



This document is scheduled to be published in the Federal Register on 12/24/2013 and available online at <http://federalregister.gov/a/2013-30553>, and on FDsys.gov

[Billing Codes: 4830-01-P; 4510-29-P; 4120-01-P]

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

REG-143172-13

RIN 1545-BL90

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

RIN 1210-AB60

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CMS-9946-P

45 CFR Part 146

RIN 0938-AS16

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: Proposed rules.

SUMMARY: This document contains proposed rules that would 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. Excepted benefits are generally

exempt from the health reform requirements that were added to those laws by the Health Insurance Portability and Accountability Act and the Patient Protection and Affordable Care Act.

DATES: Comments are due on or before [insert date 60 days from date of publication in the Federal Register].

ADDRESSES: Written comments may be submitted to the Department of Labor as specified below. Any comment that is submitted will be shared with the other Departments and will also be made available to the public. Warning: Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments may be posted on the Internet and can be retrieved by most Internet search engines. No deletions, modifications, or redactions will be made to the comments received, as they are public records. Comments may be submitted anonymously.

Comments, identified by “Excepted Benefits,” may be submitted by one of the following methods:

Federal eRulemaking Portal: <http://www.regulations.gov>. Follow the instructions for submitting comments.

Mail or Hand Delivery: Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Administration, Room N-5653, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210, Attention: Excepted Benefits.

Comments received will be posted without change to www.regulations.gov and available for public inspection at the Public Disclosure Room, N-1513, Employee Benefits Security Administration, 200 Constitution Avenue NW., Washington, DC 20210, including any personal information provided.

FOR FURTHER INFORMATION CONTACT: Amy Turner or Beth Baum, Employee Benefits Security Administration, Department of Labor, at (202) 693-8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 317-5500; Jacob Ackerman, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at (410) 786-1565.

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/cciiio) 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

¹ Pub. L. 104-204, 110 Stat. 2944 (September 26, 1996).

² Pub. L. 110-343, 122 Stat. 3881 (October 3, 2008).

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.

II. Overview of the Proposed Regulations

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.

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. (They 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 coverage¹⁰ (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 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 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.

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. These benefits are excepted only if all of the following conditions are met: (1) the benefits are provided under a

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(c)(3)(v).

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.¹²

The fourth category of excepted benefits is supplemental excepted benefits. 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.¹³

These proposed regulations would amend the second category of excepted benefits, limited excepted benefits.

A. Dental and Vision Benefits

In 2004, the Departments of the Treasury, Labor, and HHS published final regulations with respect to excepted benefits (the HIPAA regulations).¹⁴ (Subsequent references to the “Departments” include all three Departments, unless the headings or context indicate otherwise.) Under the HIPAA regulations, vision and dental benefits are excepted if they are limited in scope (described as benefits, substantially all of which are for treatment of the eyes or mouth,

¹² 26 CFR 54.9831-1(c)(4); 29 CFR 2590.732(c)(4); 45 CFR 146.145(c)(4). See also Q7 in FAQs about Affordable Care Act Implementation Part XI, available at <http://www.dol.gov/ebsa/faqs/faq-aca11.html>.

¹³ 26 CFR 54.9831-1(c)(5); 29 CFR 2590.732(c)(5); 45 CFR 146.145(c)(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).

¹⁴ 69 FR 78720 (Dec. 30, 2004).

respectively) and are either: (1) provided under a separate policy, certificate, or contract of insurance; or (2) are otherwise not an integral part of a group health plan. While only insured coverage may qualify under the first test, both insured and self-insured coverage may qualify under the second test. The HIPAA regulations provided that benefits are not an integral part of a plan if participants have the right to elect not to receive coverage for the benefits, and if participants elect to receive coverage for such benefits, they pay an additional premium or contribution for it. By contrast, health FSA benefits could qualify as excepted benefits without any participant contribution under the HIPAA regulations.¹⁵

Following enactment of the Affordable Care Act, various stakeholders asked the Departments to amend the regulations in order to remove conditions for limited-scope vision and dental benefits to be treated as excepted benefits. Specifically, some employers represented that, although their vision and dental benefits complied with the pre-Affordable Care Act requirements in title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code (such as the nondiscrimination and preexisting condition exclusion provisions), compliance with the Affordable Care Act provisions (including the 90-day waiting period limitation¹⁶ and the prohibition on annual limits¹⁷) presented additional challenges. These employers argued that, where employers are providing such benefits on a self-insured basis and without a contribution from employees, employers should not be required to charge a nominal contribution from

¹⁵ Under paragraph (c)(3)(v) of the HIPAA regulations, benefits provided under a health FSA are only excepted for a class of participants if other group health coverage, not limited to excepted benefits, is made available for the year to the class of participants; and the arrangement is structured so that the maximum benefit payable to any participant in the class for a year does not exceed an amount specified in the regulations.

¹⁶ See PHS Act section 2708. See also proposed regulations, published on March 21, 2013, at 78 FR 17313, stating that “the Departments will consider compliance with these proposed regulations as compliance with PHS Act section 2708 at least through the end of 2014.” (78 FR at 17317).

¹⁷ See PHS Act section 2711 and its implementing regulations at 26 CFR 54.9815-2711T, 29 CFR 2590.715-2711, and 45 CFR 147.126.

participants simply for the benefits to qualify as excepted benefits. In some cases, the cost of collecting the nominal contribution would be greater than the contribution itself. Moreover, they pointed out that employers providing dental and vision benefits through a separate insurance policy are not required to charge a participant any premium in order for the dental or vision benefits to be considered excepted benefits. Similarly, consumer groups argued that, if an employer offers primary group health coverage that is unaffordable to individuals, but limited-scope vision or dental coverage that is affordable, such limited-scope vision or dental coverage should qualify as excepted benefits so as not to make such individuals ineligible for the premium tax credit under section 36B of the Code for enrolling in coverage through an Affordable Insurance Exchange, or “Exchange” (also called a Health Insurance Marketplace or Marketplace).

In response to these concerns, and to level the playing field between insured and self-insured coverage, these proposed regulations would eliminate the requirement under the HIPAA regulations that participants pay an additional premium or contribution for limited-scope vision or dental benefits to qualify as benefits that are not an integral part of a plan (and therefore as excepted benefits). The Departments invite comments on this approach.

B. Limited Wraparound Coverage

The Affordable Care Act requires that non-grandfathered health plans in the individual and small group markets cover essential health benefits (EHB), which include items and services in ten statutorily specified categories that are equal in scope to a typical employer plan.¹⁸

¹⁸ For more information on grandfathered health plans, see section 1251 of the Affordable Care Act and its implementing regulations at 26 CFR 54.9815-1251T, 29 CFR 2590.715-1251, and 45 CFR 147.140. For more information on essential health benefits, see 45 CFR 156.110, incorporated into the regulations through 78 FR

Because employer group coverage varies from State to State, HHS regulations at 45 CFR 156.100 provide for States to adopt individual benchmarks from among a range of primarily small group plan offerings in each State to serve as a reference plan, reflecting both the scope of services and limits offered by a typical employer plan in that State.¹⁹

Prior to the Affordable Care Act, there was no Federal requirement that health coverage in the individual and small group market include a standardized set of benefits such as those included in EHB. Self-insured group health plans and health insurance coverage in the large group market often cover items and services in addition to the types of services included in EHB. For example, items and services that either cannot be or are unlikely to be included in EHB include routine adult vision and dental care, long-term/custodial nursing home care, non-medically necessary pediatric orthodontia, and coverage that extends beyond the benchmark plan's coverage of wellness programs, manipulative treatment, infertility, home health care, private duty nursing, hospice, or certain non-traditional treatments. In addition, some of these group health plans may provide broader provider networks, in terms of the number and types of contracted providers, than those often included in the individual and small group market. Federal law is designed to encourage employers to provide group coverage for their employees.²⁰

12834, Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule, Feb. 25, 2013.

¹⁹ 45 CFR 156.100, 78 FR 12840.

²⁰ Section 4980H of the Code generally provides that an applicable large employer is subject to an assessable payment if one or more full-time employees is certified to the employer as having received an applicable premium tax credit or cost-sharing reduction and either (1) the employer fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage (MEC) under an eligible employer sponsored plan, or (2) the employer offers its full-time employees (and their dependents) the opportunity to enroll in MEC under an eligible employer-sponsored plan but the coverage fails to meet requirements for affordability and minimum value. Section 5000A of the Code provides that MEC includes group health plans that are self-insured or are offered in the large or small group market within a State. Under section 5000A, nonexempt individuals must either maintain MEC for themselves and any nonexempt family members or include an additional payment with their Federal income tax return. Section 36B of the Code allows a premium tax credit to certain taxpayers who

Experts suggest that most workers who are offered minimum value employer-sponsored coverage will not meet the criteria for the premiums to be considered to be “unaffordable” and thus not qualify for the premium tax credit for enrolling in coverage through an Exchange.²¹ Nevertheless, in some cases, employer plans may be unaffordable for some employees. These individuals might purchase coverage through an Exchange with a premium tax credit. While such individuals might pay lower premiums for coverage through an Exchange, they might also have less generous coverage in terms of benefits or a different provider network than they would have had in their group health plan. Some group health plan sponsors have asked whether wraparound coverage could be provided for employees for whom the employer premium is unaffordable and who obtain coverage through an Exchange. This approach would allow employers to provide such employees with overall coverage that is comparable to the group health plan coverage, taking into account both the wraparound coverage and the Exchange coverage.

Accordingly, the Departments have developed these proposed regulations to treat certain wraparound coverage provided under a group health plan as excepted benefits when it is offered to individuals who could receive such benefits through their group health plan if they could afford the premiums, but who do not enroll in the employer-sponsored plan because the premium

enroll (or whose family members enroll) in a qualified health plan (QHP) through an Exchange. The credit subsidizes a portion of the premiums for the QHP. In general, the premium tax credit may not subsidize coverage for an individual who is eligible for other MEC. If the MEC is eligible employer-sponsored coverage, however, an individual is treated as eligible for that coverage only if the coverage is affordable and provides minimum value or if the individual enrolls in the coverage.

²¹ See Congressional Budget Office, CBO and JCT Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employer-Based Insurance, March 2012, at Table 2, available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-15-ACA_and_Insurance_2.pdf. See also Carter C. Price & Evan Saltzman, *Delaying the Employer Mandate*, July 2013, available at http://www.rand.org/pubs/research_reports/RR411.html.

is unaffordable under the law. As excepted benefits, the coverage would generally be exempt from the HIPAA and Affordable Care Act market reform requirements of ERISA, the PHS Act, and the Code. Wraparound coverage would only qualify as excepted benefits under limited circumstances in order to alleviate two concerns. First, the wraparound coverage could not replace group coverage for employers who drop coverage or who otherwise do not offer minimum value coverage. Instead, the wraparound coverage would only be considered to be an excepted benefit if it is used to provide additional coverage to individuals and families enrolled in non-grandfathered individual health insurance coverage and for whom minimum value coverage under the employer's group health plan is offered but is unaffordable. Second, the proposed rules aim to prevent plan sponsors from structuring wraparound coverage so that low-income workers receive fewer primary benefits than high-income workers. These proposed regulations are intended to allow a plan sponsor to maintain a comparable level of benefits for all potential enrollees, including not only high-income workers in their group health plan but also low-income workers that enroll in non-grandfathered individual market coverage, promoting equity in coverage.

The proposed regulations, which the Departments are proposing would be effective for plan years starting in 2015, describe the circumstances under which employer-provided wraparound coverage would constitute excepted benefits (limited wraparound coverage) and therefore would not disqualify an employee from eligibility for the premium tax credit and cost-sharing reductions. The Departments note that provision of excepted benefits will not satisfy an applicable large employer's responsibilities under section 4980H of the Code. Under these proposed regulations, limited wraparound coverage is an excepted benefit if five conditions are met.

First, the coverage can wrap around only certain coverage provided through the individual market. Specifically, the individual health insurance coverage must be non-grandfathered and cannot consist solely of excepted benefits. In States that elect to establish a Basic Health Program (BHP), certain low-income individuals (for example, those with household income between 133% and 200% of the Federal poverty level) who would otherwise qualify for a tax credit to obtain a qualified health plan through an Exchange will instead be enrolled in coverage through the BHP. Therefore, the Departments invite comments on how an employer might make wraparound coverage available to BHP enrollees.

Second, the limited wraparound coverage must be specifically designed to provide benefits beyond those offered by the individual health insurance coverage. Specifically, the limited wraparound coverage must provide either benefits that are in addition to EHBs, or reimburse the cost of health care providers considered out-of-network under the individual health insurance coverage, or both. The Departments invite comments on the types of benefits and provider arrangements that could be included in this coverage as well as their similarities to, or differences from, other types of excepted benefits described in the HIPAA regulations. The Departments also invite comments on whether the proposed standard should be modified to require that these wraparound coverage benefits be “substantial” or “material” and, if so, how those terms should be defined.

The limited wraparound coverage may, but is not required to, also provide benefits to reimburse for participants’ otherwise applicable cost sharing under the individual health insurance policy, but that cannot be its primary purpose. For the benefits to be considered specifically designed to wrap around the individual health insurance coverage, it must provide additional wraparound benefits as discussed in the immediately preceding paragraph; the

coverage cannot provide benefits solely pursuant to a coordination-of-benefits provision that simply pays benefits whenever the individual health insurance policy does not cover all or part of a medical expense.

The third condition requires the limited wraparound coverage to be otherwise not an integral part of a group health plan. That is, under the proposed regulations, the plan sponsor offering the limited wraparound coverage must sponsor another group health plan meeting minimum value (as defined under section 36B(c)(2)(C)(ii) of the Code) for the plan year, referred to as the “primary plan.” This primary plan must be affordable for a majority of the employees eligible for the primary plan. Only individuals eligible for this primary plan may be eligible for the limited wraparound coverage. The Departments seek input on this proposed standard, including whether the majority level is an appropriate level (or whether the primary plan should provide coverage that is affordable for a higher or lower percentage of employees), recognizing the goal of preventing plan sponsors from shifting participants from the employer-sponsored primary plan to the individual market with limited wraparound coverage. Assuming use of the 9.5% of income test set forth in section 36B(c)(2)(C)(i) of the Code as the basic definition of “affordable,” the Departments also request comments on how to implement that definition here – for example, whether the Departments should use a Form W-2 safe harbor based on employee wages like the one set forth in the proposed regulations under Code section 4980H.

Under the fourth condition set forth in the proposed regulations, the limited wraparound coverage must be limited in amount. Specifically, the total cost of coverage under the limited wraparound coverage must not exceed 15 percent of the cost of coverage under the primary plan

offered to employees eligible for the wraparound coverage.²² For this purpose, the cost of coverage includes both employer and employee contributions towards coverage and is determined in the same manner as that in which the applicable premium is calculated under a COBRA continuation provision.²³ This is similar to the standard in the 2007 enforcement safe harbor for treating supplemental health insurance coverage as excepted benefits. Under the safe harbor, the cost of coverage under the supplemental policy, certificate, or contract of insurance must not exceed 15 percent of the cost of primary coverage.²⁴ The Departments solicit comment on the level of this threshold, as well as other possible thresholds that could be used to ensure that the benefit is limited in amount, such as whether other thresholds used in the context of health FSAs or health savings accounts (HSAs) would be easier to administer or more appropriate.

The fifth and final condition for the limited wraparound coverage to qualify as excepted benefits relates to nondiscrimination. The limited wraparound coverage must not differentiate among 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 2705 of the PHS Act (as incorporated into ERISA section 715 and Code section 9815) and its

²² If an employer provides more than one primary plan option (for example, a health maintenance organization option and a preferred provider organization option), and one primary plan does not satisfy the 15% standard but another plan does, the Departments would consider the 15% standard to be met if the average value of the primary plan options meets the 15% standard.

²³ Under the COBRA rules, plans are generally permitted to charge up to 102 percent of the applicable premium. The cost of coverage for purposes of these proposed regulations is 100 percent of the applicable premium, not 102 percent of the applicable premium that the plan is generally permitted to charge under the COBRA rules.

²⁴ The Departments issued parallel guidance regarding supplemental health insurance coverage as excepted benefits under HIPAA and related legislation. 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/CCHIO/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).

implementing regulations. This condition is similar to the standard in the 2007 enforcement safe harbor treating supplemental health insurance coverage as excepted benefits. In addition to the cost standard mentioned above, the safe harbor requires that such coverage be similar to Medicare Supplemental Coverage in that it must not differentiate among individuals in eligibility, benefits, or premiums based on any health factor of an individual (or any dependent of the individual).

In addition, to satisfy the fifth condition, the limited wraparound coverage must not impose any preexisting condition exclusion, consistent with the requirements of section 2704 of the PHS Act (as incorporated into ERISA section 715 and Code section 9815) and its implementing regulations. Finally, both the primary coverage and the limited wraparound coverage must not discriminate in favor of highly compensated individuals, consistent with the provisions of section 2716 of the PHS Act (also incorporated by reference into ERISA section 715 and Code section 9815) and section 105(h) of the Code, and its implementing regulations at 26 CFR 1.105-11 as applicable.²⁵ These limitations are intended to ensure the coverage is available regardless of health status and to prevent employers from shifting employees with high medical costs to an Exchange. Conditioning excepted benefit status on meeting standards consistent with the compensation-based nondiscrimination rules, in combination with the requirement that the primary plan be affordable for a majority of the employees eligible for it, helps ensure that employers will not be able to use wraparound coverage to send excessive numbers of low wage workers to the Exchanges. Comments are invited as to whether additional nondiscrimination standards are needed to prevent such cost-shifting and abuse.

²⁵ Section 2716 of the PHS Act (as incorporated into ERISA and the Code) generally applies to insured coverage and section 105(h) of the Code and its implementing regulations generally apply to self-insured coverage.

C. Employee Assistance Programs

Employee assistance programs (EAPs) are typically programs offered by employers that can provide a wide-ranging set of benefits to address circumstances that might otherwise adversely affect employees' work and health. Benefits may include short-term substance use disorder or mental health counseling or referral services, as well as financial counseling and legal services. They are typically available free of charge to employees and are often provided through third-party vendors. To the extent an EAP provides benefits for medical care, it would generally be considered group health plan coverage, which would generally be subject to the HIPAA and Affordable Care Act market reform requirements, unless the EAP meets the criteria for being excepted benefits.

Since enactment of the Affordable Care Act, various stakeholders have asked the Departments to treat EAPs as excepted benefits for reasons analogous to the arguments described above with respect to vision and dental benefits. Specifically, some employers represented that compliance with the prohibition on annual limits could be problematic as such benefits are typically very limited, and that EAPs generally are intended to provide benefits in addition to those provided under other group health plans sponsored by employers. Moreover, consumer groups have represented that EAPs with very limited benefits, which may be the only coverage offered to employees, may prohibit the employee from obtaining a premium tax credit under section 36B of the Code if the EAP is treated as minimum essential coverage under section 5000A of the Code. At the same time, the Departments recognize that no universal definition exists for EAPs, and are concerned that employers not act to shift primary coverage to a separate

“EAP plan,” exempt from the consumer protection provisions of title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, including the mental health parity provisions.²⁶

The Departments issued guidance on September 13, 2013, which stated the Departments’ intent to amend the excepted benefits regulations with respect to EAPs.²⁷ The guidance also provided transition relief, stating, “[u]ntil rulemaking is finalized, through at least 2014, the Departments will consider an employee assistance program or EAP to constitute excepted benefits only if the employee assistance program or EAP does not provide significant benefits in the nature of medical care or treatment. For this purpose, employers may use a reasonable, good faith interpretation of whether an employee assistance program or EAP provides significant benefits in the nature of medical care or treatment.”

These proposed regulations set forth criteria for an EAP to qualify as excepted benefits beginning in 2015. Under these proposed regulations, benefits provided under EAPs are excepted if four criteria are met. First, the program cannot provide significant benefits in the nature of medical care. The Departments invite comments on how to define “significant.” For example, the Departments request comments as to whether a program that provides no more than 10 outpatient visits for mental health or substance use disorder counseling, an annual wellness checkup, immunizations, and diabetes counseling, with no inpatient care benefits, should be considered to provide significant benefits in the nature of medical care.²⁸

²⁶ The mental health parity provisions are included in PHS Act section 2726, ERISA section 712, and Code section 9812.

²⁷ See IRS Notice 2013-54 (available at <http://www.irs.gov/pub/irs-drop/n-13-54.pdf>) and DOL Technical Release 2013-03 (available at <http://www.dol.gov/ebsa/newsroom/tr13-03.html>), Q&A 9. See also CMS Insurance Standards Bulletin – Application of Affordable Care Act Provisions to Certain Healthcare Arrangements (available at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cms-hra-notice-9-16-2013.pdf>).

²⁸ Other examples of EAPs that do not provide significant benefits in the nature of medical care, discussed in IRS Notice 2004-50 Q&A-10 include (1) an EAP with benefits that consist primarily of free or low-cost confidential

The second criterion for an EAP to constitute excepted benefits is that its benefits cannot be coordinated with benefits under another group health plan. The Departments propose three conditions to meet this standard. Participants in the separate group health plan must not be required to exhaust benefits under the EAP (making the EAP a “gatekeeper”) before an individual is eligible for benefits under the other group health plan. Moreover, participant eligibility for benefits under the EAP must not be dependent on participation in another group health plan. Lastly, benefits under the EAP must not be financed by another group health plan.

The third criterion for an EAP to constitute excepted benefits is that no employee premiums or contributions be required to participate in the EAP. The fourth criterion is that there is no cost sharing under the EAP.

These criteria are intended to ensure that employers are able to continue offering EAPs as supplemental benefits to other coverage, and to ensure that in circumstances in which an EAP with limited benefits is the only coverage, or the only affordable coverage provided to an employee, that the coverage does not unreasonably disqualify an employee from otherwise being eligible for the premium tax credit for enrolling in coverage through an Exchange. The Departments request comments on whether the criteria proposed are sufficient to prevent the potential for abuse, including the evasion of compliance with the mental health parity provisions, and whether different or additional standards should be included.

D. Comment Solicitation, Applicability Date and Reliance

short-term counseling (which could address substance abuse, alcoholism, mental health or emotional disorders, financial or legal difficulties, and dependent care needs) to identify an employee’s problem that may affect job performance and, when appropriate, referrals to an outside organization, facility or program to assist the employee in resolving the problem; and (2) a wellness program that provides a wide-range of education and fitness services (also including sports and recreation activities, stress management, and health screenings) designed to improve the overall health of the employees and prevent illness, where any costs charged to the individual for participating in the services are separate from the individual’s coverage under the health plan.

The Departments invite comments on these proposed regulations generally, and on the specific issues identified in this preamble. Until rulemaking is finalized, through at least 2014, for purposes of enforcing the provisions of title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, the Departments will consider dental and vision benefits, and EAP benefits, meeting the conditions of these proposed regulations to qualify as excepted benefits. To the extent final regulations or other guidance with respect to vision or dental benefits or EAPs is more restrictive on plans and issuers than these proposed regulations, the final regulations or other guidance will not be effective prior to January 1, 2015.

III. Economic Impact and Paperwork Burden

A. Summary -- Department of Labor and Department of Health and Human Services

As stated above, these proposed regulations would amend the definition of limited excepted benefits to: (1) eliminate the requirement that participants in self-insured plans pay an additional contribution for limited-scope vision or dental benefits to qualify as benefits that are not an integral part of a plan (and therefore as excepted benefits); (2) allow plan sponsors in limited circumstances to offer wraparound coverage to individuals who, but for the unaffordability of the premium, would receive such benefits through their group health plan; and (3) set forth the criteria under which EAPs that do not provide significant benefits in the nature of medical care constitute excepted benefits.

B. Executive Order 12866 -- Department of Labor and Department of Health and Human Services

OMB has determined that this regulatory action is significant within the meaning of section 3(f)(4) of the Executive Order, and the Departments accordingly provide the following assessment of its potential benefits and costs. The Departments expect the impact of these

proposed regulations to be limited because they do not require any action or impose any requirements on employers and plan sponsors. The proposed modifications to vision, dental, and EAP benefits are primarily clarifications. Additionally, the Departments expect that the take-up with respect to limited wraparound coverage will be limited for several reasons. The proposed rules are designed so that the wraparound coverage could not replace group coverage for employers who drop coverage or who otherwise do not offer minimum value coverage. Instead, the wraparound coverage would only be considered to be an excepted benefit if it is used to provide additional coverage to individuals and families enrolled in non-grandfathered individual health insurance coverage and for whom minimum value coverage under the employer's group health plan is offered but is unaffordable. Moreover, the proposed rules aim to prevent plan sponsors from structuring wraparound coverage so that low-income workers receive fewer primary benefits than high-income workers. Lastly, the Departments note that provision of excepted benefits will not satisfy an applicable large employer's responsibilities under section 4980H of the Code.

One objective of the Affordable Care Act is to allow individuals with comprehensive health insurance plans to maintain their current level of benefits. The Departments recognize that many plan sponsors provide generous health benefits to their workers. Some employers offer EAPs or other additional benefits to their employees as part of a comprehensive set of benefits. Others are interested in newly offering wraparound coverage to employees who qualify for tax credits in an Exchange to provide them with coverage comparable to employees who enroll in a group health plan. These proposed regulations would clarify the circumstances under which plan sponsors can provide such limited wraparound coverage to make their employees' coverage "whole."

Specifically, these proposed regulations would allow plan sponsors to provide coverage for limited vision, dental, wraparound, and EAP benefits consistent with the qualifications for excepted benefits. These proposed improvements would help employees by continuing to maintain their access to health coverage that new requirements could constrain. The Departments expect these proposed regulations to have some costs, but these costs could be limited because they would not require any action or impose any requirements on employers and plan sponsors; take-up may be low; and the proposed modifications to vision, dental, and EAP benefits are primarily clarifications. With respect to vision and dental benefits, the proposed regulations would allow self-insured plans to offer dental and vision benefits to employees without charging a nominal contribution. With respect to EAPs, the proposed regulations would clarify the extent to which such benefits constitute excepted benefits rather than primary coverage.

With respect to wraparound coverage, the proposed regulations would allow plan sponsors to offer limited wraparound coverage to employees in certain limited circumstances. This proposal is not intended to replace group coverage for employers who drop coverage or who do not otherwise offer it, and offering the wraparound coverage will not satisfy an applicable large employer's responsibilities under section 4980H of the Code. Instead, the proposal is intended for plan sponsors whose goal is to provide health benefits to employees eligible for coverage through an Exchange that is, in total, comparable to the benefits offered through the sponsor's minimum value group health plan. As such, the targets of the proposed regulation are plan sponsors who otherwise would provide the full range of health benefits to qualifying enrollees. The wraparound coverage may only be offered to individuals eligible for the primary plan coverage the plan sponsor offers; and that primary coverage must provide

minimum value and must be affordable for a majority of employees who are eligible for the primary plan coverage. Plan designs will be limited by nondiscrimination rules aimed at preventing plan sponsors from discriminating in favor of highly compensated employees or offering different benefits for workers along other dimensions such as health status (i.e., discriminating against those with high medical costs).

The proposal provides additional flexibility for sponsors and does not impose additional costs on sponsors. The Federal budget impact of the proposal also depends on assumptions about the choices made by employers and workers. As with other group health coverage, employer contributions to the limited wraparound coverage would be excluded from employee income for tax purposes. The budget implications of adding limited wraparound coverage as a form of excepted benefits depend on the number of employers that elect this option and the number of employees that in turn receive it. As previously described, this proposal targets a narrow group of plan sponsors: those that offer minimum value coverage that is affordable for a majority of employees. The Departments seek input on this standard, including whether the majority level is an appropriate level (or whether the primary plan should provide coverage that is affordable for a larger or smaller fraction of employees), recognizing the goal of preventing plan sponsors from shifting employees from the primary plan to the individual market with limited wraparound coverage, and on the cost implications of different definitions. The cost of this proposal is difficult to quantify, as it is unclear how many plan sponsors will be eligible to offer and how many employees will elect the wraparound coverage. It is important to note that the cost of the proposed limited wraparound coverage can be reduced by limiting its availability. This could be accomplished by modifying the “majority” standard so that a greater proportion of employees would have to be offered a primary plan that is affordable. The majority level was

proposed 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. The Departments invite input on this level, and on other standards that would achieve these goals.

Another factor in assessing the proposal's cost is that the decision to offer the wraparound coverage is optional. There is greater administrative complexity associated with the wraparound coverage than primary coverage and, 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, let alone contribute to wraparound coverage. Employers may also continue to allow employees to simply obtain Exchange coverage with no additional wraparound benefit, and these employers would continue to pay any shared responsibility payments as applicable, resulting in no additional Federal costs.

The Departments seek comment on the effects of the proposal. Specifically, the Departments request detailed data that would inform the following questions: How many employers offer coverage that provides minimum value and is affordable for a majority of the employees who are eligible for coverage? What is the total number of individuals who are eligible for primary plan coverage that provides minimum value and is affordable for a majority of eligible employees, but would not find it affordable? To what extent would this proposed rule cause employers to drop health insurance coverage or avoid newly offering it, and what is the dollar value associated with such dropped coverage? To what extent would wrap-around coverage be offered more widely as a result of this rule, and what is the average dollar value associated with such coverage? To what extent would premiums for relatively generous health coverage change in the presence and in the absence of this rule?

C. Regulatory Flexibility Act -- Department of Labor and Department of Health and Human Services

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 of Labor 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

proposed rules 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 therefore request comments on the appropriateness of the size standard used in evaluating the impact of this proposed rule on small entities.

Because the proposed rules would impose no additional costs on employers or plans, the Departments believe that it would 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 the proposed rules, if promulgated, would not have a significant economic impact on a substantial number of small entities.

D. Special Analyses – Department of the Treasury

For purposes of the Department of the Treasury it has been determined that this notice of proposed rulemaking 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 proposed regulations, and, because these proposed regulations do not impose a collection of information on small entities, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Pursuant to section 7805(f) of the Code, this notice of proposed rulemaking has been submitted to the Small Business Administration for comment on its impact on small business.

E. 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 proposed rules 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.

F. Federalism-- Department of Labor and Department of Health and Human Services

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 proposed regulations, by clarifying policy regarding certain excepted benefits options that can be designed by employers to support their employees, would 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 affirmatively engage in outreach with officials of State and political subdivisions regarding the proposed rules and seek their input on the proposed rules and any federalism implications that they believe may be presented by it.

G. Congressional Review Act

These proposed 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.), and, if

finalized, will be transmitted to the Congress and to the Comptroller General for review in accordance with such provisions.

IV. Statutory Authority

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

The Department of Labor regulations are proposed to be 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 proposed to be 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 Dalrymple
Deputy Commissioner for Services and Enforcement,
Internal Revenue Service.

Signed this 11th day of December, 2013.

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

CMS-9946-P

Dated: November 22, 2013

Marilyn Tavenner,

Administrator,

Centers for Medicare & Medicaid Services.

Dated: December 3, 2013

Kathleen Sebelius,

Secretary,

Department of Health and Human Services.

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Accordingly, 26 CFR Part 54 is proposed to be amended as follows:

PART 54 – PENSION EXCISE TAXES

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

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

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

Paragraph 2. Section 54.9831-1 is amended by revising paragraphs (c)(3)(i) and (c)(3)(ii), and adding paragraphs (c)(3)(vi) and (c)(3)(vii), to read as follows:

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

* * * * *

(c) * * *

(3) * * *

(i) In general. Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (c)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section. Furthermore, benefits that wraparound individual health insurance coverage are excepted benefits if they satisfy the requirements of paragraph (c)(3)(vi) of this section, and benefits provided under an employee assistance program are excepted benefits if they satisfy the requirements of paragraph (c)(3)(vii) of this section.

(ii) Not an integral part of a group health plan. For purposes of this paragraph (c)(3), benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan or a separate plan) only if participants have the right to elect not to receive coverage for the benefits.

* * * * *

(vi) Limited wraparound coverage. Limited benefits that wraparound benefits provided through individual health insurance coverage are excepted benefits if all of the following requirements are satisfied –

(A) Wraps around certain individual health insurance coverage. The individual health insurance coverage is not a grandfathered health plan (as described in section 1251 of the Affordable Care Act) and does not consist solely of excepted benefits (as defined in paragraph (c) of this section).

(B) Covers benefits or providers not covered by individual health insurance coverage. The wraparound coverage is specifically designed to wrap around the individual health insurance coverage described in paragraph (c)(3)(vi)(A) of this section, as follows:

(1) The wraparound coverage must provide coverage of benefits that are not essential health benefits, or reimburse the cost of health care providers that are considered out-of-network under the individual health insurance coverage, or both. The wraparound coverage may also provide benefits for participants' otherwise applicable cost sharing under the individual health insurance policy.

(2) The wraparound coverage must not provide benefits only under a coordination-of-benefits provision.

(C) Otherwise not an integral part of the plan. The plan sponsor with respect to the wraparound coverage must sponsor another group health plan meeting minimum value (as defined under section 36B(c)(2)(C)(ii)) and that is affordable for a majority of the employees eligible for that group health plan (“primary plan”). Only individuals eligible for this primary plan may be eligible for the wraparound coverage.

(D) Limited in amount. The total cost of coverage under the wraparound coverage must not exceed 15 percent of the cost of coverage under the primary plan (as described in paragraph (c)(3)(vi)(C) of this section). For this purpose, the cost of coverage includes both employer and employee contributions towards coverage and is determined in the same manner as the applicable premium is calculated under a COBRA continuation provision.

(E) Nondiscrimination. The following conditions must be satisfied:

(1) The wraparound coverage must not differentiate among 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 2705 of the PHS Act (as incorporated into section 9815) and § 54.9802-1.

(2) The wraparound coverage must not impose any preexisting condition exclusion, consistent with the requirements of section 2704 of the PHS Act (as incorporated into section 9815).

(3) To the extent the primary coverage is insured, the primary coverage must not be discriminatory under section 2716 the PHS Act (as incorporated into section 9815). To the extent the primary coverage is self-insured, the primary coverage must not be discriminatory under section 105(h) and § 1.105-11.

(4) To the extent the wraparound coverage is insured, the wraparound coverage must not be discriminatory under section 2716 the PHS Act (as incorporated into section 9815) and. To the extent the wraparound coverage is self-insured, the wraparound coverage must not be discriminatory under section 105(h) and § 1.105-11.

(vii) Employee assistance programs. Benefits provided under employee assistance programs are excepted if they satisfy all of the following requirements --

(A) The program does not provide significant benefits in the nature of medical care.

(B) The benefits under the employee assistance program cannot be coordinated with benefits under another group health plan, as follows:

(1) Participants in the other group health plan must not be required to exhaust benefits under the employee assistance program (making the employee assistance program a gatekeeper) before an individual is eligible for benefits under the other group health plan;

(2) Participant eligibility for benefits under the employee assistance program must not be dependent on participation in another group health plan; and

(3) Benefits under the employee assistance program must not be financed by another group health plan.

(C) No employee premiums or contributions may be required as a condition of participation in the employee assistance program.

(D) There is no cost sharing under the employee assistance program.

* * * * *

Employee Benefits Security Administration

29 CFR Chapter XXV

For the reasons set forth above, 29 CFR part 2590 is proposed to be amended as follows:

Part 2590 – RULES AND REGULATIONS FOR GROUP HEALTH PLANS

1. The authority citation for part 2590 continues to read as follows:

Authority: Secs. 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).

2. Section 2590.732 is amended by revising paragraphs (c)(3)(i) and (c)(3)(ii), and adding paragraphs (c)(3)(vi) and (c)(3)(vii), to read as follows:

§ 2590.732 Special rules relating to group health plans.

* * * * *

(c) * * *

(3) * * *

(i) In general. Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (c)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section. Furthermore, benefits that wraparound individual health insurance coverage are excepted benefits if they satisfy the requirements of paragraph (c)(3)(vi) of this section, and benefits

provided under an employee assistance program are excepted benefits if they satisfy the requirements of paragraph (c)(3)(vii) of this section.

(ii) Not an integral part of a group health plan. For purposes of this paragraph (c)(3), benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan or a separate plan) only if participants have the right to elect not to receive coverage for the benefits.

* * * * *

(vi) Limited wraparound coverage. Limited benefits that wraparound benefits provided through individual health insurance coverage are excepted benefits if all of the following requirements are satisfied –

(A) Wraps around certain individual health insurance coverage. The individual health insurance coverage is not a grandfathered health plan (as described in section 1251 of the Affordable Care Act and § 2590.715-1251 of this part) and does not consist solely of excepted benefits (as defined in paragraph (c) of this section).

(B) Covers benefits or providers not covered by individual health insurance coverage. The wraparound coverage is specifically designed to wrap around the individual health insurance coverage described in paragraph (c)(3)(vi)(A) of this section, as follows:

(1) The wraparound coverage must provide coverage of benefits that are not essential health benefits, or reimburse the cost of health care providers that are considered out-of-network under the individual health insurance coverage, or both. The wraparound coverage may also provide benefits for participants' otherwise applicable cost sharing under the individual health insurance policy.

(2) The wraparound coverage must not provide benefits only under a coordination-of-benefits provision.

(C) Otherwise not an integral part of the plan. The plan sponsor with respect to the wraparound coverage must sponsor another group health plan meeting minimum value (as defined under section 36B(c)(2)(C)(ii) of the Code) and that is affordable for a majority of the employees eligible for that group health plan (“primary plan”). Only individuals eligible for this primary plan may be eligible for the wraparound coverage.

(D) Limited in amount. The total cost of coverage under the wraparound coverage must not exceed 15 percent of the cost of coverage under the primary plan (as described in paragraph (c)(3)(vi)(C) of this section). For this purpose, the cost of coverage includes both employer and employee contributions towards coverage and is determined in the same manner as the applicable premium is calculated under a COBRA continuation provision.

(E) Nondiscrimination. The following conditions must be satisfied:

(1) The wraparound coverage must not differentiate among 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 2705 of the PHS Act (as incorporated into ERISA section 715) and § 2590.715-2705.

(2) The wraparound coverage must not impose any preexisting condition exclusion, consistent with the requirements of section 2704 of the PHS Act (as incorporated into ERISA section 715) and § 2590.715-2704.

(3) To the extent the primary coverage is insured, the primary coverage must not be discriminatory under section 2716 the PHS Act (as incorporated into ERISA section 715). To

the extent the primary coverage is self-insured, the primary coverage must not be discriminatory under section 105(h) of the Code and 26 CFR 1.105-11.

(4) To the extent the wraparound coverage is insured, the wraparound coverage must not be discriminatory under section 2716 the PHS Act (as incorporated into ERISA section 715). To the extent the wraparound coverage is self-insured, the wraparound coverage must not be discriminatory under section 105(h) of the Code and 26 CFR 1.105-11.

(vii) Employee assistance programs. Benefits provided under employee assistance programs are excepted if they satisfy all of the following requirements --

(A) The program does not provide significant benefits in the nature of medical care.

(B) The benefits under the employee assistance program cannot be coordinated with benefits under another group health plan, as follows:

(1) Participants in the other group health plan must not be required to exhaust benefits under the employee assistance program (making the employee assistance program a gatekeeper) before an individual is eligible for benefits under the other group health plan;

(2) Participant eligibility for benefits under the employee assistance program must not be dependent on participation in another group health plan; and

(3) Benefits under the employee assistance program must not be financed by another group health plan.

(C) No employee premiums or contributions may be required as a condition of participation in the employee assistance program.

(D) There is no cost sharing under the employee assistance program.

* * * * *

Department of Health and Human Services

45 CFR Subtitle A

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

PART 146 – REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

1. 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).

2. Section 146.145 is amended by revising paragraphs (c)(3)(i) and (c)(3)(ii), and adding paragraphs (c)(3)(vi) and (c)(3)(vii), to read as follows:

§ 146.145 Special rules relating to group health plans.

* * * * *

(c) * * *

(3) * * *

(i) In general. Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (c)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section. Furthermore, benefits that wraparound individual health insurance coverage are excepted benefits if they satisfy the requirements of paragraph (c)(3)(vi) of this section, and benefits provided under an employee assistance program are excepted benefits if they satisfy the requirements of paragraph (c)(3)(vii) of this section.

(ii) Not an integral part of a group health plan. For purposes of this paragraph (c)(3), benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan or a separate plan) only if participants have the right to elect not to receive coverage for the benefits.

* * * * *

(vi) Limited wraparound coverage. Limited benefits that wraparound benefits provided through individual health insurance coverage are excepted benefits if all of the following requirements are satisfied –

(A) Wraps around certain individual health insurance coverage. The individual health insurance coverage is not a grandfathered health plan (as described in section 1251 of the Affordable Care Act and § 147.140 of this subchapter) and does not consist solely of excepted benefits (as defined in paragraph (c) of this section).

(B) Covers benefits or providers not covered by individual health insurance coverage. The wraparound coverage is specifically designed to wrap around the individual health insurance coverage described in paragraph (c)(3)(vi)(A) of this section, as follows:

(1) The wraparound coverage must provide coverage of benefits that are not essential health benefits, or reimburse the cost of health care providers that are considered out-of-network under the individual health insurance coverage, or both. The wraparound coverage may also provide benefits for participants' otherwise applicable cost sharing under the individual health insurance policy.

(2) The wraparound coverage must not provide benefits only under a coordination-of-benefits provision.

(C) Otherwise not an integral part of the plan. The plan sponsor with respect to the wraparound coverage must sponsor another group health plan meeting minimum value (as defined under section 36B(c)(2)(C)(ii) of the Code) and that is affordable for a majority of the employees eligible for that group health plan (“primary plan”). Only individuals eligible for this primary plan may be eligible for the wraparound coverage.

(D) Limited in amount. The total cost of coverage under the wraparound coverage must not exceed 15 percent of the cost of coverage under the primary plan (as described in paragraph (c)(3)(vi)(C) of this section). For this purpose, the cost of coverage includes both employer and employee contributions towards coverage and is determined in the same manner as the applicable premium is calculated under a COBRA continuation provision.

(E) Nondiscrimination. The following conditions must be satisfied:

(1) The wraparound coverage must not differentiate among 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 2705 of the PHS Act and §147.110 of this subchapter.

(2) The wraparound coverage must not impose any preexisting condition exclusion, consistent with the requirements of section 2704 of the PHS Act and § 147.108 of this subchapter.

(3) To the extent the primary coverage is insured, the primary coverage must not be discriminatory under section 2716 the PHS Act. To the extent the primary coverage is self-insured, the primary coverage must not be discriminatory under section 105(h) of the Code and 26 CFR 1.105-11.

(4) To the extent the wraparound coverage is insured, the wraparound coverage must not be discriminatory under section 2716 the PHS Act. To the extent the wraparound coverage is self-insured, the wraparound coverage must not be discriminatory under section 105(h) of the Code and 26 CFR 1.105-11.

(vii) Employee assistance programs. Benefits provided under employee assistance programs are excepted if they satisfy all of the following requirements --

(A) The program does not provide significant benefits in the nature of medical care.

(B) The benefits under the employee assistance program cannot be coordinated with benefits under another group health plan, as follows:

(1) Participants in the other group health plan must not be required to exhaust benefits under the employee assistance program (making the employee assistance program a gatekeeper) before an individual is eligible for benefits under the other group health plan;

(2) Participant eligibility for benefits under the employee assistance program must not be dependent on participation in another group health plan; and

(3) Benefits under the employee assistance program must not be financed by another group health plan.

(C) No employee premiums or contributions may be required as a condition of participation in the employee assistance program.

(D) There is no cost sharing under the employee assistance program.

* * * * *