 3881 (October 3, 2008).
[3] Pub. L. 104-204, 110 Stat. 2935 (September 26, 1996).
[4] Pub. L. 105-277, 112 Stat. 2681-436 (October 21, 1998).
[5] Pub. L. 110-233, 122 Stat. 881 (May 21, 2008).
[6] Pub. L. 111-3, 123 Stat. 65 (February 4, 2009).
[7] Pub. L. 110-381, 122 Stat. 4081 (October 9, 2008).
[8] The Patient Protection and Affordable Care Act, Public Law 111-148, was enacted on March 23, 2010, and the Health Care and Education Reconciliation Act, Public Law 111-152, was enacted on March 30, 2010. (These statutes are collectively known as the "Affordable Care Act".)
[9] The term "group health plan" is used in title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, and is distinct from the term "health plan," as used in other provisions of title I of the Affordable Care Act. The term "health plan" does not include self-insured group health plans.

The parallel statutory provisions establish four categories of excepted benefits. The first category includes benefits that are generally not health coverage[10] (such as automobile insurance, liability insurance, workers compensation, and accidental death and dismemberment coverage). The benefits in this category are excepted in all circumstances. In contrast, the benefits in the second, third, and fourth categories are types of health coverage but are excepted only if certain conditions are met.

The second category of excepted benefits is limited excepted benefits, which may include limited scope vision or dental benefits, and benefits for long-term care, nursing home care, home health care, or community based care. Section 2791(c)(2)(C) of the PHS Act, section 733(c)(2)(C) of ERISA, and section 9832(c)(2)(C) of the Code authorize the Secretaries of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Secretaries) to issue regulations establishing other, similar limited benefits as excepted benefits. The Secretaries exercised this authority previously with respect to certain health flexible spending arrangements (health FSAs).[11] To be excepted under this second category, the statute (specifically, ERISA section 732(c)(1), PHS Act section 2722(c)(1), and Code section 9831(c)(1)) provides that limited benefits must either: (1) be provided under a separate policy, certificate, or contract of insurance; or (2) otherwise not be an integral part of a group health plan, whether insured or self-insured.[12]

The third category of excepted benefits, referred to as "noncoordinated excepted benefits," includes both coverage for only a specified disease or illness (such as cancer-only policies), and hospital indemnity or other fixed indemnity insurance. In the group market, these

[10] See 62 FR 16894, 16903 (Apr. 8, 1997), which states that these benefits are generally not health insurance coverage.
[11] 26 CFR 54.9831-1(c)(3)(v); 29 CFR 2590.732(c)(3)(v); 45 CFR 146.145(b)(3)(v).
[12] See the discussion in the 2014 final regulations concerning the application of these requirements to benefits such as limited-scope dental and vision benefits and employee assistance programs at 79 FR 59131 (Oct. 1, 2014).

benefits are excepted only if all of the following conditions are met: (1) the benefits are provided under a separate policy, certificate, or contract of insurance; (2) there is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and (3) the benefits are paid with respect to any event without regard to whether benefits are provided under any group health plan maintained by the same plan sponsor.[13]

The fourth category of excepted benefits is supplemental excepted benefits.[14] Such benefits must be: (1) coverage supplemental to Medicare, coverage supplemental to the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) or to Tricare, or similar coverage that is supplemental to coverage provided under a group health plan; and (2) provided under a separate policy, certificate, or contract of insurance.[15]

In 2004, the Departments of the Treasury, Labor, and HHS published final regulations with respect to excepted benefits (the HIPAA regulations).[16] (Subsequent references to the "Departments" include all three Departments, unless the headings or context indicate otherwise.)

On December 24, 2013, the Departments published additional proposed regulations with respect to the second category of excepted benefits, limited excepted benefits (2013 proposed

[13] 26 CFR 54.9831-1(c)(4); 29 CFR 2590.732(c)(4); 45 CFR 146.145(b)(4). See also Q7 in Affordable Care Act Implementation FAQs Part XI, available at http://www.dol.gov/ebsa/faqs/faq-aca11.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html.

[14] On February 13, 2015, the Departments issued guidance to clarify whether insurance coverage that supplements group health coverage by providing additional categories of benefits (and does not also fill gaps in group health plan coverage for cost-sharing obligations, such as coinsurance or deductibles) can be characterized as an excepted benefit. See Affordable Care Act Implementation FAQs Part XXIII, available at http://www.dol.gov/ebsa/faqs/faq-aca23.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Supplmental-FAQ_2-13-15-final.pdf.

[15] 26 CFR 54.9831-1(c)(5); 29 CFR 2590.732(c)(5); 45 CFR 146.145(b)(5). The Departments issued additional guidance regarding supplemental health insurance coverage as excepted benefits. See EBSA Field Assistance Bulletin No. 2007-04 (available at http://www.dol.gov/ebsa/pdf/fab2007-4.pdf); CMS Insurance Standards Bulletin 08-01 (available at http://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa_08_01_508.pdf); and IRS Notice 2008-23 (available at http://www.irs.gov/irb/2008-07_IRB/ar09.html).

[16] 69 FR 78720 (Dec. 30, 2004).

regulations).[17] The 2013 proposed regulations proposed to: (1) eliminate the requirement that participants in self-insured plans pay an additional premium or contribution for limited-scope vision or dental benefits to qualify as benefits that are not an integral part of the plan; (2) set forth the criteria under which employee assistance programs (EAPs) that do not provide significant benefits in the nature of medical care constitute excepted benefits; and (3) allow plan sponsors in certain limited circumstances to offer, as excepted benefits, coverage that wraps around certain individual health insurance coverage. The intent of limited wraparound coverage is to permit employers to provide certain employees, dependents, and retirees who are enrolled in some type of individual market coverage with overall coverage that is generally comparable to the coverage provided under the employers' group health plan, without eroding employer-sponsored coverage.

After consideration of comments received on the 2013 proposed regulations, the Departments published final regulations regarding dental and vision benefits and EAP benefits on October 1, 2014 (2014 final regulations).[18] In the 2014 final regulations, the Departments also stated their intent to publish regulations that addressed limited wraparound coverage in the future, taking into account the extensive comments received on this issue.[19] After consideration of comments on the 2013 proposed regulations, on December 23, 2014, the Departments published new proposed regulations with respect to limited wraparound coverage (2014 proposed regulations), which set forth five requirements under which limited benefits provided through a group health plan that wrap around either eligible individual insurance or coverage under a Multi-State Plan would constitute excepted benefits.[20] A description of the 2014

[17] 78 FR 77632.(Dec. 23, 2014).
[18] 79 FR 59131 (Oct. 1, 2014).
[19] 79 FR 59131 (Oct. 1, 2014).
[20] 79 FR 76931 (Dec. 23, 2014).

proposed regulations is set forth below, together with a summary of the comments received on the 2014 proposed regulations and an overview of these final regulations.

II. Overview of the Final Regulations

Under the 2014 proposed regulations, limited benefits provided through a group health plan that wrap around either (1) eligible individual health insurance, or (2) coverage under a Multi-State Plan (collectively referred to as "limited wraparound coverage") could constitute excepted benefits, if five requirements were met. For this purpose, the 2014 proposed regulations defined "eligible individual health insurance" as individual health insurance coverage that is not a grandfathered health plan,[21] not a transitional individual health insurance market plan,[22] and does not consist solely of excepted benefits. The preamble to the 2014 proposed regulations acknowledged that, in States that elect to establish a Basic Health Program (BHP), certain low-income individuals (for example, those with household income between 133 percent and 200 percent of the Federal poverty level) who would otherwise qualify for a tax credit to obtain a qualified health plan through an Exchange would instead be enrolled in coverage through the BHP. The Departments invited comments on how an employer might make wraparound coverage available to BHP enrollees.[23]

Comments addressing the BHP all supported permitting wraparound of BHP coverage. The Departments agree and, therefore, these final regulations permit limited wraparound coverage of BHP coverage in the same manner as limited wraparound coverage of eligible individual health insurance.

A. Covers additional benefits

[21] See section 1251 of the Affordable Care Act, 29 CFR 2590.715-1251, and 45 CFR 147.140.
[22] As described in CMS Insurance Standards Bulletin (March 5, 2014) available at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf.
[23] 79 FR 76935, footnote 32.

The 2014 proposed regulations stated that limited wraparound coverage would have to be specifically designed to wrap around eligible individual health insurance or Multi-State Plan coverage. That is, the limited wraparound coverage would have to provide meaningful benefits beyond coverage of cost sharing under the eligible individual health insurance or Multi-State Plan coverage. The preamble to the 2014 proposed regulations provided examples, such as that limited wraparound coverage could provide coverage for expanded in-network medical clinics or providers, or provide benefits that are not essential health benefits (EHBs) and that are not covered under the eligible individual health insurance.[24] The preamble to the 2014 proposed regulations also provided that limited wraparound coverage would not be permitted to provide benefits solely under a coordination-of-benefits provision and could not be an account-based reimbursement arrangement.[25] Limited wraparound coverage that covers solely cost sharing would not be permissible, as stated in the preamble to the 2014 proposed regulations, because reduced cost sharing can be obtained by choosing an individual health insurance policy with a higher actuarial value (for example, a platinum plan with a 90 percent actuarial value).[26] The Departments invited comment on safe harbors standardizing the benefits in the limited wraparound coverage that could be established.

Many commenters requested additional clarity on the type of benefits that could be offered as meaningful benefits in limited wraparound coverage. Suggestions included reimbursement for the full cost of primary care, the cost of prescription drugs not on the formulary of the primary plan, ten physician visits per year, services considered to be provided out-of-network by 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),

[24] 79 FR 76935
[25] 79 FR 76936
[26] Id.

home health coverage, or coverage of other benefits that are not covered EHBs under the primary plan. The Departments consider all of these examples to qualify as additional, meaningful benefits under this first requirement to be limited wraparound coverage that qualifies as excepted benefits. As discussed further below, the Departments reiterate that limited wraparound coverage that is an excepted benefit cannot be an account-based mechanism and instead must be a risk-sharing product that covers a defined package of services.

B. Limited in amount

For the second requirement to be limited wraparound coverage that qualifies as excepted benefits, the Departments proposed that the limited wraparound coverage be limited in amount. Specifically, the 2014 proposed regulations provided that the annual cost of coverage per employee (and any covered dependents) under the limited wraparound coverage could not exceed the maximum annual contribution for health FSAs (which was $2,500 in 2014), indexed in the manner prescribed under Code section 125(i)(2) (which amounts to $2,550 for 2015), and the cost of coverage would include both employer and employee contributions towards coverage and be determined in the same manner as the applicable premium is calculated under a COBRA continuation provision. The preamble to the 2014 proposed regulations stated that the bright-line limitation was intended to be simpler to administer than a cap of 15 percent of the cost of the plan sponsor's primary coverage as set forth in the 2013 proposed regulations.

Many comments stated that the limits on the amount should be higher so that individuals eligible for the limited wraparound coverage would not experience gaps in coverage. Some commenters suggested that the Departments consider an alternative, referencing the higher health savings account (HSA) limits, which are $3,350 for individual coverage and $6,650 for families in 2015, indexed annually. Others suggested the Departments set the limit as the greater of: the

maximum permitted annual salary reduction towards a health FSA (as was set forth in the 2014 proposed regulations), or a percentage of the cost of coverage under the primary plan (as was set forth in the 2013 proposed regulations).

These final regulations adopt the last suggestion. Either the dollar or percent limitation would satisfy the Departments' objective of ensuring that the limited wraparound coverage provides a limited benefit, as required by the statute, and be similar to other limited excepted benefits (that is, dental benefits, vision benefits, long term care, nursing home care, home health care, community-based care, or health FSAs as described in 26 CFR 54.9831-1(c)(3); 29 CFR 2590.732(c)(3); 45 CFR 146.145(b)(3)). The percentage, as in the 2013 proposed regulations, is 15 percent of the cost of coverage under the primary plan.

The final regulations do not adopt the suggestion to use much higher limits on the cost of coverage (for example, the HSA limits). Too large a benefit that is not limited in scope (c.f., limited-scope dental and vision excepted benefits) would not constitute a "similar, limited benefit" under ERISA section 733(c)(2), PHS Act section 2791(c)(2), or Code section 9832(c)(2).

The Departments also received requests for clarification regarding the administration of the second requirement (that is, that the limited wraparound coverage be limited in amount). Some comments requested that the determination of the cost of coverage be permitted to be made on an aggregate basis in advance of each plan year by an actuary, and not based on actual experience of the group or any individual during the plan year. This approach is precisely the approach that was intended by the Departments. As stated earlier, to qualify as excepted benefits, the limited wraparound coverage could not be an account-based reimbursement arrangement. That is, the coverage must include a risk-sharing element. As such, making a

determination regarding the cost of coverage must occur on an aggregate basis. Moreover, to the extent this determination for a given plan year is made on sound actuarial principles that are appropriately documented, the actual experience of the group or any individual during the plan year would not be a factor in determining the cost of coverage for that plan year (although it could impact future years by providing additional information on which the actuarial estimate of the cost of coverage for future years would be based). The final regulations include this clarification.

C. Nondiscrimination

Under the 2014 proposed regulations, the third requirement for limited wraparound coverage to qualify as excepted benefits related to nondiscrimination. Specifically, the Departments proposed three sub-requirements relating to nondiscrimination. First, the wraparound coverage could not impose any preexisting condition exclusion, consistent with the requirements of section 2704 of the PHS Act (as incorporated into section 715 of ERISA and section 9815 of the Code) and implementing regulations.[27] Second, the wraparound coverage could not discriminate against individuals in eligibility, benefits, or premiums based on any health factor of an individual (or any dependent of the individual), consistent with the requirements of section 702 of ERISA, section 9802 of the Code, and section 2705 of the PHS Act (as incorporated into section 715 of ERISA and section 9815 of the Code) and implementing regulations.[28] Finally, neither the primary group health plan coverage nor the limited wraparound coverage could fail to comply with section 2716 of the PHS Act (as incorporated into section 715 of ERISA and section 9815 of the Code) or fail to be excludible from income

[27] 29 CFR 2590.715-2704 and 45 CFR 147.108. See also Q2 in Affordable Care Act Implementation FAQs Part XXII, available at http://www.dol.gov/ebsa/faqs/faq-aca22.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-XXII-FINAL.pdf regarding the prohibition against offering employees with high claims risk a choice between enrollment in its standard group health plan or cash.

[28] 26 CFR 54.9802-1, 29 CFR 2590.702, and 45 CFR 146.121.

with respect to any individual due to the application of section 105(h) of the Code (as applicable). These final regulations adopt the approach outlined in the 2014 proposed regulations.

The Departments received two comments on this third requirement. One commenter inquired as to the potential interaction between excepted benefits and the excise tax on high cost employer-sponsored health coverage under Code section 4980I. The Treasury and the IRS issued Notice 2015-16 on February 23, 2015 describing potential approaches with regard to a number of issues under Code section 4980I and inviting comments by May 15, 2015. Issues relating to Code section 4980I will be addressed as part of that rulemaking. Another commenter requested that the Departments consider "modernizing" the nondiscrimination provisions under Code section 105(h) and section 2716 of the PHS Act relating to prohibiting discrimination in favor of highly compensated employees. The Departments are considering this suggestion and other comments previously received for purposes of future guidance relating to these provisions.

D. Plan eligibility requirements

The fourth requirement to qualify as excepted benefits concerned plan eligibility requirements. First, under the 2014 proposed regulations, individuals eligible for the limited wraparound coverage could not be enrolled in excepted benefit coverage that is a health FSA. One commenter suggested permitting dual enrollment in limited wraparound coverage and health FSA coverage. However, as described earlier, the Departments are using their discretion under ERISA section 733(c)(2), PHS Act section 2791(c)(2), and Code section 9832(c)(2) to define "other similar, limited benefits" as excepted benefits and do not adopt this suggestion. To ensure that wraparound coverage is a limited benefit, like health FSAs, the Departments do not intend to allow plan sponsors to combine multiple excepted benefits into an arrangement that functions as

a material substitute for primary group health plan coverage and still be exempt from the health market reforms.

Under the 2014 proposed regulations, as part of the fourth requirement for limited wraparound coverage to constitute excepted benefits, coverage would be required to comply with one of two alternative sets of standards relating to eligibility and benefits: one set of plan eligibility requirements for wraparound benefits offered in conjunction with eligible individual health insurance (or BHP coverage) for persons who are not full-time employees, and a separate set of standards for coverage that wraps around certain Multi-State Plan coverage. As described further below, limited wraparound coverage for persons who are not full-time employees is intended for employers that are generally offering affordable, minimum value coverage to their full-time workers but want to offer an additional limited benefit to their part-time workers. Limited wraparound coverage offered in conjunction with a Multi-State Plan is intended for employers that were offering reasonably comprehensive coverage prior to the promulgation of these final rules, and wish to offer limited wraparound coverage while still contributing roughly the same total amount toward their employees' health benefits.

1. Limited wraparound coverage offered in conjunction with eligible individual health insurance (or BHP coverage) for persons who are not full-time employees

As under the 2014 proposed regulations, limited coverage that wraps around eligible individual health insurance (or BHP coverage) for an individual who is not a full-time employee is required to satisfy three standards relating to plan eligibility.

i. Employer obligations with respect to full-time employees

First, for each year that 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, must offer to its full-time employees coverage that: (1) is substantially similar to coverage that the employer would need to offer to its full-time employees in order not to be subject to a potential assessable payment under the employer shared responsibility provisions of section 4980H(a) of the Code, if such provisions were applicable (that is, substantially similar to an offer of minimum essential coverage (as defined in Code section 5000A(f)) to at least 95 percent of its full-time employees (or to all but five of its full-time employees, if five is greater than five percent of its full-time employees)); (2) provides minimum value (as defined in section 36B(c)(2)(C)(ii) of the Code); and (3) is reasonably expected to be affordable (permitting use of the safe harbor rules for determining affordability set forth in 26 CFR 54.4980H-5(e)(2)). The preamble to the 2014 proposed regulations stated that, if a plan or issuer providing limited wraparound coverage takes reasonable steps to ensure that employers disclose necessary information regarding their coverage offered and affordability information to the plan or issuer, the plan or issuer could rely on reasonable representations by employers regarding this information, unless the plan or issuer has specific knowledge to the contrary.

Several commenters requested that, in the context of small employers and multiemployer plans, there be an exemption from the requirement that, to be considered excepted benefits, the employer offer to its full-time employees coverage that is substantially similar to coverage that the employer would need to offer pursuant to Code section 4980H(a). However, these final excepted benefits regulations are designed to allow plan sponsors an option to offer additional workers health coverage comparable to that which they already offer, rather than to serve as a substitute for primary coverage.

Other commenters asked the Departments to clarify that any Code section 4980H-related requirements are met in instances in which the employer has no full-time employees. These final

regulations clarify that, in the event that the employer has no full-time employees, but the plan covers retirees (and their dependents), or covers part-time employees (and their dependents), the requirements to provide coverage that is substantially similar to coverage that the employer would need to offer to its full-time employees in order not to be subject to a potential assessable payment section 4980H(a) of the Code, that provides minimum value, and that is reasonably expected to be affordable, are all considered satisfied.

ii. Limited eligibility

Second, eligibility for the limited wraparound coverage must be limited to employees who are not full-time employees (and their dependents), or who are retirees (and their dependents). In the preamble to the 2014 proposed regulations, the Departments stated that "full-time employees" would be employees who are reasonably expected to work at least an average of 30 hours per week. Plans and issuers would not be required to define "full-time employees" strictly in accordance with the rules of Code section 4980H, but employers could rely on the Code section 4980H definition, or any reasonable interpretation of who is reasonably expected to work an average of 30 hours a week, for purposes of this provision. The Departments invited comment on this approach.

Some commenters argued that plan sponsors should be able to offer limited coverage that wraps around eligible individual health insurance to full-time employees. The Departments do not adopt this change. A rationale for treating the wraparound coverage as an excepted benefit is that recipients will be able to use this limited type of coverage in conjunction with individual coverage purchased through an Exchange without being disqualified from claiming the premium tax credit. This may be attractive to employers as a means of providing some health coverage to employees who may not otherwise have been offered coverage, such as part-time employees or

retirees. However, this is not intended to incentivize or permit employers to fail to offer minimum essential coverage to full-time employees, a population to whom employers have typically offered coverage.

One commenter sought clarification that plan sponsors offering limited wraparound coverage may rely on a determination of full-time employee status at the time of enrollment. The Departments agree that employers offering limited wraparound coverage will make determinations based on the expected status of an employee in the future as a part-time employee versus full-time employee. Accordingly, the final regulations include a clarification that this standard is met if it is reasonably determined at the time of enrollment that the employee will on average work fewer than 30 hours per week during the plan year. Moreover, for purposes of administering the premium tax credit under section 36B of the Code, if it is reasonably determined at the time of enrollment that the employee will on average work fewer than 30 hours per week during the plan year and therefore the employee is offered limited coverage that wraps around eligible individual health insurance, but the employee later during the coverage period meets the definition of a full-time employee, the coverage will not fail to be excepted benefits and the employee will not become ineligible for premium tax credits for the remainder of the plan year solely because the original reasonable determination proves incorrect. Whether, to be reasonable, that determination would need to be changed for future plan years will depend on all the facts and circumstances.

Several commenters sought clarification regarding the definition of "dependent." Specifically, commenters asked whether the term "dependent" includes "spouses" (as the term is defined under 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103 for purposes of chapter 100 of the Code, part 7 of ERISA, and title XXVII of the PHS Act), or whether it is

limited to "dependent children" (as the term is defined under Code section 4980H and its implementing regulations). These final regulations clarify that, for purposes of excepted benefits, the term "dependent" is defined by reference to the definitions section governing the market reforms (that is, 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103) and not the employer shared responsibility provisions under Code section 4980H and its implementing regulations. Accordingly, spouses may qualify as dependents to the extent they are eligible for coverage under the terms of the limited wraparound coverage. Moreover, some commenters sought clarification as to whether a plan could permit enrollment of a spouse beneficiary without enrollment of an employee participant. While nothing in these final regulations, nor any other provision of ERISA, the Code, or the PHS Act requires plans to enroll spouse beneficiaries for coverage (other than COBRA coverage) if the participant does not enroll, nothing in these provisions prohibits plans from enrolling such a spouse if plans choose to do so.[29]

iii. Offer of other group health plan coverage

Third, under the 2014 proposed regulations, other group health plan coverage, not limited to excepted benefits, would be required to be offered to the individuals eligible for the wraparound coverage. Only individuals eligible for other group health plan coverage could be eligible for the wraparound coverage.

Some commenters contended that plan sponsors should not be required to offer other group health plan coverage to individuals who are not full-time employees. This provision does not require employers to offer group health plan coverage to workers who are not full-time employees but it does limit the ability to offer the wrap-around coverage only to workers otherwise eligible for other group health plan coverage. That is because this provision is not

[29] See ERISA section 601, Code section 4980B and PHS Act section 2201, which requires enrollment of qualified beneficiaries (including spouses) after a loss of coverage in connection with a qualifying event.

intended to create an opportunity or incentive for employers to discontinue providing group health plan coverage and to encourage its employees to obtain coverage through the Exchange subsidized through the premium tax credit while still receiving meaningful employer-provided health benefits. Further, the same standard is applied in order for a health FSA to be an excepted benefit, and this provision in the final regulation is intended to allow employers to offer a limited benefit, similar to a health FSA.

2. Limited wraparound coverage offered in conjunction with Multi-State Plan coverage

For limited coverage that wraps around Multi-State Plan coverage, four requirements would be required to be met under the 2014 proposed regulations.

i. OPM review and approval

The first of the four standards would require that the limited wraparound coverage be specifically designed and approved by the Office of Personnel Management (OPM) to provide benefits in conjunction with coverage under a Multi-State Plan authorized under section 1334 of the Affordable Care Act. Several comments sought clarification as to whether OPM would be designing limited wraparound coverage, or whether that would more appropriately be the role of the plan sponsor or health insurance issuer. These final rules include a modification to clarify that OPM would not design limited wraparound coverage. Instead, OPM's role would be to review and approve such coverage. Moreover, as indicated in the preamble to the 2014 proposed regulations, with respect to the maintenance of effort standard (discussed below), OPM's role is to ensure that group health plans and health insurance issuers offering Multi-State Plan wraparound coverage have a reasonable process in place for assuring employers meet the criteria set forth in these regulations for excepted benefits.

ii. Maintenance of effort

The 2014 proposed regulations provided that the employer would have had to offer coverage in the plan year that began in 2014 that is substantially similar to coverage that the employer would need to have offered to its full-time employees in order to not be subject to an assessable payment under the employer shared responsibility provisions of section 4980H(a) of the Code, if such provisions had been applicable. In addition, in the plan year that began in 2014, the employer would have had to have offered coverage to a substantial portion of full-time employees that provided "minimum value" (as defined in section 36B(c)(2)(C)(ii) of the Code) and was affordable (applying the safe harbor rules for determining affordability set forth in 26 CFR 54.4980H-5(e)(2)). Finally, for the duration of the pilot program (described later in this preamble), the employer's annual aggregate contributions for both primary and limited wraparound coverage must be substantially the same as the employer's aggregate contributions for coverage offered to full-time employees in 2014. The Departments stated in the preamble that they were considering interpreting this "substantially the same" condition as a percentage (for example, 80 or 90 percent) and potentially applying it on a per-worker basis to allow for fluctuations in an employer's workforce.

Citing that some employers may have made changes to their coverage in 2014 because Exchange coverage was first available in 2014, several commenters requested that plan sponsors be permitted to use either 2013 or 2014 as the base year for this maintenance of effort requirement set forth in these second and third requirements for limited coverage that wraps around Multi-State Plan coverage. These final regulations adopt this suggestion.

Other comments stated that an employer's annual aggregate contribution toward primary and limited wraparound coverage should include any assessable payments under Code section 4980H owed by the employer. An applicable large employer may become subject to an

assessable payment if it fails to offer minimum essential coverage to its full-time employees and one or more of those employees obtains a premium tax credit, or it fails to provide a full-time employee minimum essential coverage that provides minimum value and is affordable for that employee and that employee obtains a premium tax credit. In neither case does the payment of an assessable payment provide coverage to the employee or otherwise assist that employee in obtaining coverage. Nor does the fact that the failure to provide coverage may permit the employee to obtain the premium tax credit mean that the resulting fee is contributing toward that employee's health coverage. The final regulations, therefore, do not make this change.

Some comments sought clarification regarding whether the employer's annual aggregate contributions for both primary and limited wraparound coverage must be substantially the same as the employer's aggregate contributions for coverage offered to full-time employees in 2013 or 2014. Some requested OPM be given discretion to determine whether the maintenance of effort standard has been met by each employer. Others requested a threshold of 60 percent in determining whether this standard has been met. Many factors, including fluctuations in workforce size, cost of coverage, and employer contributions towards other fringe benefits may affect employer contributions from year to year. The final regulations retain the standard set forth in the 2014 proposed regulations that the employer's annual aggregate contributions for both primary and limited wraparound coverage must be substantially the same as the employer's aggregate contributions for coverage offered to full-time employees in 2014 (or 2013). For this purpose, the Departments consider this "substantially the same" condition to be met if contributions were at least 80 percent of contributions made in 2013 or 2014, applied on an average, full-time worker basis (to allow for fluctuations in an employer's workforce). OPM may make a finding, based on all the facts and circumstances, that other employer contribution

arrangements also meet this standard. OPM may provide additional guidance (such as examples and safe harbors) in the future.

As with coverage that wraps around eligible individual health insurance (or that wraps around Basic Health Plan coverage), commenters asked the Departments to clarify that any Code section 4980H-related requirements are met in instances in which the employer has no full-time employees. These final regulations adopt a parallel clarification for coverage that wraps around Multi-State Plan coverage as for coverage that wraps around eligible individual health insurance (or that wraps around Basic Health Plan coverage). That is, while these final regulations do not permit new employers to provide wraparound coverage as an excepted benefit, these final regulations clarify that, in the event that the employer has no full-time employees, but the plan covers retirees (and their dependents), or covers part-time employees (and their dependents), the requirements that, in the plan year that began in 2013 or 2014, the employer would have had to have offered coverage to a substantial portion of full-time employees that provided minimum value and was affordable is met, as is the requirement that, for the duration of the pilot program, the employer's annual aggregate contributions for both primary and limited wraparound coverage must be substantially the same as the employer's aggregate contributions for coverage offered to full-time employees in 2013 or 2014.

For purposes of administering this provision with respect to limited wraparound coverage offered in conjunction with Multi-State Plan coverage, the Departments had proposed that the term "full-time employee" means a "full-time employee" as defined in 26 CFR 54.4980H-1(a)(21) who is not in a limited non-assessment period for certain employees (as defined in 26 CFR 54.4980H-1(a)(26)). Moreover, if a plan or issuer providing limited wraparound coverage takes reasonable steps to ensure that employers disclose necessary information regarding their

coverage offered and contribution levels for 2013 or 2014 to the plan or issuer, the plan or issuer may rely on reasonable representations by employers regarding this information, unless the plan or issuer has specific knowledge to the contrary. Consistent with the reporting and evaluation criteria described later in this preamble, the Departments stated that OPM may verify that plans and issuers have reasonable mechanisms in place to ensure that contributing employers meet these standards.

E. Reporting

The fifth and final requirement for limited wraparound coverage to qualify as excepted benefits under the 2014 proposed regulations is a reporting requirement, for group health plans and group health insurance issuers, as well as group health plan sponsors. The final regulations adopt the approach outlined in the 2014 proposed regulations.

A self-insured group health plan, or a health insurance issuer offering or proposing to offer Multi-State Plan wraparound coverage, would report to OPM, in a form and manner specified in OPM guidance, information OPM reasonably requires to determine whether the plan or issuer qualifies to offer such coverage or complies with the applicable requirements of this section.

In addition, the plan sponsor of any group health plan offering any type of limited wraparound coverage would report to HHS, in a form and manner specified in guidance, information HHS reasonably requires 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 health insurance, BHP coverage, or Multi-State Plan coverage,

with additional limited wraparound coverage offered by the plan sponsor, without causing an erosion of coverage.

Commenters requested that there be coordination of any reporting requirements with existing reporting requirements and some made specific suggestions regarding data elements that should be required for reporting. The Departments agree with the principle of non-duplication and will seek comment on any new reporting requirements through the process established by Paperwork Reduction Act of 1995.

F. Pilot Program With Sunset Date

Under the 2014 proposed regulations, limited wraparound coverage would be permitted under a pilot program for a limited time. Specifically, this type of wraparound coverage could be offered as excepted benefits if it is first offered no later than December 31, 2017, and ends on the later of: (1) the date that is three years after the date wraparound coverage is first offered; or (2) the date on which the last collective bargaining agreement relating to the plan terminates after the date wraparound coverage is first offered (determined without regard to any extension agreed to after the date the wraparound coverage is first offered). The 2014 proposed regulations invited comments on this time frame for applicability, including whether the Departments should have the option to provide for an earlier termination date.

Many commenters cited uncertainty and the lack of lead time as negatively impacting full utilization of the pilot program and requested a longer implementation period. The Departments agree that the timing for publication of these final rules makes 2015 plan year implementation impossible or impracticable for most plans. Accordingly, these final rules specify that wraparound coverage could be offered as excepted benefits if the coverage is first offered no earlier than January 1, 2016 and no later than December 31, 2018. The end date is unchanged

from the proposal, that is the later of: (1) the date that is three years after the date wraparound coverage is first offered; or (2) the date on which the last collective bargaining agreement relating to the plan terminates after the date wraparound coverage is first offered (determined without regard to any extension agreed to after the date the wraparound coverage is first offered).

III. Economic Impact and Paperwork Burden

A. Summary

As discussed in detail above, these regulations amend the definition of "limited excepted benefits" in the group market to provide plan sponsors with two options to offer limited wraparound coverage to certain individuals. Under the first option, a plan sponsor could offer limited benefits provided through a group health plan that wraps around eligible individual health insurance to employees who are not full-time employees (and their dependents), or who are retirees (and their dependents). For this purpose, full-time employees are employees who are reasonably expected to work at least an average of 30 hours per week. Under the second option, the limited wraparound coverage that satisfies the requirements outlined in the regulations must be approved by OPM and be offered in conjunction with Multi-State Plan coverage authorized under section 1334 of the Affordable Care Act. Under the first option, the limited benefits would also be permitted to wrap around the Basic Health Program authorized under section 1331 of the Affordable Care Act.

B. Executive Orders 12866 and 13563 -- Departments of Labor and HHS

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, and public health and safety effects; distributive impacts; and equity). Executive Order 13563 emphasizes the

importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility.

Section 3(f) of Executive Order 12866 defines a "significant regulatory action" as an action that is likely to result in a regulation: (1) having an annual effect on the economy of $100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local, or tribal governments or communities (also referred to as "economically significant"); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order. OMB has determined that the action is significant within the meaning of section 3(f)(4) of Executive Order 12866, and the Departments accordingly provide the following assessment of its potential benefits and costs.

The Departments recognize that many plan sponsors provide comprehensive health benefits to their workers. One objective of the Affordable Care Act is to allow individuals with comprehensive health insurance plans to maintain their current level of benefits. Some employers are interested in offering wraparound coverage to employees who are enrolled in a Multi-State Plan authorized under section 1334 of the Affordable Care Act or to part-time employees. These regulations provide two options to employers that clarify the circumstances under which plan sponsors can provide to their employees such limited wraparound coverage that qualifies as an excepted benefit.

The cost (and Federal budget impact[30]) of these final regulations is difficult to quantify. The Departments solicited comments in the regulatory impact analysis section of the preamble to the 2014 proposed regulations. Comments were invited generally and on specific questions, including: To what degree, if any, might this regulation increase employers' propensity to provide health insurance? To what extent, if any, this proposed regulation could affect plan sponsors' decision making? Are there any particular sectors of the economy in which employers will be more or less inclined to pursue wraparound coverage programs?

Comments were also invited on the effects of the proposal and the Departments requested detailed data that would inform the following questions: What will be the impact of limiting the cost of the wraparound coverage to $2,500 per employee (and any covered dependents)? How many employers offer coverage that provides minimum value and is affordable for a substantial portion (under the first option) or 95 percent (under the second option) of employees who are eligible for coverage? To what extent would premiums for comprehensive health coverage change in the presence and absence of this rule?

No specific data were received in response to this solicitation, although several commented that limited conditions under which wraparound coverage could be offered were overly restrictive and made it of limited use. Others commented that the uncertainty of the life span of a time-limited pilot program would minimize uptake of the offering of limited wraparound coverage.

These final regulations generally implement the 2014 proposed regulations with marginal change, as discussed above. Both options are designed so that wraparound coverage could not

[30] As with other group health coverage, employer contributions to the limited wraparound coverage would be excluded from employee income for tax purposes. Similar to the cost of the proposal, the budget implications of adding limited wraparound coverage as a form of excepted benefits depends on the number of employers that elect either option and the number of employees that in turn receive it.

replace employer-sponsored primary group coverage. Under the individual health insurance wraparound option, the employer also must offer other group health 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. Only individuals who are not full-time employees and who are eligible for other group health plan coverage may be eligible for the wraparound coverage. Also, the employer coverage must substantially satisfy the employer shared responsibility provisions of Code section 4980H(a), and the coverage would have to be affordable for at least 95 percent of full-time employees.

Under the Multi-State Plan wraparound option, the employer would have to offer coverage in the plan year beginning in 2013 or 2014 that would have substantially satisfied the employer shared responsibility provisions of Code section 4980H(a) if the provision had been applicable, provided minimum value, and been affordable for a substantial portion of its full-time employees.[31] The employer's annual contributions for both its primary and wraparound coverage must be substantial.

The final regulations permit limited wraparound coverage to be excepted benefits if initially offered between January 1, 2016 and December 31, 2018, and continuing for the longer of three years or the date on which the last collective bargaining agreement relating to the group health plan terminates. In addition, the maximum benefit cannot exceed the greater of the annual health FSA contribution limit ($2,550 for 2015), indexed; or 15 percent of the firm's primary plan cost. In the 2014 proposed regulations the maximum benefit was the annual health FSA contribution limits ($2,550 for 2015), indexed.

[31] The substantial level was included to help minimize the implications for the primary plan's risk pool by preventing a large number of low-wage workers from leaving the primary plan for Exchange coverage.

As with the 2014 proposed regulations, the decision to offer the limited wraparound coverage remains optional. There is greater administrative complexity associated with the wraparound coverage than primary coverage alone or primary coverage plus a health FSA which offers similar benefits. Given a choice, some plan sponsors may choose to increase the affordability of their primary coverage rather than offer limited wraparound coverage. Some plan sponsors may not have that choice: the employers may not be in a financial position to make their primary health plans affordable to more workers, let alone contribute to wraparound coverage. Employers may also continue to simply not provide employees with affordable, minimum value coverage, allowing their workers to purchase coverage and potentially qualify for premium tax credits through an Exchange with no additional wraparound benefit, and these employers would continue to make any employer shared responsibility payments as applicable, resulting in no additional cost to the employer or the Federal government.

The option to offer limited wraparound coverage would not encumber any currently existing means by which employers can provide comprehensive health insurance coverage to their employees in compliance with the Affordable Care Act. Rather, it would clarify two additional, alternative means of doing so.

For the foregoing reasons, the Departments have reached the conclusion that the impact of the benefits, costs, and transfers will be limited. The Departments do not expect many plans to offer limited wraparound coverage, and will monitor usage and impact during the pilot program through reporting, as discussed above.

C. Paperwork Reduction Act – Department of Labor and Department of the Treasury

These final regulations are not subject to the requirements of the Paperwork Reduction Act of 1995 (PRA 95) (44 U.S.C. section 3501 et seq.), because it does not contain a collection of information as defined in 44 U.S.C. section 3502(3).

D. Paperwork Reduction Act – Department of HHS

The final rule is not subject to the requirements of the Paperwork Reduction Act of 1995 (PRA 95) (44 U.S.C. section 3501 et seq.), because it does not contain a collection of information as defined in 44 U.S.C. section 3502(3). An analysis under the PRA will be conducted in the future for any future guidance establishing a collection of information related to the rule.

E. Regulatory Flexibility Act – Departments of Labor and HHS

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 et seq.) and that are likely to have a significant economic impact on a substantial number of small entities. Unless an agency certifies that a proposed rule is not likely to have a significant economic impact on a substantial number of small entities, section 603 of RFA requires that the agency present an initial regulatory flexibility analysis at the time of the publication of the notice of proposed rulemaking describing the impact of the rule on small entities and seeking public comment on such impact. Small entities include small businesses, organizations and governmental jurisdictions.

For purposes of the RFA, the Departments continue to consider a "small entity" to be an employee benefit plan with fewer than 100 participants. The basis for this definition is found in section 104(a)(2) of the act, which permits the Secretary of Labor to prescribe simplified annual

reports for pension plans that cover fewer than 100 participants. Pursuant to the authority of section 104(a)(3), the Department has previously issued at 29 CFR 2520.104-20, 2520.104-21, 2520.104-41, 2520.104-46 and 2520.104b-10 certain simplified reporting provisions and limited exemptions from reporting and disclosure requirements for small plans, including unfunded or insured welfare plans covering fewer than 100 participants and satisfying certain other requirements.

Further, while some large employers may have small plans, in general small employers maintain most small plans. Thus, the Departments believe that assessing the impact of these final regulations on small plans is an appropriate substitute for evaluating the effect on small entities. The definition of small entity considered appropriate for this purpose differs, however, from a definition of small business that is based on size standards promulgated by the Small Business Administration (13 CFR 121.201) pursuant to the Small Business Act (15 U.S.C. 631 et seq.). The Departments requested comment on the appropriateness of the size standard at the proposed rule phase and received no responses.

Because these final regulations impose no additional costs on employers or plans, the Departments believe that they do not have a significant economic impact on a substantial number of small entities. Accordingly, pursuant to section 605(b) of the RFA, the Departments hereby certify that these final regulations will not have a significant economic impact on a substantial number of small entities.

F. Special Analyses – Department of the Treasury

For purposes of the Department of the Treasury it has been determined that this final rule is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It has also been

determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these final regulations, and, because these final regulations do not impose a collection of information on small entities, an analysis under the RFA is not required. Pursuant to section 7805(f) of the Code, the notice of proposed rulemaking preceding these final regulations was submitted to the Small Business Administration for comment on its impact on small business.

G. Unfunded Mandates Reform Act

For purposes of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1501 et seq.), as well as Executive Order 12875, these final regulations do not include any federal mandate that may result in expenditures by State, local, or tribal governments, or the private sector, which may impose an annual burden of $100 million adjusted for inflation since 1995.

H. Federalism

Executive Order 13132 outlines fundamental principles of federalism. It requires adherence to specific criteria by federal agencies in formulating and implementing policies that have ‘‘substantial direct effects’’ on the states, the relationship between the national government and states, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have these federalism implications must consult with state and local officials, and describe the extent of their consultation and the nature of the concerns of state and local officials in the preamble to the final regulation.

In the Departments’ view, the final regulations, by clarifying policy regarding certain expected benefits options that can be designed by employers to support their employees, will provide more certainty to employers and others in the regulated community as well as states and political subdivisions regarding the treatment of such arrangements under ERISA. Accordingly, the Departments will continue to affirmatively engage in outreach with officials of state and

political subdivisions regarding excepted benefits and seek their input on any federalism implications that they believe may be presented.

I. Congressional Review Act

These final regulations are subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.), which specifies that, before a rule can take effect, the Federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information. These final regulations are being transmitted to Congress and the Comptroller General for review.

IV. Statutory Authority

The Department of the Treasury regulations are adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor regulations are adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161-1168, 1169, 1181-1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Public Law 104-191, 110 Stat. 1936; sec. 401(b), Public Law 105-200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Public Law 110-343, 122 Stat. 3765; Public Law 110-460, 122 Stat. 5123; Secretary of Labor's Order 1-2011, 77 FR 1088 (January 9, 2012).

The Department of Health and Human Services regulations are adopted pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended.

List of Subjects

26 CFR Part 54

Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

29 CFR Part 2590

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance, Medical child support, Reporting and recordkeeping requirements.

45 CFR Part 146

Health care, Health insurance, Reporting and recordkeeping requirements, and State regulation of health insurance.

John M. Dalrymple
Deputy Commissioner for Services and Enforcement,
Internal Revenue Service

Approved: March 11, 2015

Mark J. Mazur
Assistant Secretary of the Treasury (Tax Policy)

Signed this ___11th_____ day of ____March_____, 2015.

Phyllis C. Borzi
Assistant Secretary
Employee Benefits Security Administration
Department of Labor

Dated: March 11, 2015.

Andrew M. Slavitt,

Acting Administrator,

Centers for Medicare & Medicaid Services.

Dated: March 11, 2015.

Sylvia Burwell,

Secretary,

Department of Health and Human Services.

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Chapter I

Accordingly, 26 CFR part 54 is amended as follows:

PART 54—PENSION EXCISE TAXES

Paragraph 1. The authority citation for part 54 continues to read in part as follows:

Authority: Authority: 26 U.S.C. 7805. * * *

Section 54.9831-1 also issued under 26 U.S.C. 9833; * * *

Par 2. Section 54.9831-1 is amended by adding paragraph (c)(3)(vii) to read as follows:

§ 54.9831-1 Special rules relating to group health plans.

***** ***** ***** ***** *****

(c) * * *

(3) * * *

(vii) Limited wraparound coverage. Limited benefits provided through a group health plan that wrap around eligible individual health insurance (or Basic Health Plan coverage described in section 1331 of the Patient Protection and Affordable Care Act); or that wrap around coverage under a Multi-State Plan described in section 1334 of the Patient Protection and Affordable Care Act, collectively referred to as "limited wraparound coverage," are excepted benefits if all of the following conditions are satisfied. For this purpose, eligible individual health insurance is individual health insurance coverage that is not a grandfathered health plan (as described in section 1251 of the Patient Protection and Affordable Care Act and 29 CFR 2590.715-1251), not a transitional individual health insurance plan (as described in the March 5, 2014 Insurance Standards Bulletin Series – Extension of Transitional Policy through October 1,

2016), and does not consist solely of excepted benefits (as defined in paragraph (c) of this section).

(A) Covers additional benefits. The limited wraparound coverage provides meaningful benefits beyond coverage of cost sharing under either the eligible individual health insurance, Basic Health Program coverage, or Multi-State Plan coverage. The limited wraparound coverage must not provide benefits only under a coordination-of-benefits provision and must not consist of an account-based reimbursement arrangement.

(B) Limited in amount. The annual cost of coverage per employee (and any covered dependents, as defined in § 54.9801-2) under the limited wraparound coverage does not exceed the greater of the amount determined under either paragraph (c)(3)(vii)(B)(1) or (2) of this section. Making a determination regarding the annual cost of coverage per employee must occur on an aggregate basis relying on sound actuarial principles.

(1) The maximum permitted annual salary reduction contribution toward health flexible spending arrangements, indexed in the manner prescribed under section 125(i)(2). For this purpose, the cost of coverage under the limited wraparound 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.

(2) Fifteen percent of the cost of coverage under the primary plan. For this purpose, the cost of coverage under the primary plan and under the limited wraparound coverage includes both employer and employee contributions towards the coverage and each is determined in the same manner as the applicable premium is calculated under a COBRA continuation provision.

(C) Nondiscrimination. All of the conditions of this paragraph (c)(3)(vii)(C) are satisfied.

(1) No preexisting condition exclusion. The limited wraparound coverage does not impose any preexisting condition exclusion, consistent with the requirements of section 2704 of the PHS Act (incorporated by reference into section 9815) and 29 CFR 2590.715-2704.

(2) No discrimination based on health status. The limited wraparound coverage does not discriminate against individuals in eligibility, benefits, or premiums based on any health factor of an individual (or any dependent of the individual, as defined in § 54.9801-2), consistent with the requirements of section 9802 and section 2705 of the PHS Act (incorporated by reference into section 9815).

(3) No discrimination in favor of highly compensated individuals. Neither the limited wraparound coverage, nor any other group health plan coverage offered by the plan sponsor, fails to comply with section 2716 of the PHS Act (incorporated by reference into section 9815) or fails to be excludible from income for any individual due to the application of section 105(h)(as applicable).

(D) Plan eligibility requirements. Individuals eligible for the wraparound coverage are not enrolled in excepted benefit coverage under paragraph (c)(3)(v) of this section (relating to health FSAs). In addition, the conditions set forth in either paragraph (c)(3)(vii)(D)(1) or (2) of this section are met.

(1) Limited wraparound coverage that wraps around eligible individual insurance for persons who are not full-time employees. Coverage that wraps around eligible individual health insurance (or that wraps around Basic Health Plan coverage) must satisfy all of the conditions of this paragraph (c)(3)(vii)(D)(1).

(i) For each year for which limited wraparound coverage is offered, the employer that is the sponsor of the plan offering limited wraparound coverage, or the employer participating in a

plan offering limited wraparound coverage, offers to its full-time employees coverage that is substantially similar to coverage that the employer would need to offer to its full-time employees in order not to be subject to a potential assessable payment under the employer shared responsibility provisions of section 4980H(a), if such provisions were applicable; provides minimum value (as defined in section 36B(c)(2)(C)(ii)); and is reasonably expected to be affordable (applying the safe harbor rules for determining affordability set forth in **§** 54.4980H-5(e)(2)). 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. In the event that the employer that is the sponsor of the plan offering wraparound coverage, or the employer participating in a plan offering wraparound coverage, has no full-time employees for any plan year limited wraparound coverage is offered, the requirement of this paragraph (c)(3)(vii)(D)(1)(i) is considered satisfied.

(ii) Eligibility for the limited wraparound coverage is limited to employees who are reasonably determined at the time of enrollment to not be full-time employees (and their dependents, as defined in § 54.9801-2), or who are retirees (and their dependents, as defined in § 54.9801-2). For this purpose, full-time employees are employees who are reasonably expected to work at least an average of 30 hours per week.

(iii) Other group health plan coverage, not limited to excepted benefits, is offered to the individuals eligible for the limited wraparound coverage. Only individuals eligible for the other group health plan coverage are eligible for the limited wraparound coverage.

(2) Limited coverage that wraps around Multi-State Plan coverage. Coverage that wraps around Multi-State Plan coverage must satisfy all of the conditions of this paragraph (c)(3)(vii)(D)(2). For this purpose, the term "full-time employee" means a "full-time employee" as defined in **§** 54.4980H-1(a)(21) who is not in a limited non-assessment period for certain employees (as defined in **§** 54.4980H-1(a)(26)). Moreover, 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 contribution levels for 2013 or 2014 (as applicable), and for any year in which limited wraparound coverage is offered, 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. Consistent with the reporting and evaluation criteria of paragraph (c)(3)(vii)(E) of this section, the Office of Personnel Management may verify that plans and issuers have reasonable mechanisms in place to ensure that contributing employers meet these standards.

(i) The limited wraparound coverage is reviewed and approved by the Office of Personnel Management, consistent with the reporting and evaluation criteria of paragraph (c)(3)(vii)(E) of this section, to provide benefits in conjunction with coverage under a Multi-State Plan authorized under section 1334 of the Patient Protection and Affordable Care Act. The Office of Personnel Management may revoke approval if it determines that continued approval is inconsistent with the reporting and evaluation criteria of paragraph (c)(3)(vii)(E) of this section.

(ii) The employer offered coverage in the plan year that began in either 2013 or 2014 that is substantially similar to coverage that the employer would need to have offered to its full-time employees in order to not be subject to an assessable payment under the employer shared responsibility provisions of section 4980H(a), if such provisions had been applicable. In the

event that a plan that offered coverage in 2013 or 2014 has no full-time employees for any plan year limited wraparound coverage is offered, the requirement of this paragraph (c)(3)(vii)(D)(2)(ii) is considered satisfied.

(iii) In the plan year that began in either 2013 or 2014, the employer offered coverage to a substantial portion of full-time employees that provided minimum value (as defined in section 36B(c)(2)(C)(ii)) and was affordable (applying the safe harbor rules for determining affordability set forth in § 54.4980H-5(e)(2)). In the event that the plan that offered coverage in 2013 or 2014 has no full-time employees for any plan year limited wraparound coverage is offered, the requirement of this paragraph (c)(3)(vii)(D)(2)(iii) is considered satisfied.

(iv) For the duration of the pilot program, as described in paragraph (c)(3)(vii)(F) of this section, the employer's annual aggregate contributions for both primary and limited wraparound coverage are substantially the same as the employer's total contributions for coverage offered to full-time employees in 2013 or 2014.

(E) Reporting – (1) Reporting by group health plans and group health insurance issuers. A self-insured group health plan, or a health insurance issuer, offering or proposing to offer limited wraparound coverage in connection with Multi-State Plan coverage pursuant to paragraph (c)(3)(vii)(D)(2) of this section reports to the Office of Personnel Management (OPM), in a form and manner specified in guidance, information OPM reasonably requires to determine whether the plan or issuer qualifies to offer such coverage or complies with the applicable requirements of this section.

(2) Reporting by group health plan sponsors. The plan sponsor of a group health plan offering limited wraparound coverage under paragraph (c)(3)(vii) of this section, must report to

the Department of Health and Human Services (HHS), in a form and manner specified in guidance, information HHS reasonably requires.

(F) Pilot program with sunset. The provisions of paragraph (c)(3)(vii) of this section apply to limited wraparound coverage that is first offered no earlier than January 1, 2016 and no later than December 31, 2018 and that ends no later than on the later of:

(1) The date that is three years after the date limited wraparound coverage is first offered; or

(2) The date on which the last collective bargaining agreement relating to the plan terminates after the date limited wraparound coverage is first offered (determined without regard to any extension agreed to after the date limited wraparound coverage is first offered).

* * * * *

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Chapter XXV

For the reasons stated in the preamble, the Department of Labor amends 29 CFR part 2590 as follows:

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

3. The authority citation for Part 2590 continues to read as follows:

Authority: 29 U.S.C. 1027, 1059, 1135, 1161-1168, 1169, 1181-1183, 1181 note, 1185, 1185a, 1185b, 1185c, 1185d, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L.104-191, 110 Stat. 1936; sec. 401(b), Pub. L. 105-200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110-343, 122 Stat. 3765; Pub. L. 110-460, 122 Stat. 5123; Secretary of Labor's Order 1-2011, 77 FR 1088 (January 9, 2012).

4. Section 2590.732 is amended by adding paragraph (c)(3)(vii) to read as follows:

§ 2590.732 Special rules relating to group health plans.

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(c) * * *

(3) * * *

(vii) Limited wraparound coverage. Limited benefits provided through a group health plan that wrap around eligible individual health insurance (or Basic Health Plan coverage described in section 1331 of the Patient Protection and Affordable Care Act); or that wrap around coverage under a Multi-State Plan described in section 1334 of the Patient Protection and Affordable Care Act, collectively referred to as "limited wraparound coverage," are excepted benefits if all of the following conditions are satisfied. For this purpose, eligible individual

health insurance is individual health insurance coverage that is not a grandfathered health plan (as described in section 1251 of the Patient Protection and Affordable Care Act and § 2590.715-1251), not a transitional individual health insurance plan (as described in the March 5, 2014 Insurance Standards Bulletin Series – Extension of Transitional Policy through October 1, 2016), and does not consist solely of excepted benefits (as defined in paragraph (c) of this section).

(A) Covers additional benefits. The limited wraparound coverage provides meaningful benefits beyond coverage of cost sharing under either the eligible individual health insurance, Basic Health Program coverage, or Multi-State Plan coverage. The limited wraparound coverage must not provide benefits only under a coordination-of-benefits provision and must not consist of an account-based reimbursement arrangement.

(B) Limited in amount. The annual cost of coverage per employee (and any covered dependents, as defined in § 2590.701-2) under the limited wraparound coverage does not exceed the greater of the amount determined under either paragraph (c)(3)(vii)(B)(1) or (2) of this section. Making a determination regarding the annual cost of coverage per employee must occur on an aggregate basis relying on sound actuarial principles.

(1) The maximum permitted annual salary reduction contribution toward health flexible spending arrangements, indexed in the manner prescribed under section 125(i)(2) of the Code. For this purpose, the cost of coverage under the limited wraparound 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.

(2) Fifteen percent of the cost of coverage under the primary plan. For this purpose, the cost of coverage under the primary plan and under the limited wraparound coverage includes

both employer and employee contributions towards the coverage and each is determined in the same manner as the applicable premium is calculated under a COBRA continuation provision.

(C) Nondiscrimination. All of the conditions of this paragraph (c)(3)(vii)(C) are satisfied.

(1) No preexisting condition exclusion. The limited wraparound coverage does not impose any preexisting condition exclusion, consistent with the requirements of section 2704 of the PHS Act (incorporated by reference into section 715 of ERISA) and § 2590.715-2704.

(2) No discrimination based on health status. The limited wraparound coverage does not discriminate against individuals in eligibility, benefits, or premiums based on any health factor of an individual (or any dependent of the individual, as defined in § 2590.701-2), consistent with the requirements of section 702 of ERISA and section 2705 of the PHS Act (incorporated by reference into section 715 of ERISA).

(3) No discrimination in favor of highly compensated individuals. Neither the limited wraparound coverage, nor any other group health plan coverage offered by the plan sponsor, fails to comply with section 2716 of the PHS Act (incorporated by reference into section 715 of ERISA) or fails to be excludible from income for any individual due to the application of section 105(h) of the Code (as applicable).

(D) Plan eligibility requirements. Individuals eligible for the wraparound coverage are not enrolled in excepted benefit coverage under paragraph (c)(3)(v) of this section (relating to health FSAs). In addition, the conditions set forth in either paragraph (c)(3)(vii)(D)(1) or (2) of this section are met.

(1) Limited wraparound coverage that wraps around eligible individual insurance for persons who are not full-time employees. Coverage that wraps around eligible individual health

insurance (or that wraps around Basic Health Plan coverage) must satisfy all of the conditions of this paragraph (c)(3)(vii)(D)(1).

(i) For each year for which limited wraparound coverage is offered, the employer that is the sponsor of the plan offering limited wraparound coverage, or the employer participating in a plan offering limited wraparound coverage, offers to its full-time employees coverage that is substantially similar to coverage that the employer would need to offer to its full-time employees in order not to be subject to a potential assessable payment under the employer shared responsibility provisions of section 4980H(a) of the Code, if such provisions were applicable; provides minimum value (as defined in section 36B(c)(2)(C)(ii) of the Code); and is reasonably expected to be affordable (applying the safe harbor rules for determining affordability set forth in 26 CFR 54.4980H-5(e)(2)). 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. In the event that the employer that is the sponsor of the plan offering wraparound coverage, or the employer participating in a plan offering wraparound coverage, has no full-time employees for any plan year limited wraparound coverage is offered, the requirement of this paragraph (c)(3)(vii)(D)(1)(i) is considered satisfied.

(ii) Eligibility for the limited wraparound coverage is limited to employees who are reasonably determined at the time of enrollment to not be full-time employees (and their dependents, as defined in § 2590.701-2), or who are retirees (and their dependents, as defined in § 2590.701-2). For this purpose, full-time employees are employees who are reasonably expected to work at least an average of 30 hours per week.

(iii) Other group health plan coverage, not limited to excepted benefits, is offered to the individuals eligible for the limited wraparound coverage. Only individuals eligible for the other group health plan coverage are eligible for the limited wraparound coverage.

(2) Limited coverage that wraps around Multi-State Plan coverage. Coverage that wraps around Multi-State Plan coverage must satisfy all of the conditions of this paragraph (c)(3)(vii)(D)(2). For this purpose, the term "full-time employee" means a "full-time employee" as defined in 26 CFR 54.4980H-1(a)(21) who is not in a limited non-assessment period for certain employees (as defined in 26 CFR 54.4980H-1(a)(26)). Moreover, 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 contribution levels for 2013 or 2014 (as applicable), and for any year in which limited wraparound coverage is offered, 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. Consistent with the reporting and evaluation criteria of paragraph (c)(3)(vii)(E) of this section, the Office of Personnel Management may verify that plans and issuers have reasonable mechanisms in place to ensure that contributing employers meet these standards.

(i) The limited wraparound coverage is reviewed and approved by the Office of Personnel Management, consistent with the reporting and evaluation criteria of paragraph (c)(3)(vii)(E) of this section, to provide benefits in conjunction with coverage under a Multi-State Plan authorized under section 1334 of the Patient Protection and Affordable Care Act. The Office of Personnel Management may revoke approval if it determines that continued approval is inconsistent with the reporting and evaluation criteria of paragraph (c)(3)(vii)(E) of this section.

(ii) The employer offered coverage in the plan year that began in either 2013 or 2014 that is substantially similar to coverage that the employer would need to have offered to its full-time employees in order to not be subject to an assessable payment under the employer shared responsibility provisions of section 4980H(a) of the Code, if such provisions had been applicable. In the event that a plan that offered coverage in 2013 or 2014 has no full-time employees for any plan year limited wraparound coverage is offered, the requirement of this paragraph (c)(3)(vii)(D)(2)(ii) is considered satisfied.

(iii) In the plan year that began in either 2013 or 2014, the employer offered coverage to a substantial portion of full-time employees that provided minimum value (as defined in section 36B(c)(2)(C)(ii) of the Code) and was affordable (applying the safe harbor rules for determining affordability set forth in 26 CFR 54.4980H-5(e)(2)). In the event that the plan that offered coverage in 2013 or 2014 has no full-time employees for any plan year limited wraparound coverage is offered, the requirement of this paragraph (c)(3)(vii)(D)(2)(iii) is considered satisfied.

(iv) For the duration of the pilot program, as described in paragraph (c)(3)(vii)(F) of this section, the employer's annual aggregate contributions for both primary and limited wraparound coverage are substantially the same as the employer's total contributions for coverage offered to full-time employees in 2013 or 2014.

(E) Reporting – (1) Reporting by group health plans and group health insurance issuers. A self-insured group health plan, or a health insurance issuer, offering or proposing to offer limited wraparound coverage in connection with Multi-State Plan coverage pursuant to paragraph (c)(3)(vii)(D)(2) of this section reports to the Office of Personnel Management (OPM), in a form and manner specified in guidance, information OPM reasonably requires to

determine whether the plan or issuer qualifies to offer such coverage or complies with the applicable requirements of this section.

(2) Reporting by group health plan sponsors. The plan sponsor of a group health plan offering limited wraparound coverage under paragraph (c)(3)(vii) of this section, must report to the Department of Health and Human Services (HHS), in a form and manner specified in guidance, information HHS reasonably requires.

(F) Pilot program with sunset—The provisions of paragraph (c)(3)(vii) of this section apply to limited wraparound coverage that is first offered no earlier than January 1, 2016 and no later than December 31, 2018 and that ends no later than on the later of:

(1) The date that is three years after the date limited wraparound coverage is first offered; or

(2) The date on which the last collective bargaining agreement relating to the plan terminates after the date limited wraparound coverage is first offered (determined without regard to any extension agreed to after the date limited wraparound coverage is first offered).

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Subtitle A

For the reasons stated in the preamble, the Department of Health and Human Services amends 45 CFR part 146 as set forth below:

PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

5. The authority citation for part 146 continues to read as follows:

Authority: Secs. 2702 through 2705, 2711 through 2723, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg-1 through 300gg-5, 300gg-11 through 300gg-23, 300gg-91, and 300gg-92).

6. Section 146.145 is amended by adding paragraph (b)(3)(vii) to read as follows:

§ 146.145 Special rules relating to group health plans.

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(b) * * *

(3) * * *

(vii) Limited wraparound coverage. Limited benefits provided through a group health plan that wrap around eligible individual health insurance (or Basic Health Plan coverage described in section 1331 of the Patient Protection and Affordable Care Act); or that wrap around coverage under a Multi-State Plan described in section 1334 of the Patient Protection and Affordable Care Act, collectively referred to as "limited wraparound coverage," are excepted benefits if all of the following conditions are satisfied. For this purpose, eligible individual health insurance is individual health insurance coverage that is not a grandfathered health plan (as described in section 1251 of the Patient Protection and Affordable Care Act and § 147.140 of this subchapter), not a transitional individual health insurance plan (as described in the March 5, 2014 Insurance Standards Bulletin Series – Extension of Transitional Policy through October 1,

2016), and does not consist solely of excepted benefits (as defined in paragraph (b) of this section).

(A) Covers additional benefits. The limited wraparound coverage provides meaningful benefits beyond coverage of cost sharing under either the eligible individual health insurance, Basic Health Program coverage, or Multi-State Plan coverage. The limited wraparound coverage must not provide benefits only under a coordination-of-benefits provision and must not consist of an account-based reimbursement arrangement.

(B) Limited in amount. The annual cost of coverage per employee (and any covered dependents, as defined in § 144.103 of this subchapter) under the limited wraparound coverage does not exceed the greater of the amount determined under either paragraph (b)(3)(vii)(B)(1) or (2) of this section. Making a determination regarding the annual cost of coverage per employee must occur on an aggregate basis relying on sound actuarial principles.

(1) The maximum permitted annual salary reduction contribution toward health flexible spending arrangements, indexed in the manner prescribed under section 125(i)(2) of the Internal Revenue Code. For this purpose, the cost of coverage under the limited wraparound 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.

(2) Fifteen percent of the cost of coverage under the primary plan. For this purpose, the cost of coverage under the primary plan and under the limited wraparound coverage includes both employer and employee contributions towards the coverage and each is determined in the same manner as the applicable premium is calculated under a COBRA continuation provision.

(C) Nondiscrimination. All of the conditions of this paragraph (b)(3)(vii)(C) are satisfied.

(1) No preexisting condition exclusion. The limited wraparound coverage does not impose any preexisting condition exclusion, consistent with the requirements of section 2704 of the PHS Act and § 147.108 of this subchapter.

(2) No discrimination based on health status. The limited wraparound coverage does not discriminate against individuals in eligibility, benefits, or premiums based on any health factor of an individual (or any dependent of the individual, as defined in § 144.103 of this subchapter), consistent with the requirements of section 2705 of the PHS Act.

(3) No discrimination in favor of highly compensated individuals. Neither the limited wraparound coverage, nor any other group health plan coverage offered by the plan sponsor, fails to comply with section 2716 of the PHS Act or fails to be excludible from income for any individual due to the application of section 105(h) of the Internal Revenue Code (as applicable).

(D) Plan eligibility requirements. Individuals eligible for the wraparound coverage are not enrolled in excepted benefit coverage under paragraph (b)(3)(v) of this section (relating to health FSAs). In addition, the conditions set forth in either paragraph (b)(3)(vii)(D)(1) or (2) of this section are met.

(1) Limited wraparound coverage that wraps around eligible individual insurance for persons who are not full-time employees. Coverage that wraps around eligible individual health insurance (or that wraps around Basic Health Plan coverage) must satisfy all of the conditions of this paragraph (b)(3)(vii)(D)(1).

(i) For each year for which limited wraparound coverage is offered, the employer that is the sponsor of the plan offering limited wraparound coverage, or the employer participating in a plan offering limited wraparound coverage, offers to its full-time employees coverage that is substantially similar to coverage that the employer would need to offer to its full-time employees

in order not to be subject to a potential assessable payment under the employer shared responsibility provisions of section 4980H(a) of the Internal Revenue Code, if such provisions were applicable; provides minimum value (as defined in section 36B(c)(2)(C)(ii) of the Internal Revenue Code); and is reasonably expected to be affordable (applying the safe harbor rules for determining affordability set forth in 26 CFR 54.4980H-5(e)(2)). 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. In the event that the employer that is the sponsor of the plan offering wraparound coverage, or the employer participating in a plan offering wraparound coverage, has no full-time employees for any plan year limited wraparound coverage is offered, the requirement of this paragraph (b)(3)(vii)(D)(1)(i) is considered satisfied.

(ii) Eligibility for the limited wraparound coverage is limited to employees who are reasonably determined at the time of enrollment to not be full-time employees (and their dependents, as defined in § 144.103 of this subchapter), or who are retirees (and their dependents, as defined in § 144.103 of this subchapter). For this purpose, full-time employees are employees who are reasonably expected to work at least an average of 30 hours per week.

(iii) Other group health plan coverage, not limited to excepted benefits, is offered to the individuals eligible for the limited wraparound coverage. Only individuals eligible for the other group health plan coverage are eligible for the limited wraparound coverage.

(2) Limited coverage that wraps around Multi-State Plan coverage. Coverage that wraps around Multi-State Plan coverage must satisfy all of the conditions of this paragraph

(b)(3)(vii)(D)(2). For this purpose, the term "full-time employee" means a "full-time employee" as defined in 26 CFR 54.4980H-1(a)(21) who is not in a limited non-assessment period for certain employees (as defined in 26 CFR 54.4980H-1(a)(26)). Moreover, 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 contribution levels for 2013 or 2014 (as applicable), and for any year in which limited wraparound coverage is offered, 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. Consistent with the reporting and evaluation criteria of paragraph (b)(3)(vii)(E) of this section, the Office of Personnel Management may verify that plans and issuers have reasonable mechanisms in place to ensure that contributing employers meet these standards.

(i) The limited wraparound coverage is reviewed and approved by the Office of Personnel Management, consistent with the reporting and evaluation criteria of paragraph (b)(3)(vii)(E) of this section, to provide benefits in conjunction with coverage under a Multi-State Plan authorized under section 1334 of the Patient Protection and Affordable Care Act. The Office of Personnel Management may revoke approval if it determines that continued approval is inconsistent with the reporting and evaluation criteria of paragraph (b)(3)(vii)(E) of this section.

(ii) The employer offered coverage in the plan year that began in either 2013 or 2014 that is substantially similar to coverage that the employer would need to have offered to its full-time employees in order to not be subject to an assessable payment under the employer shared responsibility provisions of section 4980H(a) of the Internal Revenue Code, if such provisions had been applicable. In the event that a plan that offered coverage in 2013 or 2014 has no full-

time employees for any plan year limited wraparound coverage is offered, the requirement of this paragraph (b)(3)(vii)(D)(2)(ii) is considered satisfied.

(iii) In the plan year that began in either 2013 or 2014, the employer offered coverage to a substantial portion of full-time employees that provided minimum value (as defined in section 36B(c)(2)(C)(ii) of the Internal Revenue Code) and was affordable (applying the safe harbor rules for determining affordability set forth in 26 CFR 54.4980H-5(e)(2)). In the event that the plan that offered coverage in 2013 or 2014 has no full-time employees for any plan year limited wraparound coverage is offered, the requirement of this paragraph (b)(3)(vii)(D)(2)(iii) is considered satisfied.

(iv) For the duration of the pilot program, as described in paragraph (b)(3)(vii)(F) of this section, the employer's annual aggregate contributions for both primary and limited wraparound coverage are substantially the same as the employer's total contributions for coverage offered to full-time employees in 2013 or 2014.

(E) Reporting – (1) Reporting by group health plans and group health insurance issuers. A self-insured group health plan, or a health insurance issuer, offering or proposing to offer limited wraparound coverage in connection with Multi-State Plan coverage pursuant to paragraph (b)(3)(vii)(D)(2) of this section reports to the Office of Personnel Management (OPM), in a form and manner specified in guidance, information OPM reasonably requires to determine whether the plan or issuer qualifies to offer such coverage or complies with the applicable requirements of this section.

(2) Reporting by group health plan sponsors. The plan sponsor of a group health plan offering limited wraparound coverage under paragraph (b)(3)(vii) of this section, must report to

the Department of Health and Human Services (HHS), in a form and manner specified in guidance, information HHS reasonably requires.

(F) Pilot program with sunset—The provisions of paragraph (b)(3)(vii) of this section apply to limited wraparound coverage that is first offered no earlier than January 1, 2016 and no later than December 31, 2018 and that ends no later than on the later of:

(1) The date that is three years after the date limited wraparound coverage is first offered; or

(2) The date on which the last collective bargaining agreement relating to the plan terminates after the date limited wraparound coverage is first offered (determined without regard to any extension agreed to after the date limited wraparound coverage is first offered).

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