NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Submitted electronically at www.regulations.gov

Re: Amendments to Excepted Benefits

Dear Ladies and Gentlemen:

The National Coordinating Committee for Multiemployer Plans (NCCMP) appreciates the opportunity to provide comments on the above-referenced proposed rule issued by the Departments of Labor (DOL), Health and Human Services (HHS), and Treasury (collectively, the "Departments"), as published in the Federal Register on December 24, 2013 (the "Proposed Rule").[1]

The NCCMP is the only national organization devoted exclusively to protecting the interests of the over 20 million active and retired American workers and their families who rely on multiemployer plans for retirement, health and other benefits. The NCCMP's purpose is to assure an environment in which multiemployer plans can continue their vital role in providing benefits to working men and women. The NCCMP is a nonprofit, non-partisan organization, with members, plans and contributing employers in every major segment of the multiemployer plan universe, including in the airline, agriculture, building and construction, bakery and confectionery, entertainment, health care, hospitality, longshore, manufacturing, mining, retail food, service, steel and trucking industries.

NCCMP supports the overall objective of the Proposed Rule, which is to enable employees to continue to maintain a level of health coverage similar to what is provided through a group health plan today, through a combination of individual coverage and limited wraparound coverage provided under a group health plan. NCCMP agrees that this type of arrangement, if structured properly could be a way to enable employers to continue to provide group health coverage in the wake of the game-changing modifications made by the Affordable Care Act

[1] 78 Fed Reg 77632 (Dec. 24, 2013).

(ACA). However, the specific provisions of the Proposed Rule unduly limit the circumstances in which the wraparound coverage may be provided, making the wrap coverage virtually unavailable as a practical matter in situations when it would be most attractive and appropriate as a plan design. In particular, NCCMP believes that the circumstances under which the wrap coverage is considered "not an integral part" of a group health plan need to be modified. In addition, NCCMP recommends changes to the benefits that may be provided under the wrap coverage. While the NCCMP agrees that employers should not be encouraged to drop coverage, this is already occurring. Therefore, the rules on wraparound coverage should recognize that reality and create flexible rules that allow plan sponsors to provide comprehensive coverage in combination with individual market coverage available in the Health Insurance Marketplaces.

Detailed comments are below, following an overview of multiemployer plans.[2]

I. BACKGROUND RELATING TO MULTIEMPLOYER PLANS

One of the crowning achievements of collective bargaining over the past 50 years is the creation of thousands of labor-management, multiemployer health and welfare trust funds that provide to covered workers and their dependents various benefit coverages, including medical, hospitalization, preventive and wellness care, prescription drugs, dental care, and vision care. These trust funds are often referred to as "Taft-Hartley funds" because they are regulated by the Labor Management Relations ("Taft-Hartley") Act of 1947, as well as by ERISA and the Code ("Code"). We note, however, that some single-employer plans may operate as joint labor-management funds and therefore believe the more appropriate term is "multiemployer" plans with respect to comments contained herein.

Multiemployer plans provide health and welfare plan coverage to plan participants and their beneficiaries pursuant to the negotiated wages, hours, and other terms and conditions of employment (including requiring contributions to be made to a multiemployer benefit trust) of a collective bargaining agreement between one or more unions and more than one employer. Even for employees who are not union members but whose work is covered as part of a certified bargaining unit, existing labor law provides that discussions of employee benefits are a mandatory subject of bargaining and therefore subject to negotiation with the union under their status as the statutory bargaining agent. The ACA did not repeal the Labor Management Relations Act. Relationships are established between employers and employees under the Taft-Hartley Act, and these relationships should continue to be recognized in regulations implementing the ACA.

Health and welfare trust funds cover workers in industries as diverse as agriculture, aerospace, bakery and confectionery, building and construction, trucking, transportation, retail, food production, distribution, and sales, clothing, health care, textiles, service, mining, entertainment, hospitality , maritime, longshore, and manufacturing. But for these trust funds, millions more working families would be uninsured and at risk for financial ruin in the event of a serious illness. Indeed, were it not for these plans, many millions of workers in these funds would not be eligible for coverage even under the enhanced eligibility requirements mandated for employers

[2] Consistent with the NCCMP's mission, these comments focus on the impact of the Proposed Rule as it relates to multiemployer plan coverage. NCCMP notes that the Proposed Rule is not limited to such plans and applies outside the multiemployer plan context.

by the ACA. The transient, project-based, mobile and seasonal employment patterns that characterize many of these industries would prevent workers from obtaining health coverage absent a central, pooled fund through which portable coverage is provided to workers as they move from employer to employer.

II. DETAILED COMMENTS ON THE PROPOSED RULE -- WRAP COVERAGE

A. Requirement that the Wrap Coverage Not be an Integral Part of a Group Health Plan

Proposed Rule

In order for the wrap coverage to be an excepted benefit, the Proposed Regulation requires the following:

> The plan sponsor with respect to the wraparound coverage must sponsor another group health plan meeting minimum value (as defined under section 36B(c)(2)(C)(ii)) and that is affordable for a majority of the employees eligible for that group health plan ("primary plan"). Only individuals eligible for this primary plan may be eligible for the wraparound coverage.

The preamble indicates that, in proposing these requirements, the Departments wanted to discourage employers from dropping group health plan coverage. The preamble refers specifically to the employer responsibility provisions in Code section 4980H as reflecting a Federal policy to encourage employers to provide group coverage. The preamble also notes various studies that indicate that most workers who are offered minimum value (MV) group health coverage will not find the coverage unaffordable as determined under the ACA. Thus, the proposal is targeted at individuals who are offered group coverage and for whom the coverage is unaffordable.

Issues and Discussion

In developing these comments, NCCMP and its members analyzed a number of core issues that are essential to understanding both the Proposed Rule and the basis for the NCCMP comments.

(1) In what situations is the ability to provide wrap coverage likely to be most attractive?

Since the enactment of the ACA, NCCMP and its members have focused on how the Act will impact employer decisions with respect to health coverage and multiemployer group health plans. While there are a variety of reasons employers provide coverage (including company culture), essentially it is a question of remaining competitive in the marketplace, and involves such factors as the need to hire and retain employees and the costs of coverage. Under the ACA, employers who previously offered and contributed to health coverage may now determine that economically it is not advantageous to do so (even where a penalty must be paid), knowing that coverage and subsidies are available to qualifying employees in the Marketplaces.

As recognized in the Proposed Rule, although Marketplace coverage is required to meet the ACA standards, it still may provide less generous coverage in some respects as the coverage currently provided by the group health plan. Thus, the ability of group health plans to

supplement individual health coverage purchased on Marketplaces allows employers to ensure that their employees continue to receive the same level of coverage as they did previously. Currently, multiemployer plans typically offer coverage of at least the gold level, with little or no employee contributions and with wider networks than is reportedly the situation with typical Marketplace coverage. While there may be a variety of situations in which wrap coverage might be considered, our analysis indicates it will be of most interest in lower wage industries where Marketplace coverage is most attractive from an economic perspective, industries where there is significant competition from employers that do not offer health coverage, and those that utilize a high percentage of part-time employees. In such cases the ability to offer a wrap keeps employers engaged and allows employees the ability to maintain coverage comparable to what is offered today under the group health plan.

(2) In what situations will the Proposed Rule allow plan sponsors to provide wrap coverage?

NCCMP and its members have undertaken actuarial analysis to determine how the Proposed Rule would apply in real life situations. In particular, we examined the requirements that the primary plan be affordable for a majority of those eligible for that plan and that, to be eligible for the wrap coverage, an individual must be eligible for the primary plan.

The analysis recognizes that, currently one of the benefits of multiemployer plan coverage is that it is designed to be affordable. Multiemployer plans typically have no or low employee premiums. Thus, the analysis addresses the level of employee contribution that would need to be imposed to make coverage "unaffordable" for less than a majority of eligible employees so that qualified employees could access Marketplace coverage and benefit from the wrap coverage.[3]

The analysis looked at sample W-2 data for a real multiemployer population using Federal Poverty Levels (FPL) for 2013, and used the W-2 affordability safe harbor that is available under the employer penalties. Affordability is based on the cost of employee-only coverage, consistent with the employer penalty and premium tax subsidy rules. That analysis yielded the following observations:

- In a population with an average wage of $25,000,[4] coverage would be unaffordable for 10% of the population when employee contributions are $91.00 per month for employee-only coverage. That is, once coverage costs $91.00 per month, it exceeds 9.5% of that

[3] In addition to the factors taken into account in this analysis, given the manner in which the allocations of the wage package are determined, if one accepts the premise that the wage allocation to the health fund represents the full cost of coverage, in order to have the coverage deemed unaffordable, either the employee will have to be charged a second time through a supplemental premium or the contribution rate will have to be reduced, converting more of the wage package to wage income and increasing the costs once again to contributing employers since those costs would become subject to other wage taxes. Once again, this creates additional disincentives for employers to continue in the system, contrary to the stated goal of encouraging employers to continue to offer coverage.

[4] To place this wage level in context, as published by HHS, the FPL for a family of four in the 48 contiguous states for 2013 was $23,550 and for 2014 is $23,850. For an individual in the 48 contiguous states, $22,980 was 200% of the FPL for 2013, and $23,340 is 200% of the FPL for 2014. For 2013 FPLs, see http://aspe.hhs.gov/poverty/13poverty.cfm and for 2014 see http://aspe.hhs.gov/poverty/14poverty.cfm.

group of employees' W-2 wages and would be unaffordable under the ACA safe-harbor standards.
    - All of the employees for whom coverage would be unaffordable would also be eligible for Medicaid (in a State that expanded Medicaid).
    - To expand the pool of employees for whom coverage is unaffordable, contribution rates would have to increase. For example, for the coverage to be unaffordable for 25% of the population, the contribution rate would have to be $130.00/month.
    - At contributions of $173.33/month for employee-only coverage, the coverage would be unaffordable for 43% of the population.

- A population with an average wage of $33,000 had very similar findings.

A general conclusion of the study is that contributions would have to be much higher than what the employee is paying currently (generally zero) for employee-only coverage in order to make the coverage unaffordable for even a very small percentage of the group. This small percentage would be the only people who could take advantage of the wrap (for those not eligible for Medicaid), even though a much larger percentage of the population would be within income ranges eligible for substantial premium tax credits.

It is estimated that in some cases, over 80% of persons eligible for a multiemployer plan would have incomes below 400% of FPL. Thus, it would be practically impossible in many cases to draw a line between similarly situated employees and offer a plan that is affordable to some and not to others.

Thus, this analysis indicates that the wrap coverage would generally not be available in circumstances where it is needed most. Further, a plan structure that offers an unaffordable plan, with the understanding that certain groups of employees should not elect coverage but rather should decline coverage so they can purchase coverage through the Marketplace and obtain the wrap will be confusing to employees. Such an arrangement would be practically impossible to effectively put in place given a pre-ACA environment in which coverage is available at little or no cost and provides comprehensive benefits (often at a gold level). As a result, it would be far more transparent to be able to offer the wrap to certain employees without a requirement that they must also be eligible for primary coverage and it is highly unlikely that merely making such coverage available would substantially influence employers' decisions to exit the system.

(3) What health coverage options will be available in situations where the wrap coverage cannot be provided under the Proposed Rule?

Since the enactment of the ACA, the NCCMP has advocated for rules that would encourage employers to remain in the multiemployer plan system. While the employer penalties may provide a disincentive to drop coverage for certain groups of full-time employees, the fact of the matter is that the ACA does not mandate that any employer provide group health coverage. Rather, the employer penalties and availability of premium tax subsidies are just new economic factors in the employer decision-making process which, in some cases, actually favor the dropping of coverage. While we would certainly hope and prefer that, in the above scenarios, the result would be that all employees are offered a primary plan that meets minimum value standards, existing evidence shows that will often not be the case.

Economic analysis performed by NCCMP members and the multiemployer community and previously provided to the Departments demonstrates that employers may achieve significant cost savings from dropping health plan coverage, even if penalties apply.[5] The media has reported that several large national employers have already dropped coverage post-ACA. On the ground in the bargaining process, NCCMP members have already experienced the reality that economics and the desire of employers to remain competitive are pushing many employers to want to discontinue coverage and to pursue bargaining strategies to achieve that objective.

What is the role of the wrap plan option given this reality? NCCMP believes that the wrap option can be viable in appropriate circumstances, allowing employers to achieve cost savings needed to remain competitive, while providing an incentive to "stay in the game" to the greatest extent possible. In order for the wrap coverage to be a viable option, however, it must be structured in a more flexible way and reflect the reality that employers will make decisions as to whether or not to offer coverage based on other factors. Properly structured, however, the wrap option can provide an incentive for employers to continue to provide some group health plan coverage.

Recommendations

(1) Wrap coverage should be available regardless of whether a primary plan is offered.

We strongly recommend that wrap coverage should be permitted as an excepted benefit where no primary plan is offered. As discussed above, there are many circumstances in which the economics are such that a decision will be made (or may already have been made) that a primary plan will no longer be offered, even though such coverage had been previously provided. In such situations, wrap coverage should nevertheless be able to be offered in order to ensure that employees have the same quality coverage that had been previously available. Removing the requirement that there be a primary plan will also ensure that the plan is not an integral part of a group health plan, because there will not be another group health plan.

[5] Detailed economic analysis was provided in previous NCCMP submissions to the Departments.

(2) If the final regulations retain a requirement that a primary plan be offered, the requirements with respect to the primary plan should be modified.

We believe that the approach recommended immediately above is needed in order to make the wrap coverage available to the intended group, i.e., those who will lose high quality, affordable coverage, and that any other approach will severely reduce the utility of the rule. However, in the event that the Departments do not adopt the recommended approach, we offer some alternatives below which will make wrap coverage more workable in some circumstances.

Requirement that the primary plan be affordable for a majority of eligible employees: If the final regulations retain a requirement that the plan sponsor offer a primary plan, we recommend that the wrap would be considered not an integral part of a group health plan if the primary plan is affordable to a majority of employees **enrolled** in the primary plan. (As discussed further below, we recommend that the plan sponsor be able to decide whether or not to include part-time employees and retirees in making this determination.) The change from eligibility to enrollment will make wrap coverage available in a broader range of circumstances. The current rule may potentially work for some industries where there are relatively few lower wage workers, but (as discussed above) does not work for many of the industries served today by multiemployer plans.

Requirement that an employee must be eligible for the primary plan to be eligible for the wrap plan: We offer the following alternatives with respect to this requirement:

- Eliminate the requirement that the employee must be eligible for the primary plan in order to be eligible for the wrap. It would be more transparent to employees and employers if the plan could be designed to exclude certain groups of employees from the primary (i.e., those for whom coverage would otherwise be unaffordable) and instead have such employees eligible for the wrap if they purchase individual coverage. The nondiscrimination requirements that apply under the Proposed Rule to both the wrap plan and the primary plan provide appropriate boundaries that will prevent inappropriate plan designs.
- Alternatively, provide that employees who are eligible for the wrap do not have to be eligible for the primary plan if the wrap plan is provided without any employee contribution. This approach is an alternative means to ensure that employers retain a commitment to health care coverage, by requiring that they provide the cost of the wrap plan.

Prior plans: We also recommend that a prior plan be considered a primary plan for any requirements relating to primary coverage. For example, a prior plan could be a plan maintained immediately prior to the time the wrap coverage was adopted for a similar group of employees. This recognizes the unfortunate fact that there may no longer be a primary plan.

(3) Any requirements relating to a primary plan should not apply with respect to part-time employees.

The final rule should conform to the ACA treatment of part-time employees generally. In particular, the ACA does not provide an incentive to continue coverage for such employees, because the employer penalties do not apply to part-time employees. Thus, consistent with those penalties and the references to Code section 4980H in the preamble to the Proposed Rule, wrap

coverage should be available to part-time employees without a requirement that there be a primary plan or that such employees are eligible to participate in a primary plan.

Plan sponsors should have the option whether or not to consider part-time employees in applying any requirements with respect to a primary plan that are contained in a final rule. This could be an issue, for example, to the extent part-time employees are eligible for the primary plan.

Allowing part-time employees free access to wraparound coverage to individual market coverage will undoubtedly encourage greater rates of sign-up for individual market coverage.

(4) Any requirements relating to a primary plan should not apply with respect to retirees (or other former employees).

The Proposed Rule does not specifically mention retirees and it is not clear whether or not the references to employees in various places are meant to refer to former employees. As is the case with respect to part-time employees, the employer penalties do not apply to retirees. In addition, the eligibility rules for retirees with respect to the premium tax credits are different than for active employees, in particular, retirees are not considered eligible for employer-sponsored minimum essential coverage unless they are actually enrolled in such coverage.

Consistent with these rules for retirees, wrap plan coverage should be available to retirees without the requirement of a primary plan and without a requirement that the retiree be eligible for the primary plan.

Plan sponsors should have the option whether or not to consider retirees in applying any requirements with respect to a primary plan that are contained in a final rule. This could be an issue, for example, to the extent retired employees are eligible for a primary plan.

(5) There should be flexibility in making any affordability determinations that are included under a final rule.

Comments were specifically requested on the standard for determining affordability under the Proposed Rule. In particular, assuming the use of the 9.5% affordability standard under Code Section 36B(c)(2)(C)(i) of the Code as the basic definition of ''affordable,'' the preamble asks for comments as to how to implement that definition here, for example, whether there should be a Form W–2 safe harbor based on employee wages like the one set forth in the regulations under Code Section 4980H.[6]

The safe harbors for determining affordability under Code Section 4980H were provided by the Treasury Department in recognition of the fact that plans and employers will not have the household income information needed to make a precise affordability determination as provided under Code Section 36B. Thus, several safe harbors for determining affordability were provided in the regulations under Code Section 4980H in order to make the rules administrable. The same administrative issues apply here. Thus, to the extent that any affordability requirements are included in the final rule, NCCMP recommends that a plan sponsor should be able to use any

[6] Final regulations under Code Section 4980H were issued following the publication of the Proposed Rule.

safe harbor definition of affordability that may be used under Code Section 4980H and should also have the flexibility here to apply different safe harbors for different employees. (We note that these safe harbors will be only for purposes of the Proposed Rule, and will not apply in determining affordability for purposes of Code Section 36B. This is consistent with the safe harbor approach under Code Section 4980H.)

B. Benefits That Can Be Provided By the Wrap Coverage

Proposed Rule

The wraparound coverage must be specifically designed to wrap around non-grandfathered individual health insurance coverage that does not consist solely of excepted benefits, as follows:

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

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

(3) The total cost of the wraparound coverage must not exceed 15% of the cost of the primary coverage, determined in the same manner as COBRA premiums are calculated.

Comments are specifically requested on these requirements, including with respect to other benefits that could be provided under the wrap coverage and the 15% limitation. The Departments also asked for comments on whether wrap around benefits in addition to filling cost-sharing should be "substantial" or "material".

Issues and Discussion

The preamble to the Proposed Rule references as precedent for the specific parameters of the wrap coverage EBSA Field Assistance Bulletin 2007-04 and CMS Insurance Standards Bulletin 08–01 (the "Prior Guidance"), which were coordinated among all the Departments. The Prior Guidance was issued under HIPAA, and relates to circumstances under which coverage is considered an excepted benefit by reason of providing coverage that is supplemental to Medicare or other similar coverage under a group health plan. A review of the Prior Guidance indicates that a different, less restrictive approach to the wrap coverage is warranted here.

The Prior Guidance indicates that a primary concern at the time was what was viewed as potential avoidance of the HIPAA protections. Thus, in issuing the Prior Guidance, HHS expressed concern about arrangements that, although called supplemental plans, are "designed to provide a major portion of the medical benefits to the participants of the primary group health plan."[7] Similarly, DOL indicated that it was seeking to prevent insurers "from avoiding

[7] *Id.*, at p. 2.

compliance with ERISA's health reform provisions by issuing multiple insurance contracts in connection with a plan," none of which would be considered subject to the HIPAA reforms.[8]

Given the ACA's reforms, these same concerns simply are not present here. In particular, the underlying coverage that is "wrapped" or "supplemented" must be non-grandfathered, individual market coverage. Such coverage is required to meet all the ACA reforms, including coverage of essential health benefits, limits on cost-sharing, and compliance with mental health parity standards, just to name a few. Further, the proposed wrap coverage excepted benefit will not satisfy the employer responsibility requirements, thus providing a potential disincentive for employers to structure plans in this way. The additional requirements imposed under the Proposed Rules on the wrap coverage, i.e., the prohibition on discrimination based on health status and the prohibition on preexisting condition exclusions, provide additional safeguards. Thus, it should be possible to design the wrap coverage to adequately supplement non-grandfathered individual coverage, with the knowledge that the various provisions of the ACA itself, including the market reforms and employer penalty provisions, provide not only sufficient but strong safeguards to prevent against abuses of the sort that may have been possible when the pre-ACA Prior Guidance was issued.

The preamble also indicates that the specific 15% limitation (that the cost of the wrap coverage be no more than 15% of the cost of the primary plan) was drawn from the Prior Guidance. Again, a close review of the prior guidance indicates that a different approach should be applied here. In particular, the Prior Guidance was aimed at supplemental coverage that was similar to Medicare supplemental coverage. CMS actuaries at the time determined that cost sharing under Medicare was approximately 15%.[9] Comparing the relative costs of coverage appears to be a proxy for filling in this difference. Thus, the underlying principle of the Prior Guidance is to look at the plan that is being supplemented, i.e., non-grandfathered individual market coverage.

Currently (or pre-ACA), typical multiemployer plans provide coverage at a gold or higher level, and have broader networks than is reportedly the case for many Marketplace plans. In contrast, current information indicates that silver plans are most frequently purchased in the Marketplace (62%), with bronze plans being the next most frequently purchased level (19%).[10] Bronze plans may be attractive for some persons because of their lower premium (and may require no out of pocket premium payment for qualifying individuals); however, they subject the individual to potentially much greater expenses through higher cost sharing when expenses are incurred.

Thus, to "fill the gaps" in the underlying coverage, the wrap coverage should be able to fill in cost sharing requirements to lower the exposure of the individual, as well as provide additional benefits as contemplated under the Proposed Rule, such as benefits that are not essential health

[8] EBSA Field Assistance Bulletin 2007-04, at p. 2.

[9] "One important factor in determining whether coverage is similar to Medicare supplemental insurance or TRICARE is that the proportion of total benefits that is charged to a policyholder as cost-sharing should be similar to the proportion of total Medicare benefits that is charged to beneficiaries as cost-sharing. According to CMS actuaries, this proportion is currently around 15 percent. We will consider any product that is 15 percent or less to meet this requirement of the regulations." CMS Insurance Standards Bulletin 08–01, at p. 3.

[10] See ASPE Issue Brief, "HEALTH INSURANCE MARKETPLACE: FEBRUARY ENROLLMENT REPORT, For the period: October 1, 2013 – February 1, 2014", February 12, 2014, available at http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Feb2014/ib_2014feb_enrollment.pdf.

benefits, and out of network benefits. Prescription drug benefits are an example of an additional benefit that could be provided by wrap coverage. Although such benefits are essential benefits, a wrap plan may have more generous coverage in some cases than is required for the Marketplace plan. An example of what may fall within the concept of out of network coverage is where an employee is enrolled in an HMO that does not offer coverage for out of network providers. If an enrollee travels out of the HMO coverage area, they may have no health coverage at all (other than certain emergency coverage). In such a case, wrap coverage could fill in that gap.

Overall, the Prior Guidance supports a different approach to the wrap coverage here, with fewer restrictions on the coverage that may be provided.

Recommendations

(1) The wrap coverage should not be subject to a specific limitation on the cost of the coverage or the amount of the coverage.

We strongly recommend that the wrap coverage should not be subject to any particular percentage, dollar or similar limitation. Thus, we recommend eliminating the reference in the Proposed Rule to the 15% limitation. We also recommend clarifying the language in the preamble that indicates that a primary purpose of the wrap coverage cannot be to reimburse cost sharing. This is confusing, as it invites potential question as to what might be considered a "primary" purpose. Rather, the preamble should conform to the regulations itself, which states that such benefits cannot be the only benefit provided by the wrap coverage.

As discussed in more detail above, the percentage limitation in the Prior Guidance was adopted for reasons that are simply not present here, as a result of the ACA and the other requirements in the Proposed Rule. It is consistent with the Prior Guidance to allow wrap coverage that better reflects the underlying coverage and does not contain any specific dollar limitation.

(2) Alternative approaches

We believe that the recommendation immediately above (no percentage, dollar, or similar limitation) is most consistent with the stated goals of the Proposed Rule as well as the Prior Guidance. However, in the event that the recommended approach is not adopted, we offer the following as alternatives. Any of these alternatives will undercut the usefulness of the rule (compared to the first approach), but may be helpful in particular situations.

Because of the range of current plan designs, a "one size fits all" approach to an overall limit on wrap coverage is difficult to formulate. Thus, if an overall limit on the value of the wrap coverage is provided in the final rule, we recommend that a variety of different options be provided to plan sponsors. The options suggested below are not intended as an exhaustive list. Also, it is possible that some plan sponsors might prefer one approach over another based on administrative reasons, even if another approach might allow for more generous wrap benefits.

Possible approaches:

- The value of the wrap coverage cannot exceed 30% of the value of primary coverage offered by the plan sponsor (even if the particular employee is not offered that coverage).

For example, in the case of part-time employees, the value of the wrap coverage could be measured by the plan offered to full-time employees.

- The value of the wrap coverage cannot exceed the limits on contributions to health savings accounts (for 2014, $3,330 for individual coverage and twice that amount for family coverage).

C. Application to Basic Health Plans

The Departments specifically request comments on how wrap coverage might supplement coverage provided under a basic health plan (BHP). In general, NCCMP recommends that wrap coverage be permitted to supplement coverage under a BHP and suggests that it may be appropriate to revisit this issue in further detail at a later date, when further information regarding such plans is available.

D. Reasonable Interpretations/Inadvertent Errors

From an administrative perspective, plan sponsors and participants need assurance that the wrap coverage qualifies as an excepted benefit. Thus, inadvertent errors with respect to various aspects of the rule (e.g., mistakes with respect to any affordability or determination of part-time status) should not cause the wrap coverage to cease being an excepted benefit. Similarly, reasonable efforts to apply the provisions of the rule, including reasonable interpretations of the rule, should not result in the wrap coverage failing to be an excepted benefit. This is consistent with enforcement approaches generally adopted by the Departments, and the approach taken by the Departments in other areas, for example, the adopting of the "substantially all" requirement under Code Section 4980H, so that inadvertent errors or reasonable interpretations do not result in inappropriate consequences.

III. DETAILED COMMENTS ON THE PROPOSED RULE – OTHER ISSUES

A. Stand-alone Dental and Vision Coverage

The Proposed Rule modifies the circumstances under which stand-alone dental and vision coverage may be treated as excepted benefits under a self-funded plan, in particular by eliminating the requirement that a separate premium be charged for the coverage.

The NCCMP supports the changes in the Proposed Rule, with the following modification. The requirement that the participant have an opportunity to elect not to receive the coverage should not apply where the dental or vision coverage is provided without charge to the participant. The requirement of a separate election just serves to confuse participants and add meaningless administrative burden. This is the case even if the election may be structured as an "opt-out" where the default is to provide the coverage. If the Departments determine that this requirement is maintained, then the final rule should clarify that an opt-out is permitted.

B. Effective Dates

The provisions regarding wrap plan coverage are proposed to be effective for plan years beginning on or after January 1, 2015. The NCCMP recommends that the effective date should

not be delayed until 2015, but should be effective as soon as the rules are finalized. The NCCMP recommends that the rules be finalized sufficiently promptly so that plans can begin to structure arrangements in accordance with the final rules.

The provisions regarding dental and vision plans and employee assistance programs are also proposed to be effective for plan years beginning on or after January 1, 2015; however, the Departments have stated that plan sponsors may rely on the Proposed Rules with respect to these issues until final guidance is issued, at least through 2014. NCCMP appreciates that these changes may be implemented immediately by plan sponsors.

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We greatly appreciate the opportunity to comment on the Proposed Rule as it may apply to multiemployer plans and are more than happy to discuss any questions you may have regarding these comments.

Respectfully submitted,

Randy G. DeFrehn
Executive Director