

Implementation of Address Quality Assessment Fee

The Postal Service plans to implement the Address Quality Assessment Fee during the calendar year of 2015, after appropriate regulatory approvals.

Notice about changes regarding the extension of free address correction service and any withdrawal of the requirement for the payment of manual address correction notices for Periodicals will be provided at a later date.

The Postal Service invites all comments and feedback.

List of Subjects in 39 CFR Part 111

Administrative practice and procedure, Postal Service.

Although we are exempt from the notice and comment requirements of the Administrative Procedure Act (5 U.S.C. 553(b), (c)) regarding proposed rulemaking by 39 U.S.C. 410(a), we invite public comments on the following proposed revisions to *Mailing Standards of the United States Postal Service*, Domestic Mail Manual (DMM), incorporated by reference in the Code of Federal Regulations. See 39 CFR 111.1. Accordingly, 39 CFR part 111 is proposed to be amended as follows:

PART 111—[AMENDED]

■ 1. The authority citation for 39 CFR part 111 continues to read as follows:

Authority: 5 U.S.C. 552(a); 13 U.S.C. 301–307; 18 U.S.C. 1692–1737; 39 U.S.C. 101, 401, 403, 404, 414, 416, 3001–3011, 3201–3219, 3403–3406, 3621, 3622, 3626, 3632, 3633, and 5001.

■ 2. Revise the following sections of *Mailing Standards of the United States Postal Service*, Domestic Mail Manual (DMM), as follows:

Mailing Standards of the United States Postal Service, Domestic Mail Manual (DMM)

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600 Basic Mailing Standards for All Mailing Services

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602 Addressing

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[Revise the title of 602.5.0 as follows:]

5.0 Move Update and Address Quality Standards

5.1 Basic Standards for Move Update

[Revise the introductory paragraph only of 602.5.1 as follows:]

The Move Update standard requires the periodic matching of a mailer's address records with customer-filed

change-of-address orders maintained by USPS. Each address, except for mail bearing an alternative address format (under 3.0) or meeting the Address Quality Measurement and Assessment Standards (under 5.4), in a mailing at commercial First-Class Mail presorted or automation prices, First-Class Package Service presorted parcel prices, Standard Mail, or Parcel Select Lightweight prices is subject to the Move Update standard and must meet these requirements: * * *

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5.3 Basis for Move Update Assessment Charges

[Revise 602.5.3b as follows:]

b. Each of the assessed pieces is subject to the per piece assessment charge. See Notice 123—Price List.

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[Revise 602.5.4 and rename as 602.5.6 and add entirely new 602.5.4 as follows:]

5.4 Basic Standards for Address Quality Measurement and Assessment

Mailings that meet these requirements will not be subject to the Move Update standards in 1.0 to 4.0. Mailers of mailings that meet the Address Quality Measurement Standards will receive access to data showing the metrics on the currency of address updating. Mailings with sufficient errors to meet the criteria under 5.5 will be subject to the Address Quality Assessment Fee. The following mailings are subject to Address Quality Measurement if they:

- Use a Basic or full-service IMb on their mailpieces,
- Use eDoc to submit mailing information, and
- Qualify at least 75 percent or more of their mailpieces per calendar month as full-service.

[Add new 602.5.5 as follows:]

5.5 Basis for Address Quality Assessment Fee

Mailings that meet the standards in 5.4 are subject to an Address Quality Assessment Fee if more than [a specified percentage] of the mail has change of address (COA) errors, as determined by an analysis of the data captured during mail processing. Specifically, the mailpieces with addresses containing COA errors in excess of the error threshold will pay a per piece charge as follows:

- The mailpiece's processing indicates that it contains a COA's old address and the COA "Move Effective Date" or "Filed Date," whichever is later, is between 95 days and up to 18 months of the postage statement

finalization date. This is called a Change of Address error.

b. If the percentage of mailpieces with COA errors in a calendar month is greater than the address quality error threshold for all qualifying pieces mailed in a calendar month, any pieces above the threshold are subject to an assessment.

c. Each of the assessed pieces is subject to an Address Quality Assessment Fee.

d. Mail pieces sent to an address determined to be associated with a change of address that is temporary, foreign, Moved, Left No Address (MLNA), or Box Closed No Order (BCNO) will not be included in determining the assessment.

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We will publish an appropriate amendment to 39 CFR part 111 to reflect these changes, if our proposal is adopted.

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Attorney, Federal Requirements.

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DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

[REG-132751-14]

RIN 1545-BM44

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-P2]

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: 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 (the Code), and the Public Health Service Act related to limited wraparound coverage. Excepted benefits are generally exempt from the 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 January 22, 2015.

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 Web site (<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) Web site (www.cms.gov/ccio) 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.

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 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 section 9831(c)(1) of the Code) provides that limited benefits must either: (1) Be provided under a separate policy, certificate, or contract of insurance; or (2) otherwise not be an

¹ Public Law 104-204, 110 Stat. 2944 (September 26, 1996).

² Public Law 110-343, 122 Stat. 3881 (October 3, 2008).

³ Public Law 104-204, 110 Stat. 2935 (September 26, 1996).

⁴ Public Law 105-277, 112 Stat. 2681-436 (October 21, 1998).

⁵ Public Law 110-233, 122 Stat. 881 (May 21, 2008).

⁶ Public Law 111-3, 123 Stat. 65 (February 4, 2009).

⁷ Public Law 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.

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).

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 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. 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.¹⁴

In 2004, the Departments of the Treasury, Labor, and HHS published final regulations with respect to excepted benefits (the HIPAA regulations).¹⁵ (Subsequent references to the “Departments” include all three Departments, unless the headings or context indicate otherwise.)

On December 24, 2013, the Departments issued additional proposed regulations with respect to the second category of excepted benefits, limited excepted benefits (2013 proposed regulations).¹⁶ These 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 limited circumstances to offer, as excepted benefits, coverage that wraps around certain individual health insurance coverage in certain circumstances.

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).¹⁷ Consistent with the 2013 proposed regulations, the 2014 final regulations eliminated the requirement under the HIPAA regulations that participants pay an additional premium or contribution for limited-scope vision or dental benefits to qualify as excepted benefits. With respect to EAPs, the Departments finalized the proposal with one modification related to financing.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

As explained in the preamble to the 2013 proposed regulations, some group health plan sponsors have asked whether certain limited benefits that “wrap around” employer-sponsored group health plan coverage²⁰ could be considered an excepted benefit if such benefits are provided to employees for whom the employer’s group health plan coverage that is otherwise offered to them (“primary” coverage) is unaffordable, and who instead obtain major medical coverage through the individual market, including through the Affordable Insurance Exchange, or “Exchange” (also called a Health

Insurance Marketplace, or Marketplace). Specifically, the preamble to the 2013 proposed regulations noted that experts suggest that most workers who are offered minimum value coverage under their employer’s primary group health plan will not meet the criteria for that coverage to be considered

“unaffordable” within the meaning of the statute and thus will not qualify for the premium tax credit for enrolling in individual health coverage through an Exchange.²¹ However, the preamble went on to note that coverage under such a primary group health plan may be unaffordable for some employees, who might instead purchase individual health coverage through an Exchange with a premium tax credit. While such individuals might pay lower premiums for such individual health coverage through an Exchange than they would pay for major medical coverage offered through their employer’s group health plan, the individual coverage in the Exchange might also provide less generous coverage in terms of benefits or a different provider network than the coverage provided under their employer’s group health plan. The 2013 proposed regulations intended to permit employers to provide such employees with overall coverage that is comparable to the employer’s group health plan by providing them with limited employer-sponsored coverage that would add to and wrap around the individual market coverage that the employee purchases through the Exchange. If the employer chose to provide such limited employer-sponsored wraparound coverage, that coverage would qualify as an excepted benefit and therefore would not preclude the employee from obtaining a premium tax credit to assist in purchasing the individual coverage through the Exchange if the employee was otherwise eligible for a premium tax credit.

The 2013 proposed regulations outlined requirements under which certain employer-sponsored wraparound coverage provided under a group health plan would be treated as excepted benefits when offered to individuals who could have received the benefits provided in the wraparound coverage through their employer’s primary group health plan, however the primary plan is unaffordable and they

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).

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>.

¹⁴ 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).

¹⁵ 69 FR 78720 (Dec. 30, 2004).

¹⁶ 78 FR 77632.

¹⁷ 79 FR 59131 (Oct. 1, 2014).

¹⁸ The 2014 final regulations do not include the requirement set forth in the 2013 proposed regulations that EAP benefits cannot be financed by another group health plan in order to qualify as excepted benefits. See 79 FR 59134.

¹⁹ 79 FR 59131.

²⁰ A group health plan may be sponsored by an employer, an employee organization, or both. For simplicity, this preamble generally refers to employer-sponsored coverage. However, these proposed regulations would be equally applicable to group health plans sponsored by employee organizations, or jointly by employers and employee organizations.

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.

do not enroll in that primary plan. The 2013 proposed regulations were intended to allow a plan sponsor to pursue equity in coverage by maintaining a comparable level of benefits for all potential enrollees, including not only higher-income workers enrolled in the employer's primary group health plan but also lower-income workers, enrolled in non-grandfathered individual market coverage. Under the 2013 proposed regulations, 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, if five conditions were met.

First, under the 2013 proposed regulations, the coverage could wrap around only certain coverage provided through the individual market. Specifically, the individual health insurance coverage would have to be non-grandfathered and could not 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 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.

Second, the 2013 proposed regulations would have required that limited wraparound coverage be specifically designed to provide benefits beyond those offered by the individual health insurance coverage. Specifically, the limited wraparound coverage would have been required to provide either benefits that are in addition to essential health benefits (EHBs), or reimburse the costs of items and services provided by health care providers considered out-of-network under the individual health insurance coverage, or both. Additionally, the 2013 proposed regulations stated that the limited wraparound coverage could, but would not be required to, provide benefits to reimburse for participants' otherwise applicable cost sharing under the individual health insurance policy. Reimbursement for participants' otherwise applicable cost sharing could not be its primary purpose since Affordable Care Act-compliant individual health insurance policies already offer lower cost sharing at higher metal tiers (gold and platinum). For the benefits to be considered

specifically designed to wrap around the individual health insurance coverage, they would have to provide additional benefits; the coverage could not, under the proposed regulations, 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 of the 2013 proposed regulations would have required the plan sponsor offering the limited wraparound coverage to sponsor another group health plan providing 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 would have to be affordable for a majority of the employees eligible for the primary plan, and only individuals eligible for this primary plan could be eligible for the limited wraparound coverage.

Under the fourth condition set forth in the 2013 proposed regulations, the total cost of the employer's limited wraparound coverage would have to be limited, so as not to exceed 15 percent of the cost of coverage under the employer's primary plan offered to employees eligible for the wraparound coverage.²² For this purpose, the cost of coverage would include both employer and employee contributions towards coverage and would be determined in the same manner as that in which the applicable premium is calculated under a Consolidated Omnibus Reconciliation Act of 1985 (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 which the cost of coverage under the supplemental policy, certificate, or contract of insurance must not exceed

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 percent standard but another plan does, the Departments stated in the preamble to the 2013 proposed regulations that they would consider the 15 percent standard to be met if the average value of the primary plan options meets the 15 percent standard.

²³ Under the COBRA rules, plans are generally permitted to charge up to 102 percent of the applicable premium. See § 4980B(f)(2)(C)(i) of the Code. 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. "Applicable premium" is defined at § 4980B(f)(4) of the Code.

15 percent of the cost of primary coverage.²⁴

The fifth and final condition for the limited wraparound coverage to qualify as excepted benefits under the 2013 proposed regulations relates to nondiscrimination. The limited 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 2705 of the PHS Act (incorporated by reference into ERISA section 715 and Code section 9815) and its implementing regulations. As explained in the preamble to the 2013 proposed regulations, this condition is similar to the standard in the 2007 enforcement safe harbor treating supplemental health insurance coverage as excepted benefits and rules for Medicare supplemental coverage.²⁵

To satisfy the fifth condition under the 2013 proposed regulations, the limited wraparound coverage also could 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 could 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.²⁶ The preamble to the 2013 proposed regulations clarified that these limitations were 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.²⁷ Conditioning excepted benefit status on meeting standards consistent with the compensation-based nondiscrimination rules, in combination with the

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/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).

²⁵ 75 FR 77636.

²⁶ 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.

²⁷ 78 FR at 77636.

requirement that the primary plan be affordable for a majority of the employees who are eligible for it, was intended to help ensure that employers would not be able to use wraparound coverage to send excessive numbers of low wage workers to the Exchanges.²⁸

After consideration of comments on the 2013 proposed regulations, the Departments are publishing these proposed regulations to address limited wraparound coverage and solicit comment before promulgation of final regulations on limited wraparound benefits.

II. Overview of These Proposed Regulations

The Departments received general comments on the 2013 proposed regulations, as well as on the five conditions for wraparound coverage to qualify as excepted benefits. Many commenters suggested that limited wraparound coverage should be considered supplemental excepted benefits instead of limited excepted benefits, which would eliminate the need for the wraparound coverage to not be an integral part of a group health plan.²⁹ Some commenters suggested a more simplified approach to wraparound coverage rather than the five conditions outlined in the proposed regulations, such as adopting a more subjective test so that reasonable efforts to comply with the conditions to be excepted benefits will not cause a plan to fail to qualify as such. Others requested that the standards for limited wraparound coverage to qualify as excepted benefits track the same standards and safe harbors for applicable large employers under section 4980H of the Code and its implementing regulations, for ease of administration and consistency.

Many commenters suggested modifications to the second condition of the 2013 proposed regulations, requiring that limited wraparound coverage be specifically designed to provide benefits beyond those offered by the individual health insurance coverage. Some suggested that the goal of limited wraparound coverage should be to fill gaps in cost sharing, as the individual health insurance policy would provide coverage of EHB. Others disagreed, requesting that this condition be

changed so that cost sharing would not be the primary purpose of the wraparound coverage, because individuals who wish to reduce their cost sharing can do so by purchasing a higher “metal level” of coverage. Additionally, commenters questioned how to choose which benefits to offer in addition to what is covered under the individual health insurance policy without knowing what benefits each employee will receive under their individual health insurance coverage. Some commenters suggested that benefits provided under the wraparound coverage mirror the benefits offered under the employer’s primary plan.

Commenters also recommended changes to the third condition, that the plan sponsor offer another, primary group health plan that provides minimum value and is affordable for a majority of the employees eligible for the primary plan. Some asked that this requirement be deleted altogether. Others stated that the “majority” test conflicts with the 95% test under section 4980H(a) of the Code, and that this difference would introduce complexity and confusion, and suggested that Form W–2 employee wages and other safe harbor rules under section 4980H of the Code and the accompanying regulations be used to compute affordability. Some commenters requested that the eligibility test exclude part-time employees, Medicaid-eligible employees, and retirees. Other commenters asked that wraparound coverage be considered to meet this standard if the primary plan is affordable to the majority of employees enrolled in the primary plan (as opposed to the majority eligible for the primary plan).

Additionally, commenters addressed the limit that the total cost of coverage under the wraparound coverage not exceed 15 percent of the cost of coverage under the primary plan. Some commenters suggested increasing this percentage, stating that the 15 percent benchmark was based on rough Medicare estimates for supplemental coverage and is too low to wrap around a bronze or silver plan. Others asked that the limit be a simple dollar amount, similar to limits on health savings accounts or health FSAs. Additional commenters pointed out that as minimum value increases, so does the total cost of the wraparound coverage (and vice versa), and that wrapping around individual coverage makes these calculations confusing and uncertain.

After consideration of comments on the 2013 proposed regulations, the Departments are publishing these new

proposed regulations with respect to limited wraparound coverage. These proposed regulations seek comment on two options for limited wraparound coverage to be considered an excepted benefit. The Departments intend that, after notice and comment, one or both options could be finalized. (That is, they are not necessarily alternatives and, therefore, could be implemented side by side).

The regulations include a sunset date and, therefore, would operate as a pilot program. While some elements of this proposal are the same as those in the previous proposal, this new proposal contains changes in response to suggestions and adds new elements for reporting and data collection to gather information to inform future rulemaking.

A. Requirements of These New Proposed Regulations

These proposed regulations 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 (limited wraparound coverage) constitute excepted benefits. For this purpose, “eligible individual health insurance” is individual health insurance coverage that is not a grandfathered health plan,³⁰ not a transitional individual health insurance market plan,³¹ and does not consist solely of excepted benefits.

1. Covers Additional Benefits

The limited wraparound coverage would have to be specifically designed to wrap around eligible individual health insurance.³² That is, the limited wraparound coverage would have to provide meaningful benefits beyond coverage of cost sharing under the eligible individual health insurance. For example, the limited wraparound coverage could provide coverage for expanded in-network medical clinics or providers, or provide benefits that are not EHB and that are not covered under

³⁰ See section 1251 of the Affordable Care Act, 29 CFR 2590.715–1251, and 45 CFR 147.140.

³¹ 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>.

³² 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.

²⁸ *Id.*

²⁹ The Departments note that the exception for supplemental excepted benefits is for coverage that is supplemental to coverage provided under Medicare or Tricare, or similar supplemental coverage provided to coverage under a group health plan. None of these circumstances apply here. That is, the limited wraparound coverage that is the subject of these proposed regulations is supplemental to individual insurance.

the eligible individual health insurance. The limited wraparound coverage would not be permitted to provide benefits solely under a coordination-of-benefits provision and could not be solely an account-based reimbursement arrangement. Limited wraparound coverage that covers solely cost sharing is not permissible 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). Because the proposed regulations would permit certain eligible individuals to select any eligible individual health insurance (that is, individual health insurance coverage that is not a grandfathered health plan, not a transitional individual health insurance market plan, and does not consist solely of excepted benefits), and recognizing the complications some plan sponsors might encounter in determining what benefits or providers are not covered under that individual policy, the Departments invite comment on safe harbors standardizing the benefits in the limited wraparound coverage that could be established under this second proposed requirement.

2. Limited in Amount

The second requirement is that the limited wraparound coverage be limited in amount. For this purpose, 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 is \$2,500 in 2014, indexed in the manner prescribed under section 125(i)(2) of the Code, 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 bright-line \$2,500 limitation is intended to be simpler to administer than the 15 percent cap set forth in the 2013 proposed regulations.

3. Nondiscrimination

The limited wraparound coverage must meet three requirements relating to nondiscrimination in order to qualify as excepted benefits. 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.³³ 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.³⁴ 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 with respect to any individual due to the application of section 105(h) of the Code (as applicable).

4. Plan Eligibility Requirements

The fourth requirement to qualify as excepted benefits would be that individuals eligible for the limited wraparound coverage cannot be enrolled in excepted benefit coverage that is a health FSA. In addition, plans must comply with one of two alternative sets of standards relating to eligibility and benefits. One set of plan eligibility requirements applies to wraparound benefits offered in conjunction with eligible individual health insurance for persons who are not full-time employees. A separate set of standards applies to coverage that wraps around certain Multi-State Plan coverage.

a. *Eligible individual health insurance for individuals who are not full-time employees*

Limited coverage that wraps around eligible individual health insurance for an individual who is not a full-time employee must satisfy three standards relating to plan eligibility. 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

³³ 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> regarding the prohibition against offering employees with high claims risk a choice between enrollment in its standard group health plan or cash.

³⁴ 26 CFR 54.9802–1, 29 CFR 2590.702, and 45 CFR 146.121.

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 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 (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 necessary information regarding their coverage offered and affordability information 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. 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). For this purpose, the Departments propose that “full-time employees” would be employees who are reasonably expected to work at least an average of 30 hours per week. The Departments proposal would not require plans and issuers to define “full-time employees” strictly in accordance with the rules of section 4980H of the Code. Because this proposal is for part-time employees, some employers who wish to take advantage of this excepted benefits option may be exempt from Code 4980H and may not already be operating under that detailed set of rules. The Departments intend that employers could rely on the 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 affecting part-time employees and invite comment on this approach.

Third, other group health plan coverage, not limited to excepted benefits, must be offered to the individuals eligible for the wraparound coverage. Only individuals eligible for other group health plan coverage may be eligible for the wraparound coverage. This third requirement is consistent with the requirement for a health FSA to qualify as excepted benefits under the Departments’ excepted benefits regulations.³⁵

b. *Multi-State Plan coverage*

³⁵ See 26 CFR 54.9831–1(c)(3)(v); 29 CFR 2590.732(c)(3)(v); 45 CFR 146.145(b)(3)(v).

For Multi-State Plan coverage limited wraparound coverage, four requirements must be satisfied. The first of the four standards requires 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. The Departments anticipate that health insurance issuers with whom OPM contracts to offer Multi-State Plans will be in the best position to offer this type of limited wraparound coverage. OPM may revoke approval if it determines that continued approval is inconsistent with the reporting and evaluation criteria in the proposed regulations. Second, the employer must have offered coverage in the plan year that begins 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 (that is, substantially similar to an offer of minimum essential coverage (as defined in section 5000A(f) of the Code) 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). Third, in the plan year that begins in 2014, the employer must 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)). Fourth, 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 2014. The Departments are considering interpreting this "substantially the same" condition as a percentage (e.g., 80 or 90 percent) and potentially applying it on a per-worker basis to allow for fluctuations in an employer's workforce. The Departments seek comment on such an interpretation, as well as on all aspects of this maintenance of effort condition.

For purposes of administering this provision, with respect to limited wraparound coverage offered in conjunction with Multi-State Plan coverage, the Departments propose 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 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, OPM may verify that plans and issuers have reasonable mechanisms in place to ensure that contributing employers meet these standards.

5. Reporting

The fifth and final requirement for limited wraparound coverage to qualify as excepted benefits is a reporting requirement, for group health plans and group health insurance issuers, as well as group health plan sponsors.

A self-insured group health plan, or a health insurance issuer offering or proposing to offer Multi-State Plan wraparound coverage, reports 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 either limited wraparound coverage that wraps around eligible individual health insurance or Multi-State Plan coverage must report to HHS, in a form and manner specified in guidance, information HHS reasonably requires to determine whether the exception for limited wraparound coverage under these proposed regulations 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 a qualified health plan with additional limited wraparound coverage offered by the plan sponsor, without causing an erosion of coverage.

B. Pilot Program With Sunset Date

Under these 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 to coverage that is first offered no later than December 31,

2017 and that 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 Departments invite comments on this time frame for applicability, including whether the Departments should have the option to provide for an earlier termination date.

C. Comment Solicitation

The Departments invite comments on these proposed regulations generally, and on the specific issues identified earlier in this preamble. The Departments also seek comments on the special circumstances of small businesses that are not subject to section 4980H of the Code. Small employers may qualify to purchase coverage through the Small-Business Health Options Program (SHOP) in their State, or they may elect to buy coverage in their state's small group market outside of the SHOP. Small businesses, like other employers, can also contribute towards a health savings account (HSA) under section 223 of the Code, which may be used in combination with a high deductible health plan (HDHP). In addition, the Departments invite comments on whether modifications to health FSAs or other existing policies tailored to the needs of small businesses may also be beneficial to employers and employees.

III. Economic Impact and Paperwork Burden

A. Summary

As discussed in detail above, these proposed regulations would amend the definition of "limited excepted benefits" to provide plan sponsors with two mutually exclusive options to offer limited wraparound coverage to certain individuals. Under the first option, plan sponsors 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.

*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, seasonal, or part-year employees. These proposed regulations provide two options to employers that clarify the circumstances under which plan sponsors can provide such limited wraparound coverage to their employees.

The cost (and Federal budget impact³⁶) of this proposal is difficult to quantify, because it is unclear how many plan sponsors will be eligible to offer and how many employees will be covered by limited wraparound benefits. It is important to note that the cost of the proposed limited wraparound coverage is limited by the proposed conditions on its availability.

For example, in order to qualify as limited excepted benefits under the individual coverage option, limited wraparound coverage can be offered only to individuals who are not full-time employees (and their dependents) or who are retirees (and their dependents), and can only wrap around eligible individual health insurance.³⁷ The limited wraparound coverage must provide meaningful benefits beyond coverage of cost sharing under the individual health insurance 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 certain other dimensions such as health status. The total cost of the wraparound coverage per employee (and any covered dependents) under both options is limited to \$2,500 indexed in the manner prescribed under section 125(i)(2) of the Code.

Under the Multi-State Plan wraparound 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. As part of the approval process, OPM will require the wraparound coverage to provide meaningful benefits other than coverage of cost sharing under the Multi-State Plan.³⁸

Coverage under both options applies to limited wraparound coverage that is

³⁶ 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.

³⁷ As described earlier in this preamble, “eligible individual health insurance” is individual health insurance coverage is not a grandfathered health plan, not a transitional individual health insurance market plan, and does not consist solely of excepted benefits.

³⁸ For example, the wraparound coverage may provide coverage for expanded in-network medical clinics or providers, or provide benefits that are not essential health benefits that are not covered under the Multi-State Plan.

first offered no later than December 31, 2017, and that 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 the wraparound coverage is first offered.

Both options are designed so that wraparound coverage could not replace employer-sponsored primary group coverage. Under the individual coverage 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 workers 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 responsibility provisions of section 4980H(a) of the Code (whether applicable or not), and the coverage would have to be affordable for at least 95% of full-time employees.

Under the Multi-State Plan option, the employer would have to offer coverage in the plan year beginning in 2014 that would have substantially satisfied the employer responsibility provisions of section 4980H(a) of the Code if the provision had been applicable, provided minimum value, and been affordable for a substantial portion of its full-time employees.³⁹ The employer’s annual contributions for both its primary and wraparound coverage must be substantial (*e.g.*, at least 80% or 90% of the employer’s total contributions for coverage offered to full-time employees in 2014).

Another factor in assessing the proposal’s cost is that the decision to offer the limited wraparound coverage is 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

³⁹ The substantial 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 Marketplace coverage.

employees with affordable, minimum value coverage, allowing their workers to purchase coverage and potentially qualify for premium tax credits in the Marketplace with no additional wraparound benefit, and these employers would continue to pay any shared responsibility payments as applicable, resulting in no additional cost to the employer or the Federal government.

This proposed regulation 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. In light of this, the Departments invite comment on to what degree, if any, might this regulation increase employers' propensity to provide health insurance. Existing rules against discrimination in favor of highly compensated employees would limit employer's decisions. The Departments invite comment on to what extent, if any, this proposed regulation could affect plan sponsors' decision making. Employers' (and their employees') economic incentive, if any, to pursue a program of wrap coverage will depend importantly on the demographics of each employer's work force—that is, the distribution of their employees by part-time, seasonal, and temporary employment status, and by pay and income. In light of this, the Departments invite comment on whether there are particular sectors of the economy in which employers will be more or less inclined to pursue wraparound coverage programs.

The Departments seek comment on the other effects of the proposal. Specifically, the Departments request 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?

*C. Paperwork Reduction Act—
Department of Labor and Department of
the Treasury*

The proposed rule is not subject to the requirements of the Paperwork Reduction Act of 1995 (PRA 95) (44

U.S.C. 3501 *et seq.*), because it does not contain a collection of information as defined in 44 U.S.C. 3502(3).

*D. Paperwork Reduction Act—
Department of HHS*

The proposed rule is not subject to the requirements of the Paperwork Reduction Act of 1995 (PRA 95) (44 U.S.C. 3501 *et seq.*), because it does not contain a collection of information as defined in 44 U.S.C. 3502(3). An analysis under the PRA will be conducted for any 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 this proposed rule 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 rule 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 rule, if promulgated, would 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 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, an analysis under the RFA 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.

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 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.

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 proposed regulations, by clarifying policy regarding certain expected 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 rule and seek their input on the proposed rules and any federalism implications that they believe may be presented by it.

I. Congressional Review Act

This proposed rule is 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, and has been transmitted to Congress and the Comptroller General for review.

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.

Signed this 17th day of December, 2014.

John M. Dalrymple,

Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Signed this 18th day of December 2014.

Phyllis C. Borzi,

Assistant Secretary, Employee Benefits Security Administration, Department of Labor.

Dated: December 17, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

Dated: December 17, 2014.

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 proposed to be amended as follows:

■ **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.

■ **Paragraph 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 either “eligible individual health insurance” or coverage under a Multi-

State Plan (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 § 54.9815–1251), not a transitional individual health insurance market 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 or Multi-State Plan coverage. The wraparound coverage must not provide benefits only under a coordination-of-benefits provision and must not merely be an account-based reimbursement arrangement.

(B) *Limited in amount.* The annual cost of coverage per employee (and any covered dependents) under the limited wraparound coverage does not exceed the maximum annual salary reduction contributions toward health flexible spending arrangements, which is \$2,500 for 2014, indexed in the manner prescribed under section 125(i)(2). 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.

(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), consistent with the requirements of section 9802 and § 54.9802–1, and section 2705 of the PHS Act (incorporated by reference into section 9815) and § 54.9815–2705.

(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 offered in conjunction with individual insurance for persons who are not full-time employees.* Wraparound benefits offered in conjunction with eligible individual health insurance satisfies all of the following requirements—

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

(ii) Eligibility for the wraparound coverage is limited 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.

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

(2) *Limited wraparound coverage offered in conjunction with Multi-State Plan coverage.* Limited wraparound coverage offered in conjunction with Multi-State Plan coverage satisfies 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 2014 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 specifically designed, 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 has offered coverage in the plan year that begins 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), if such provisions had been applicable.

(iii) In the plan year that begins in 2014, the employer has 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)).

(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 wraparound coverage are substantially the same as the employer’s total contributions for coverage offered to full-time employees in 2014.

(E) *Reporting—(1) Reporting by group health plans and group health insurance issuers.* A self-insured plan, or a health insurance issuer, offering or proposing to offer Multi-State Plan wraparound 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 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 later than December 31, 2017 and that 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 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 proposes to amend 29 CFR part 2590 as follows:

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

■ 1. 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).

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

§ 2590.732 Special rules relating to group health plans.

* * * * *

(c) * * *

(3) * * *

(vii) *Limited wraparound coverage.*

Limited benefits provided through a group health plan that wrap around either “eligible individual health insurance” or coverage under a Multi-State Plan (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 market 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 or Multi-State Plan coverage. The wraparound coverage must not provide benefits only under a coordination-of-benefits provision and must not merely be an account-based reimbursement arrangement.

(B) *Limited in amount.* The annual cost of coverage per employee (and any covered dependents) under the limited wraparound coverage does not exceed the maximum annual salary reduction contributions toward health flexible spending arrangements, which is \$2,500 for 2014, indexed in the manner prescribed under section 125(i)(2) of the Code. 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.

(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), consistent with the requirements of section 702 of ERISA and § 2590.715–702, and section 2705 of the PHS Act (incorporated by reference into section 715 of ERISA) and § 2590.715–2705.

(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 offered in conjunction with individual insurance for persons who are not full-time employees.* Wraparound benefits offered in conjunction with eligible individual health insurance satisfies all of the following requirements—

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

(ii) Eligibility for the wraparound coverage is limited 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.

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

(2) *Limited wraparound coverage offered in conjunction with Multi-State Plan coverage.* Limited wraparound coverage offered in conjunction with Multi-State Plan coverage satisfies 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 2014 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.

(j) The limited wraparound coverage is specifically designed, 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 has offered coverage in the plan year that begins 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.

(iii) In the plan year that begins in 2014, the employer has 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)).

(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 wraparound coverage are substantially the same as the employer's total contributions for coverage offered to full-time employees in 2014.

(E) *Reporting*—(1) *Reporting by group health plans and group health insurance issuers.* A self-insured plan, or a health insurance issuer, offering or proposing to offer Multi-State Plan wraparound 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 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 later than December 31, 2017 and that 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 wraparound coverage is first offered).

* * * * *

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Subtitle A

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

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 adding paragraph (b)(3)(vii) to read as follows:

§ 146.145 Special rules relating to group health plans.

* * * * *

(b) * * *

(3) * * *

(vii) *Limited wraparound coverage.*

Limited benefits provided through a group health plan that wrap around either “eligible individual health insurance” or coverage under a Multi-State Plan (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 market 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 or Multi-State Plan coverage. The wraparound coverage must not provide benefits only under a coordination-of-benefits provision and must not merely be an account-based reimbursement arrangement.

(B) *Limited in amount.* The annual cost of coverage per employee (and any covered dependents) under the limited wraparound coverage does not exceed

the maximum annual salary reduction contributions toward health flexible spending arrangements, which is \$2,500 for 2014, indexed in the manner prescribed under section 125(i)(2) of the Code. 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.

(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), consistent with the requirements section 2705 of the PHS Act and § 146.121.

(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 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 offered in conjunction with individual insurance for persons who are not full-time employees.* Wraparound benefits offered in conjunction with eligible individual health insurance satisfies all of the following requirements—

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

(ii) Eligibility for the wraparound coverage is limited 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.

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

(2) *Limited wraparound coverage offered in conjunction with Multi-State Plan coverage.* Limited wraparound coverage offered in conjunction with Multi-State Plan coverage satisfies 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 2014 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 specifically designed, 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 has offered coverage in the plan year that begins 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.

(iii) In the plan year that begins in 2014, the employer has 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)).

(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 wraparound coverage are substantially the same as the employer's total contributions for coverage offered to full-time employees in 2014.

(E) *Reporting*—(1) *Reporting by group health plans and group health insurance issuers.* A self-insured plan, or a health insurance issuer, offering or proposing to offer Multi-State Plan wraparound 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 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 to determine whether the exception for limited wraparound coverage under this

paragraph (b)(3)(vii) 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 a qualified health plan with additional limited wraparound coverage offered by the plan sponsor, without the causing an erosion of coverage.

(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 later than December 31, 2017 and that 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 wraparound coverage is first offered).

* * * * *

[FR Doc. 2014-30010 Filed 12-19-14; 11:15 am]

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FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 20

[WT Docket Nos. 07-250, 10-254; DA 14-1688]

Request for Updated Information and Comment on Wireless Hearing Aid Compatibility Regulations

ACTION: Proposed rule.

SUMMARY: In this document, the Wireless Telecommunications Bureau and the Consumer and Governmental Affairs Bureau seek updated input to better understand the current consumer experience, to explore technical or other barriers to the provision of hearing aid compatible devices on new wireless technologies, and to consider changes to its rules that may be necessary to ensure that wireless handsets used with advanced communications services are accessible in light of directives contained in the Twenty-First Century Communications and Video Accessibility Act (CVAA).

DATES: Effective 30 days from publication in the **Federal Register**. Reply Comments 45 days from publication in the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: Eli Johnson, Wireless Telecommunications Bureau, (202) 418-1395, email Eli.Johnson@fcc.gov. Bob Aldrich, Consumer and Governmental Affairs