February 24, 2014

Submitted electronically via http://www.regulations.gov

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

Re: Amendments to Excepted Benefits

Sir or Madam:

I write on behalf of the American Benefits Council ("Council") to provide comment on proposed rules ("Proposed Rules") amending regulations regarding excepted benefits under the Employee Retirement Income Security Act of 1974 ("ERISA"), the Internal Revenue Code ("Code"), and the Public Health Service Act ("PHSA"). The Proposed Rules were published in the Federal Register on December 24, 2013 by the Department of Labor, the Department of the Treasury, and the Department of Health and Human Services (collectively, the "Departments").

The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to health and retirement plans that cover more than 100 million Americans.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") added Part 7 to ERISA, Chapter 100 to the Code, and Title XXVII to the PHSA, providing portability and nondiscrimination provisions with respect to health coverage. These provisions were later modified by numerous laws, including the Patient Protection and Affordable Care Act ("ACA"). Among other things, these provisions of ERISA, the

Code, and the PHSA, as amended by the ACA, subject group health plans and health insurance issuers in the group and individual markets to certain market reform requirements. However, excepted benefits, which are described in ERISA Section 733, Code Section 9832, PHSA Sections 2722 and 2763, and related regulations, are generally exempt from these market reform requirements.

The Proposed Rules propose to modify the category of excepted benefits known as limited excepted benefits in three ways, as described in more detail below. Currently, limited excepted benefits may include limited scope dental and vision benefits, and benefits for long-term care, nursing home care, home health care, or community-based care. The regulations authorize the Secretaries of the Departments to issue regulations establishing other, similar limited benefits as excepted benefits, so long as they are either (i) provided under a separate policy, certificate, or contract of insurance, or (ii) otherwise not an integral part of a group health plan, whether insured or self-insured.

The Proposed Rules include important clarifications with respect to excepted benefits. We appreciate the opportunity to comment, and we particularly appreciate that employers may rely on these Proposed Rules at least through the end of 2014.

LIMITED SCOPE DENTAL AND VISION BENEFITS

As noted above, in order for dental and vision benefits to qualify as excepted benefits, they must satisfy one of two tests: (i) they must be provided under a separate policy, certificate, or contract of insurance ("First Test"); or (ii) they must otherwise not be an integral part of a group health plan ("Second Test"). With respect to the First Test, coverage can only qualify if it is insured coverage. With respect to the Second Test, coverage can qualify regardless of whether it is insured or self-insured coverage, so long as participants have the right to elect not to receive coverage for the benefits, and, if participants elect to receive coverage for such benefits, they pay an additional premium or contribution for it.

The Proposed Rules would eliminate the requirement that participants pay an additional premium or contribution for dental or vision benefits in order to constitute excepted benefits under the Second Test. The Council supports the proposed elimination of the Second Test's requirement that participants pay an additional premium or contribution for dental or vision benefits in order for such benefits to constitute excepted benefits. As noted in the preamble to the Proposed Rules, elimination of this requirement would place self-insured and insured dental and vision benefits on more equal footing, given that insured dental and vision plans do not have to charge a separate premium or contribution in order to constitute excepted benefits so long as they are provided under a separate policy, certificate or contract of insurance (a requirement that self-insured benefits cannot satisfy). In addition, from a practical perspective, many employers would like to offer self-insured dental and vision benefits

at their sole expense, with no contributions from employees. The proposed change will enable employers to offer these types of coverage without requiring the imposition of some nominal employee cost. We believe this makes good policy and practical sense and are supportive of the proposed change.

As noted above, under current regulations, in addition to the separate contribution requirement, participants must have the right to elect not to receive coverage for limited scope dental or vision in order to constitute excepted benefits under the Second Test. We encourage the Departments to confirm in final regulations that participants will be considered to have the right to elect not to receive coverage if such coverage automatically enrolls participants but provides an opportunity for opt-out. Employers increasingly offer valuable dental and vision benefits to employees, often at no cost to employees on an automatic-enrollment basis. Employees benefit from this practice by receiving dental and vision coverage in which, given the power of inertia, employees may otherwise not enroll. In order to preserve these valuable benefits, we encourage the Departments to provide in final regulations that automatic enrollment with a permitted opt-out will be considered to allow participants the right to elect not to receive coverage and thus enable such coverage to qualify as excepted benefits under the Second Test.

Finally, we note that many employers use administrative services only ("ASO") arrangements to administer self-funded limited scope dental and vision benefits. Particularly in situations in which these employers are contractually obligated to offer these benefits, we encourage the Departments to examine whether it would be possible to treat these arrangements as satisfying the First Test (i.e., providing limited scope dental or vision benefits under a separate policy, certificate, or contract of insurance). Given that one of the goals of the Proposed Rules is to put valuable limited scope dental and vision benefits on a level playing field without regard to whether they are insured or self-insured, it would make good policy sense to make clear in final regulations that self-funded limited scope dental and vision benefits that are administered under an ASO arrangement may satisfy the First Test in order to constitute excepted benefits. The Council believes that the Departments have regulatory authority to take action in this manner.

It is our understanding that there may be some doubt as to whether self-funded limited scope dental and vision benefits that are offered by an employer that does not also offer major medical coverage may qualify as excepted benefits. There is no question that fully insured limited scope vision or dental benefits are excepted benefits regardless of whether other group health coverage is offered. The funding mechanism (i.e., insured versus self-funded) should not be significant for purposes of determining status as excepted benefits. In the spirit of creating a level playing field for insured and self-funded limited scope dental and vision, we encourage the Departments to clarify that self-funded limited scope dental and vision benefits that are offered by an employer that does not also offer major medical coverage may qualify as excepted benefits.

LIMITED WRAPAROUND COVERAGE

The preamble to the Proposed Rules states that some employer-sponsored group health plans may be unaffordable for some employees, and that those employees might purchase individual coverage through an Exchange with a premium tax credit. The preamble further provides that, although such individuals might pay lower premiums for such coverage, they might also have less generous benefits or a different provider network than they would have had if they had participated in the employer-sponsored group health plan. The Proposed Rules set forth the following circumstances, all of which must be satisfied in order for limited wraparound coverage offered by an employer to be considered an excepted benefit and thus not subject to the market reforms:

- The wraparound coverage must wrap around non-grandfathered individual health insurance coverage that does not consist solely of excepted benefits.

- The wraparound coverage must cover benefits that are not essential health benefits and/or it must reimburse the cost of health care providers that are considered out-of-network under the individual health insurance coverage. It may also provide benefits for otherwise applicable cost sharing under the individual health insurance policy. In addition, the wraparound coverage must not provide benefits only under a coordination-of-benefits provision.

- The plan sponsor must sponsor another group health plan meeting minimum value and that is affordable for a majority of the employees eligible for that group health plan. Only individuals eligible for this primary plan may be eligible for the wraparound coverage.

- The total cost of coverage under the wraparound coverage must not exceed 15% of the cost of coverage under the primary plan.

- The wraparound coverage must: (i) not differentiate among individuals in eligibility, benefits, or premiums based on a health factor; (ii) not impose any preexisting condition exclusions; and (iii) satisfy applicable nondiscrimination rules. The primary plan must also satisfy applicable nondiscrimination rules.

The Council appreciates that the Proposed Rules extend excepted benefit status to certain limited wraparound coverage. Given that a goal of the ACA is to expand access to comprehensive health coverage, permitting employers to voluntarily provide supplemental benefits in the form of limited wraparound coverage for employees who purchase individual coverage, without the additional burden of requiring that such coverage comply with the ACA market reforms, helps further that goal.

We request, however, that the final rules clarify that limited wraparound coverage does not have to be offered only to individuals for whom primary employer-sponsored coverage is unaffordable in order to qualify as an excepted benefit. The text of the Proposed Rules could be read to provide that the limited wraparound coverage can only cover individuals with respect to whom the primary employer-sponsored coverage is unaffordable. We encourage the Departments to make clear that limited wraparound coverage may be offered to all individuals who are eligible for the primary employer-sponsored coverage, regardless of its affordability on an individual basis. A requirement that employers only offer limited wraparound coverage to individuals for whom the primary employer-sponsored coverage is unaffordable would be administratively burdensome for employers and may preclude them from offering wraparound coverage to their employees at all. Such a restriction would result in fewer individuals being covered by the wraparound coverage (thus increasing its cost per enrollee for the employer) and significant additional risk for employers, since the wraparound coverage could inadvertently become subject to market reforms if erroneously provided to individuals for whom primary employer-sponsored coverage is affordable but who choose not to enroll in such coverage.

In addition, it is not clear whether individual coverage subject to the wraparound coverage must be purchased through an Exchange (as opposed to outside of an Exchange). We encourage the Departments to allow limited wraparound coverage to be offered to individuals who enroll in individual coverage without regard to whether such individual coverage is purchased through an Exchange; a contrary rule would impose significant burdens on employers and could limit employees' access to wraparound coverage.

Finally, we note that, as a purely technical matter, it appears to the Council that the provisions relating to limited wraparound coverage set forth in the Proposed Regulations could also be considered similar supplemental coverage described in 29 C.F.R. Section 2590.732(c)(5), 26 C.F.R. Section 54.9831-1(c)(5), and 45 C.F.R. Section 146.145(b)(5). Accordingly, to avoid any confusion, it would be helpful if this could be expressly acknowledged in the final rulemaking.

EMPLOYEE ASSISTANCE PROGRAMS AND WELLNESS PROGRAMS

The Council supports the standards set forth in the Proposed Rules regarding when an Employee Assistance Program ("EAP") will be considered to be an excepted benefit and thus not subject to the ACA market reforms. Employers have long faced uncertainty as to whether their EAPs qualify as excepted benefits. Because EAPs are an important tool for employers to use in providing benefits to employees, we are pleased that the Departments have developed the following criteria, set forth in the Proposed Rules, which, if satisfied, would cause an EAP to qualify as an excepted benefit:

- The EAP does not provide significant benefits in the nature of medical care.

- The benefits under the EAP cannot be coordinated with benefits under another group health plan.

- No employee premiums or contributions may be required as a condition of participation in the EAP.

- There can be no cost sharing under the EAP.

The Council believes that the four criteria set forth in the Proposed Rules are generally in line with common practice, subject to the following discussion.

In the preamble to the Proposed Rules, the Departments request comment with respect to what constitutes "significant benefits in the nature of medical care." Specifically, the Departments request comment regarding whether an EAP that provides no more than 10 outpatient visits for mental health or substance use disorder counseling, an annual wellness checkup, immunizations, and diabetes counseling, with no inpatient care benefits, should be considered to provide significant benefits in the nature of medical care. The Council believes that the other three criteria (i.e., no coordination of benefits, no employee premiums or contributions, and no cost sharing) operate to ensure that an EAP does not provide significant benefits in the nature of medical care. Accordingly, we do not believe a specific limit on the number of visits is necessary.

However, to the extent that the Departments decide that the final regulations should set forth a specific limit on the number of visits an EAP may permit in order for it to qualify as an excepted benefit, we encourage the Departments to adopt a "safe harbor" in terms of the number of visits, whereby an EAP that provides no more than the safe harbor limit is deemed to comply with the first criterion, i.e., that it does not provide significant benefits in the nature of medical care, with application of a facts-and-circumstances analysis in the event an EAP offers more than the specified number of visits.

If the Departments impose a limit on the number of visits an EAP may provide, we urge the Departments to consider that many EAPs are problem-focused, allowing individuals to use up to a specified number of visits for a given category of short-term counseling, evaluation and/or referral (*e.g.*, substance abuse, grief, family issues). EAPs are frequently designed in this manner in order to allow individuals to explore counseling and referral opportunities with respect to multiple categories without approximating major medical care. Frequently, individuals use less than the maximum number of visits per category permitted under the EAP. However, to ensure that EAPs may continue to reflect this design, which provides valuable services to affected participants, we encourage the Departments to provide in final regulations that EAP

visit limits, if any, apply on a per-issue basis while still qualifying as excepted benefits. In this regard, we believe a 10-visit limit, applied on a per-issue basis as discussed below, would be reasonable.

We strongly encourage the Departments to use their regulatory authority to provide a similar safe harbor for employer-sponsored wellness programs. Wellness programs are effective tools for promoting health and productivity by encouraging employees to become more engaged in addressing their health care needs. Employers have typically encountered similar concerns with respect to both EAPs and wellness programs regarding the potential application of the ACA and its market reform requirements. Accordingly, we encourage the Departments to promulgate a safe harbor rule establishing the circumstances in which wellness programs will qualify as excepted benefits and thus not be subject to the ACA market reforms. Such a rule would provide increased certainty for employers in implementing and maintaining their wellness programs for their employees.

CLARIFICATION OF PRIOR DEPARTMENT GUIDANCE ON SUPPLEMENTAL HEALTH INSURANCE COVERAGE

Department of Labor Field Assistance Bulletin 2007-04, Internal Revenue Service Notice 2008-23, and Centers for Medicare and Medicaid Services Insurance Standards Bulletin 08-01 describe circumstances pursuant to which certain supplemental health insurance coverage qualifies as an excepted benefit ("Supplemental Benefits"). Specifically, they state that coverage providing Supplemental Benefits will be treated as HIPAA-excepted if it meets the following general requirements:

- the coverage is provided under a separate policy, certificate, or contract of insurance issued by an entity that does not provide the primary coverage under the plan;

- the coverage is specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles, but does not encompass coverage that becomes secondary or supplemental only under a coordination-of-benefits provision;

- the cost of the supplemental coverage does not exceed 15% of the cost of the underlying group health coverage; and

- the coverage does not differentiate among individuals in eligibility, benefits, or premiums based on any health factor of an individual (or any dependent of the individual).

This guidance has been very helpful in allowing employees to access coverage that supplements other employer-sponsored coverage. However, the Council understands

that certain of the above requirements remain open to interpretation – specifically the requirement that Supplemental Benefits be designed for the sole purpose of filling gaps in coverage. In this regard, questions remain regarding whether a qualifying arrangement must be designed solely to "top-off" benefits otherwise covered by the underlying group health plan (*e.g.*, through providing for copayment reimbursement) or whether the guidance also encompasses arrangements that provide coverage for a specific benefit that may not be covered at all by the underlying group health plan (*e.g.*, autism coverage, organ transplant coverage, or coverage for certain experimental procedures). We believe that both the former and latter types of arrangements should qualify as Supplemental Benefits, and we encourage the Departments to clarify this as part of future rulemaking. Such an interpretation will help to ensure that employees continue to have access to important supplemental coverage that may provide benefits not offered by an employer's primary group health plan.

We also encourage the Departments to extend the Supplemental Benefits safe harbor described above to include self-insured arrangements. Such a change would be in accordance with good public policy, because it would ensure that employees have access to cost-efficient supplemental coverage where appropriate. Additionally, as noted by the Departments in the preamble to the Proposed Rules, such a change would place self-insured plans on more equal footing with insured arrangements.

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Thank you for considering these comments submitted in response to the Proposed Rules issued with regard to excepted benefits. If you have any questions or would like to discuss these comments further, please contact me at (202) 289-6700.

Sincerely,

Kathryn Wilber
Senior Counsel, Health Policy