



# AMERICAN BENEFITS COUNCIL

January 22, 2015

*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**

Dear Sir or Madam:

We write on behalf of the American Benefits Council (“Council”) to provide comment in connection with the proposed rule published in the Federal Register on December 23, 2014, by the Departments of Labor, Health and Human Services, and the Treasury (“Departments”) entitled “Amendments to Excepted Benefits” (“Proposed Rule”).

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 Council appreciates the flexibility that the Proposed Rule would provide to employers to offer coverage that best suits their workforces. By allowing employers to supplement individual market coverage with limited wraparound coverage, the Proposed Rule has the potential to provide employers with an important tool to help formulate benefits offerings for their employees that are cost-efficient and also comprehensive in nature. Additionally, the Proposed Rule has the potential to help

employers manage their benefits to minimize the application of the excise tax on high-cost employer-sponsored health coverage under Internal Revenue Code (“Code”) section 4980I – the so-called “Cadillac Tax.”

The Council appreciates the opportunity to provide comment with respect to the Proposed Rule.

**THE PROPOSED RULE NEEDS TO BE SIMPLIFIED TO FOSTER COMPLIANCE AND UTILIZATION BY EMPLOYERS.**

The Proposed Rule, as promulgated, is quite confusing and overly restrictive. This is due, in part, to the dual frameworks provided in the Proposed Rule. One framework allows employers to offer limited wraparound coverage to full-time employees, part-time employees, and retirees only if they offered certain levels of group health plan coverage during the 2014 plan year, and only if the limited wraparound coverage is designed and approved by the Office of Personnel Management (“OPM”) and offered in conjunction with Multi-State Plan (“MSP”) coverage (“MSP Rule”). The other framework allows employers to offer limited wraparound coverage to part-time employees and retirees (but not to full-time employees) if they comply with slightly different (and arguably less restrictive) requirements (“Non-MSP Rule”).

To better ensure that employers are able to make practical use of the guidance and to foster increased understanding of, and compliance with, the rules applicable to limited wraparound guidance, we strongly urge that any final rulemaking be simplified.

**FINAL RULES SHOULD RETAIN AN EMPLOYER’S ABILITY TO USE INSURED OR SELF-FUNDED LIMITED WRAPAROUND COVERAGE.**

The Proposed Rule expressly permits the use of either insured or self-funded coverage. The Council strongly supports retention of this provision as part of any final rulemaking. Many of our member companies self-fund the health coverage they provide to their employees. This is due to many factors, including providing more cost-effective and efficient health coverage to employees, as well as the ability for employers to design and offer coverage that is best suited to their employees. Thus, to ensure that employers have the greatest ability to offer limited wraparound coverage to employees that is cost-effective and best-suited to their employees’ interests and needs, we urge that any final rule preserve the ability of employers to offer self-funded limited wraparound coverage.

**THE AVAILABILITY OF LIMITED WRAPAROUND COVERAGE SHOULD BE EXPANDED BEYOND THE END OF THE PILOT PERIOD.**

The Proposed Rule provides that the availability of limited wraparound coverage as an excepted benefit will sunset after a period of time. Specifically, the Proposed Rule provides that limited wraparound coverage may be offered no later than December 31, 2017 and must end on the later of (i) the date that is three years after the date coverage is first offered, or (ii) 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).

The Council is concerned that the time-limited nature of the program as described in the Proposed Rule may lead to less than full utilization of limited wraparound coverage by employers. This is especially so given the cost, time, and employee education that would be required in establishing a successful program that includes limited wraparound coverage as a component. In performing a cost-benefit analysis regarding whether to offer limited wraparound coverage, it seems likely that many employers may conclude that the short time period during which it could be offered is not worth the time and expense it would cost to establish the program.

As noted above, the Council believes that limited wraparound coverage could provide value to employers and employees alike. Accordingly, the Council urges the Departments to issue a final rule that provides for a pilot program of meaningful duration (for example, 7-10 years) or otherwise provides for a permanent HIPAA-excepted category for limited wraparound coverage. Additionally, any extension of time should be clearly set forth in any final rule so that employers and employees may make informed decisions regarding the offering of, and enrollment in, limited wraparound coverage.

**THE LIMITATION ON THE ANNUAL COST OF COVERAGE PER EMPLOYEE SHOULD BE MODIFIED TO PROVIDE EMPLOYERS WITH A CHOICE OF LIMITATIONS.**

The Proposed Rule would require that the annual cost of coverage per employee (and any covered dependents) under the limited wraparound coverage not exceed the maximum annual salary reduction contributions toward health flexible spending arrangements (“Health FSAs”), as indexed (such maximum contribution, the “Health FSA Limit”). The Health FSA Limit for 2015 is \$2,550, and will be indexed to the Consumer Price Index (“CPI”) in future years.

In a prior iteration of the Proposed Rule,<sup>1</sup> the Departments had proposed to limit the

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<sup>1</sup> See Amendments to Excepted Benefits, 78 Fed. Reg. 77,632 (Dec. 24, 2013).

total cost of limited wraparound coverage to 15% of the cost of coverage under the employer's primary plan offered to employees eligible for the wraparound coverage.

While the Council recognizes the need for a limit on the cost of limited wraparound coverage, we urge the Departments to issue a final rule that limits the coverage to the greater of (i) 15% of the cost of coverage under the employer's primary plan, or (ii) the Health FSA Limit, indexed using CPI. Alternatively, we urge the Departments to use an indexing rate for the Health FSA Limit that better accords with actual health inflation. Otherwise, it seems quite likely, if not certain, that over time employers will be unable to offer valuable wraparound coverage to their employees and retirees.

**CLARIFICATION IS NEEDED AS TO WHAT CONSTITUTES "MEANINGFUL" ADDITIONAL BENEFITS.**

The Proposed Rule would require that limited wraparound coverage provide "meaningful" benefits beyond providing for increased cost-sharing benefits. The Proposed Rule further provides that the wraparound coverage must not provide benefits only under a coordination-of-benefits provision and must not merely be an account-based reimbursement arrangement.

Despite the requirements set forth in the Proposed Rule, it is not clear what type and amount of benefits would constitute sufficient "meaningful" benefits. Moreover, from a practical perspective, how meaningful could these benefits be if they are capped at a maximum dollar limit of \$2,500 (subject to indexing)? Additionally, unless an employer requires employees to obtain coverage through a limited subset of individual market plans, an employer likely will have limited or no knowledge of the specific benefits available to his or her employees vis-a-vis their individual insurance coverage.

In light of the above, we encourage the regulators to provide additional information regarding this requirement in the final regulations. Moreover, we request that such information take account of the dollar-limited nature of the coverage and the fact that employers may lack full and complete information related to the nature and extent of the related individual insurance in which an employee is enrolled.

The Council would welcome the promulgation of safe harbors for use by employers and plans in satisfying the meaningful additional benefit requirement. For example, the final rules could establish a safe harbor providing that limited wraparound coverage provides meaningful additional benefits if it reimburses 100% of the costs for specific services or prescriptions that are not covered by the underlying plan or if the coverage includes access to an on-site clinic for health care services.<sup>2</sup>

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<sup>2</sup> In this regard, the Council believes that low- or no-cost care through on-site medical clinics could, itself, constitute an excepted benefit. To the extent that such care may be provided through limited wraparound coverage without causing such coverage to cease to be an excepted benefit, the Council would encourage

At minimum, examples of benefits that may constitute “meaningful” additional benefits would be helpful to employers as they contemplate the structure of their limited wraparound coverage.

**THE NONDISCRIMINATION RULES MUST BE MODERNIZED IN ORDER TO APPLY THEM TO LIMITED WRAPAROUND COVERAGE.**

The Proposed Rule would require that both limited wraparound coverage and the primary group health plan coverage satisfy certain nondiscrimination requirements, including the requirements imposed by Public Health Service Act (“PHSA”) section 2716 (as incorporated into the Employee Retirement Income Security Act and the Code) (imposing nondiscrimination requirements on insured plans) and Code section 105(h) (imposing nondiscrimination requirements on self-funded plans).

The Council appreciates the rationale for applying the nondiscrimination rules to both the limited wraparound coverage and the primary group health plan. However, as the Council has previously noted,<sup>3</sup> it is imperative that (i) the rules under Code section 105(h) relating to self-funded plans be modernized, and (ii) the rules under PHSA section 2716 be based on such modernized rules, before the Departments begin enforcing them, both with regard to their application in the context of limited wraparound coverage and more generally.

**DUAL ENROLLMENT IN LIMITED WRAPAROUND COVERAGE AND HEALTH FSAs SHOULD BE PERMITTED.**

The Proposed Rule would prohibit dual enrollment in a Health FSA and limited wraparound coverage. The Council suggests that the final rule not impose such a prohibition on dual enrollment.

The rationale for the dual-enrollment prohibition is not entirely clear based on either the text of, or the preamble to, the Proposed Rule. Concededly, individuals who enroll in limited wraparound coverage may require less coverage under a Health FSA because of reduced out-of-pocket exposure as a result of their limited wraparound coverage. However, it is quite conceivable that in many instances individuals covered by limited wraparound coverage will still have health care expenses that are not fully covered by either the individual insurance policy or the HIPAA-excepted limited wraparound

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the Departments to consider issuing future guidance providing that low- or no-cost care through on-site medical clinics constitutes an excepted benefit.

<sup>3</sup> See Council Letter dated November 4, 2010, available at [http://www.americanbenefitscouncil.org/documents/hcr\\_nondiscrim-comments110410.pdf](http://www.americanbenefitscouncil.org/documents/hcr_nondiscrim-comments110410.pdf).

coverage. Thus, many individuals will have a need for continued participation in a Health FSA.

For these reasons, we encourage the Departments to make clear in any final rule that an individual *may* be covered under both a Health FSA and limited wraparound coverage for the same period of time. A contrary rule could result in individuals having to use after-tax monies to satisfy their remaining out-of-pocket expenses. The Council believes sound public policy supports allowing for dual enrollment in order to avoid such a result.

**COMMENTS SPECIFIC TO LIMITED WRAPAROUND COVERAGE OFFERED IN CONJUNCTION WITH INDIVIDUAL INSURANCE FOR PERSONS WHO ARE NOT FULL-TIME EMPLOYEES:**

As noted in our introductory comments, the Proposed Rule sets forth two potential frameworks that employers may be able to use in offering limited wraparound coverage to their employees. The comments in this section are specific to the portion of the Proposed Rule addressing limited wraparound coverage offered in conjunction with individual insurance for persons who are not full-time employees (“Non-MSP Rule”).

**Full-time employees should be permitted to enroll in limited wraparound coverage.**

Pursuant to the Non-MSP Rule, the Proposed Rule provides that limited wraparound coverage may be offered only to part-time employees and retirees. Accordingly, under the rule as proposed, limited wraparound coverage may not be offered to full-time employees.

The policy rationale for excluding full-time employees from access to limited wraparound coverage in connection with enrollment in non-MSP coverage is not clearly set forth in Proposed Rule. We see no basis for the exclusion and note that one of the principal policy reasons for allowing access to HIPAA-excepted limited wraparound coverage applies equally to all employees regardless of part-time or full-time status – namely, an employer’s interest in ensuring that employees have access to appropriate and comprehensive health care coverage.

Interestingly, under the rules governing limited wraparound coverage offered in conjunction with MSP coverage, full-time employees may be offered such limited wraparound coverage. Thus, at least in instances involving employee enrollment in MSP coverage, the Departments believe it is appropriate to permit full-time employees access to limited wraparound coverage. The reasoning for imposing different rules in the event of enrollment in MSP coverage or other coverage is unclear and not explained in the preamble to the Proposed Rule. To the extent the asymmetry is based on fostering increased enrollment and/or carrier participation in MSP coverage, the Council does not believe this provides sufficient reason for imposing more limiting

rules with respect to non-MSP coverage.

As part of final rulemaking, the Council urges the Departments to allow full-time employees to enroll in limited wraparound coverage regardless of whether they enroll in MSP coverage.

**Employers should not be required to offer group health coverage to individuals eligible for limited wraparound coverage.**

The Proposed Rule would require that other group health plan coverage, not limited to excepted benefits, be offered to the part-time employees and retirees eligible for the wraparound coverage offered pursuant to the Non-MSP Rule. The Council does not believe this requirement advances the purpose of the rule, i.e., to provide comparable benefits to those that would be offered under a group health plan to an individual who elects to enroll in individual market coverage. Moreover, it reduces the flexibility afforded to employers that might consider offering limited wraparound coverage to their employees, because employers would have to bear the costs of sponsoring a plan for such employees, even where there is low uptake among employees and the benefits offered under such plan may not be as generous as those available in the individual market.

**Employers should not be required to offer affordable, minimum value coverage to their full-time employees.**

The Proposed Rule would require employers offering limited wraparound coverage pursuant to the Non-MSP Rule to also offer to their full-time employees coverage that (i) is substantially similar to coverage that the employer would need to offer to not be subject to an assessable payment under Code section 4980H(a) (i.e., provides minimum essential coverage and is offered to at least 95% of full-time employees), (ii) provides minimum value, and (iii) is reasonably expected to be affordable.

The Council urges the Departments to eliminate this requirement in final regulations. Employers have made informed decisions as to whether to “pay” or to “play” for purposes of Code section 4980H based on guidance issued to date with respect to that provision. Adding this additional requirement on employers at this late date in order to be able to offer limited wraparound coverage under the Non-MSP Rule effectively precludes many employers from being able to offer limited wraparound coverage in accordance with the Non-MSP Rule. In addition, it unnecessarily penalizes part-time employees and retirees through no real fault of the employer; if an employer does not offer affordable, minimum coverage to its full-time employees, then part-time employees and retirees are essentially penalized because they may not obtain limited wraparound coverage to supplement individual market coverage.

As discussed above, even if employers might be willing to elect to “play” over time

in order to offer their employees limited wraparound coverage, the time-limited nature of the pilot program and the related limited wraparound coverage program will dissuade many employers from doing so.

**COMMENTS SPECIFIC TO LIMITED WRAPAROUND COVERAGE OFFERED IN CONJUNCTION WITH MULTI-STATE PLAN COVERAGE :**

The comments in this section are specific to the portion of the Proposed Rule addressing limited wraparound coverage offered in conjunction with MSP coverage (“MSP Rule”).

**Employers should be allowed to use the MSP rule regardless of behavior during the 2014 plan year.**

As discussed above, the Proposed Rule allows limited wraparound coverage to be expanded to full-time employees if employers abide by the MSP Rule instead of the Non-MSP Rule. In order to offer limited wraparound coverage in conjunction with the MSP Rule (and thus to their full-time employees), employers must have offered coverage in the 2014 plan year that is “substantially similar” to coverage that it would have had to offer to at least 95% of full-time employees to avoid an assessable payment under Code section 4980H(a) (regardless of whether the employer would have actually been subject to Code section 4980H(a)). In addition, the employer must have offered coverage to a substantial portion of full-time employees in the 2014 plan year that provided minimum value and was affordable.

The Council strongly urges the Departments to allow employers to offer limited wraparound coverage pursuant to the MSP Rule regardless of plan offerings during the 2014 plan year. The reasons for this are two-fold: (i) employers did not know that this rule would be imposed and therefore made choices related to their benefits in 2014 that will have the unintended effect of disqualifying them from being able to offer limited wraparound coverage to their full-time employees; and (ii) because of the no-enforcement policy of the Administration with regard to Code section 4980H for the 2014 plan year, many employers that might have otherwise offered qualifying coverage during the 2014 plan year either did not offer such coverage or elected to delay full implementation of such coverage until 2015. It seems unfair that the Departments would issue guidance effectively penalizing employers (and their employees) for actions taken based on past Administration guidance.

To ensure that all employers - and their employees - have meaningful access to the sponsorship and/or use of limited wraparound coverage, we urge the Departments to not condition the use of the MSP Rule on what the employer did (or did not do) in 2014. To the extent that the Departments believe it is necessary to condition use of the MSP Rule on certain employer behavior, guidance should be issued that clearly explains to



employers what will be required so that employers can make an informed decision as to how to qualify for the rule. As promulgated, the Proposed Rule unfairly penalizes employers for conduct and behavior that was taken prior to issuance of the Proposed Rule.

**Clarification is needed regarding what it means to provide “aggregate contributions” that are “substantially the same” as 2014 contributions.**

In order to utilize the MSP Rule and offer limited wraparound coverage to its full-time employees, an employer must, in each year, make annual aggregate contributions for both primary and limited wraparound coverage that are “substantially the same” as the employer’s aggregate contributions for coverage offered to full-time employees in 2014.

The Council does not support conditioning access to the MSP Rule based on an employer having to satisfy a maintenance-of-effort requirement. Such requirements limit employer flexibility and over time can have the effect of stifling innovation in benefit plan design or offerings. Moreover, such requirements (including the Proposed Rule) have the effect of disadvantaging those employers that may have provided relatively higher employer contributions to the cost of their employees’ health care – as compared to those employers that may have provided relatively less, or even no, contributions to their employees’ cost of coverage.

In the event the Departments believe it is necessary to retain a maintenance-of-effort requirement as part of final rulemaking, the Council recommends that employers be deemed to satisfy such requirement if they provide the lesser of (i) the amount that would be “substantially the same” as the 2014 plan year, or (ii) 100% employer-paid limited wraparound coverage. Such a rule will better ensure that employers who may have provided relatively higher contributions to their employees’ cost of health care are not unduly penalized.

**Do not require limited wraparound coverage to be specifically designed and approved by the office of personnel management.**

Under the MSP Rule, an employer must offer limited wraparound coverage that is specifically designed and approved by OPM to provide benefits in conjunction with MSP coverage.

The Council encourages the Departments to eliminate the requirement that limited wraparound coverage be specifically designed and approved by OPM. As discussed above, the Proposed Rule permits limited wraparound coverage that is insured or self-funded. Requiring OPM approval could discourage self-funded limited wraparound coverage, as employers may be unwilling to assume the administrative burden of obtaining OPM approval for such coverage.

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Thank you for considering these comments submitted in response to the Proposed Rule. If you have any questions or would like to discuss these comments further, please contact us at (202) 289-6700.

Sincerely,

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Katy Spangler  
Senior Vice President, Health Policy

A handwritten signature in black ink, appearing to read "Kathryn Wilber". The signature is cursive and elegant, with a large initial "K" and a long, sweeping underline.

Kathryn Wilber  
Senior Counsel, Health Policy