

# NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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January 22, 2015

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

*Submitted electronically at [www.regulations.gov](http://www.regulations.gov)*

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 23, 2014 (the “Proposed Rule”).<sup>1</sup>

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 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 insurance coverage and limited wraparound coverage provided under a group health plan. We believe that the Proposed Rule is a significant step forward to address the needs of many of the workers who are most at risk for losing comprehensive group health plan coverage, particularly part-time workers, spouses, pre-Medicare retirees, and employees in low-wage industries. In this letter, we make recommendations that would strengthen and clarify application of the Proposed Rule to these individuals, as well as expanding it to other at-risk groups.

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

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<sup>1</sup> 79 Fed. Reg. 76931 (December 23, 2014).

## **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 Affordable Care Act (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 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. OVERVIEW**

The Proposed Rule contemplates a new model under which an employer could provide a supplemental plan for certain categories of employees or retirees that wraps around individual market health insurance. In the multiemployer plan context, this means that the individual market coverage, together with the wraparound coverage provided through the multiemployer plan, would provide comprehensive health coverage. The Proposed Rule contemplates two different structures, depending on whether the major medical coverage is “eligible individual health insurance” (e.g., Marketplace coverage) or coverage provided under a Multi-State Plan (MSP). In either case, however, the Proposed Rule is structured to allow the affected employees or retirees to receive subsidized individual coverage through the Marketplace plan or MSP, supplemented with the multiemployer wrap plan.

It is important to allow this limited wraparound benefit to be offered by multiemployer plans. 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 industries that utilize a high percentage of part-time employees. In such cases, the ability to offer a wrap benefit keeps employers engaged and gives employees the ability to maintain coverage comparable to what has been traditionally offered under the group health plan. In that regard, both the option for employees who are not full-time and retirees and the multi-state option should be retained as part of the final rule.

### III. DETAILED COMMENTS ON THE PROPOSED RULE

- a. **Coverage of “Meaningful Benefits”** 26 CFR §54.9831-1(c)(3)(vii)(A); 29 CFR §2590.732(c)(3)(vii)(A); 45 CFR §146.145(b)(3)(vii)(A)

The Proposed Rule provides that limited wraparound coverage must provide meaningful benefits beyond coverage of cost sharing under individual health insurance or a Multi-State Plan. We support this requirement and in response to the request for comments provide suggestions for safe harbors.

A recent study by The Commonwealth Fund found that in 2015, bronze plans have average deductibles of \$5,203; silver plans, \$2,965; gold plans, \$1,215; and platinum plans, \$552.<sup>2</sup> According to recent information, 65 percent of all Marketplace enrollees and 76 percent of subsidized enrollees have selected a silver plan.<sup>3</sup> Multiemployer plans typically provide coverage similar to the gold or platinum level, with wider network access and little or no employee premium. It is important to provide meaningful coverage in the wraparound plan in order to match this previous level of coverage.

Several ways exist to provide meaningful benefits through limited wraparound coverage (in addition to cost sharing). Some of those that we have identified, and which could be safe harbors (adjusted as necessary to meet the annual cost limit on the wrap benefit), include:

- i. Reimburse 100% of primary care costs (including pediatric care) with no deductible plus out-of-pocket expenses for other services covered under the individual insurance or Multi-State Plan coverage; and/or
- ii. Reimburse each covered individual for the cost of prescription drugs that are not on the formulary of the person’s individual insurance or Multi-State Plan coverage plus out-of-pocket expenses for other services covered under the individual insurance or Multi-State Plan coverage and/or

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<sup>2</sup> Gabel, et al, “Analysis Finds No Nationwide Increase in Health Insurance Marketplace Premiums,” The Commonwealth Fund (December 22, 2014); <http://www.commonwealthfund.org/publications/blog/2014/dec/zero-inflation-nationwide-for-marketplace-premiums?omnicid=rssblog>

<sup>3</sup> Taylor, et. al, “More Choice in Health Insurance Marketplaces may Reduce the Value of the Subsidies Available to Low-Income Enrollees,” *Health Affairs* (January 2015).

- iii. Provide each covered individual with access to an on-site clinic, or specific health facility or network, at no additional cost and/or access to an on-site pharmacy with reduced costs plus reimburse out-of-pocket expenses for other services covered under the individual insurance or Multi-State Plan coverage; and/or
- iv. Reimburse individuals for ten (10) physician visits each year plus reimburse out-of-pocket expenses for other services covered under the individual insurance or Multi-State Plan coverage; and/or
- v. Provide any benefit, such as home health care services, which is a permissible medical expense under IRC Section 213(d) but not covered under the individual insurance or Multi-State Plan;
- vi. , such as home health care services, which is not covered under the individual insurance or Multi-State Plan; and/or
- vii. Provide a benefit targeted to a specific population in the plan, such as increased coverage for orthopedic injuries for certain occupations, or increased benefits for retirees; and/or
- viii. Provide reimbursement for out-of-network services that would have been treated as in-network under a group health plan maintained by the sponsor of the wrap plan.

Because the limited wraparound benefit would be an excepted benefit, the group health mandates of the ACA would not apply. Consequently, for example, the limited wraparound benefit could have a maximum annual or lifetime limit on essential health benefits, such as prescription drugs or hospital benefits, and would not have to provide ACA-required preventive benefits, which will already be available in the Marketplace plan.

We request clarification whether the wraparound plan may place a maximum reimbursement on plan benefits. For example, the plan could provide benefits up to an annual maximum of \$2,550 (or whatever the final amount is) in order to avoid exceeding the maximum value permitted, discussed below.

Some plan sponsors may be interested in making eligibility for the wrap benefit contingent on a participant's enrollment in a specific individual market or Multi-State Plan. This may make it easier for plan sponsors to design a wrap benefit that effectively complements the primary coverage. We are not aware of anything in the Proposed Rule or elsewhere that would prohibit such an approach. Clarification that this is permitted (but not required) would be helpful.

Finally, we understand that the benefit is not intended to be solely an account-based plan, such as a Health Reimbursement Arrangement. However, we request that the Departments clarify whether, if meaningful benefits are provided, the wraparound plan can also have an HRA. We also suggest that if the plan is a retiree-only plan, there should be no prohibition against the

limited wraparound benefit being an HRA only. Such an approach is consistent with the exception under the ACA for retiree-only plans.

**b. Limitation on Amount of Wraparound Benefit** 26 CFR §54.9831-1(c)(3)(vii)(B); 29 CFR §2590.732(c)(3)(vii)(B); 45 CFR §146.145(b)(3)(vii)(B)

The Proposed Rule would limit the annual cost of wrap benefits to the maximum annual salary reduction contributions toward health Flexible Spending Arrangements (FSAs), which is \$2,550 for 2015, indexed under IRC §125(i)(2). Our previous comments had suggested a higher limit on the permitted annual cost of wrap benefits – perhaps the contributions limits for Health Savings Accounts (for 2015, \$3,350 for individual coverage and \$6,650 for family coverage). We believe consideration should be given to the higher amount. We also suggest that a higher limit be permitted for retirees – this is consistent with other, related areas of the law, for example, a higher contribution limit or HSAs is provided for individuals age 55 or older.

We believe that a higher annual cost is consistent with the objective of the wrap coverage. For example, reportedly many individual market and Multi-State Plans have narrow networks and/or limit their roster of in-network providers to those who work in the states in which members live. Thus, many plan participants may find that their provider is no longer in network. As another example, an individual who lives in one state but has long used a health care provider based in another state (or the District of Columbia) will likely find that such health care provider is not in-network under the individual or MSP coverage. Unless the annual cost limit for wrap benefit coverage is increased, it may not be possible to design a plan that meets the annual cost limit and allow its members to experience continuity of medical care without significantly increased out of pocket expenses.

Regardless of the amount, we suggest that regulations clarify the methodology under which the amount is calculated, and the implications of that amount for the plan and plan participants.

Specifically, we recommend that guidance clarify whether the amount is determined based on the plan participant or individual (i.e., whether the amount is \$2,550 per participant and does not increase if there are dependents or a family). If the amount is not increased, then applying the limit on an individual basis would be particularly important to ensure an appropriate level of wrap coverage. We also recommend that guidance clarify that the amount is calculated on a group basis, and whether any particular individual meets or exceeds the amount is not relevant to the group calculation.

Most importantly, we recommend that a safe harbor be announced which would allow the plan sponsor to rely on an actuarial determination that the cost of coverage under the plan is expected to be equal to or less than the maximum allowed amount. If the plan's experience during the year results in a cost of coverage that exceeds the applicable maximum, this would not affect whether the plan was considered an "excepted benefit" during the year for which the actuarial determination applies. The actuarial determination could be a certification or other statement from an actuary as to the expected cost of coverage.

**c. Plan Eligibility Requirements for Non-Full-Time Employees** 26 CFR §54.9831-1(c)(3)(vii)(D)(1); 29 CFR §2590.732(c)(3)(vii)(D)(1); 45 CFR §146.145(b)(3)(vii)(D)(1)

Limited wraparound coverage may be offered to individuals who are not full-time employees (and their dependents) or who are retirees (and their dependents). We have several comments concerning eligibility for wraparound benefits for these individuals.

#### *Recommendation concerning spouses*

We recommend that the final rule clarify that limited wraparound coverage may be offered to spouses as well as to employees and their dependent children. This includes allowing a spouse to elect the wraparound coverage when the employee or retiree does not elect or is not eligible for the wrap coverage. Given the employer penalty structure, as well as the rules relating to eligibility for premium tax credits, spouses are another category of individuals who are at risk for losing group coverage under the ACA and, thus, should be treated like part-timers and retirees for purposes of the wrap benefit. This is particularly true of spouses of full-time employees since the final regulations on employer responsibility payments specifically exclude a spouse from the definition of “dependent.”

#### *Recommendations concerning IRC Section 4980H*

The Proposed Rule requires that the employer sponsoring the plan or the employer participating in a plan offering wraparound coverage offer full-time employees coverage that is (1) substantially similar to coverage required under 4980H(a), i.e., minimum essential coverage offered to at least 95 percent of full-time employees; (2) minimum value; and (3) affordable. We recommend that the final rule clarify the following:

- The requirement to offer coverage under Section 4980H(a) or (b) should not apply if the employer is participating in a multiemployer plan.

In order to make the wrap concept workable to a broad spectrum of plans and contributing employers, these rules should not apply. Multiemployer plans may have numerous employers contributing to the plan – the numbers could range from a few dozen to several thousand. The employers are various sizes, and will be complying with 4980H in a variety of ways. The Proposed Rule places too much of a burden on the multiemployer plan to police the activities of all of these employers. This aspect of the Proposed Rule may be effective for a single employer, but is not appropriate for a multiemployer plan. The rule is also problematic if individuals work for more than one employer. In that situation it is not possible for the plan to identify a single employer to which the requirement can be linked. Moreover, as currently written, the inability to obtain information from all employers could make it impossible for the plan to offer the wrap benefit to anyone.

Concerns regarding employers dropping coverage would not apply, because benefits are collectively bargained, and the plan should not have to be concerned about offers of coverage that contributing employers make to their non-bargained employees. Further, as mentioned in our comments on the original proposed rule, the ability to offer wrap coverage is not itself going to be a factor as to whether an employer will offer coverage or not; rather that decision will be based on other factors. The Proposed Rule should not indirectly impose the 4980H requirements or an approximation of those requirements.

- Small employers that are not subject to the rules under IRC Section 4980H should not be required to comply with the requirement to offer coverage under Section 4980H(a) or (b).

The majority of employers that contribute to multiemployer plans have fewer than 50 full-time employees (or their equivalents). The final rule should clarify that these small employers are not required to comply with 4980H for their full-time employees in order for a multiemployer plan to offer limited wraparound coverage to non-full-time employees or retirees (or spouses).

*Recommendation concerning offer of other group health coverage*

The Proposed Rule requires that other group health plan coverage, not limited to excepted benefits, be offered to part-time employees or retirees in order for them to be eligible for limited wraparound benefits. We believe that this requirement is a significant improvement compared to the previous proposal published on December 24, 2013, which would have required that the other group health plan coverage be affordable for a majority of employees eligible for the primary plan. However, we believe that this requirement should be eliminated for non-full-time employees and retirees, particularly those in multiemployer plans.

The requirement that other group health plan coverage be offered to those eligible for the wraparound coverage originates with the excepted benefit rules applicable to health FSAs. Health FSAs that meet the following requirements are excepted benefits:

- Other group health plan coverage, not limited to excepted benefits, is also offered, and
- The maximum benefit payable is two times the salary reduction (or, if greater, does not exceed \$500 plus the salary reduction).

We see no reason to link the wrap benefit to the structure required for excepted health FSAs. In a multiemployer plan, it would be extremely rare for an employer to offer coverage through the multiemployer plan and to offer a health FSA. Similarly, health FSAs are completely unavailable for retirees because there is no salary reduction available and that is the traditional vehicle for funding health FSAs. In our view, no purpose is served by requiring plan sponsors to design and offer a new group health plan that is intended to be less than minimum value or not affordable and *not elected by anyone*, just so the plan sponsor may also offer a wrap benefit.<sup>4</sup> Consequently, we recommend elimination of the requirement to offer other group health plan coverage in addition to the limited wraparound coverage.

Under the Proposed Rule, the coverage offered does not have to be affordable or provide minimum value. For example, a so-called “skinny plan” which covers preventive care and perhaps just a few office visits would satisfy this requirement. Thus, while the current Proposed Rule is an improvement over the prior proposal, it creates a similar situation – some employees will be offered coverage that it is not in their best interests to accept, thus creating confusion for employees and employers.

We request that if it is determined that multiemployer plans must offer other group health plan coverage to non-full-time employees, that the limited wraparound coverage may be offered as the default option, and the employee would have to affirmatively reject the wrap coverage to enroll in the other group health plan coverage.

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<sup>4</sup> Under a proposed rule published by Treasury/IRS on May 3, 2013, a retiree (unlike an employee) could be offered affordable, minimum value retiree coverage without that offer of coverage affecting the retiree’s eligibility for subsidized Marketplace coverage. The retiree would merely have to decline the offer of retiree coverage. See Proposed 26 CFR § 1.36B-2(c)(3)(iv) relating to post-employment coverage. 78 Fed. Reg. 25909, 25914 (May 3, 2013). That proposed rule has not been finalized.

### *Recommendation concerning determination of non-full-time status*

Although the Proposed Rule does not address determination of non-full-time status, we recommend that the final rule permit plan sponsors that offer limited wraparound coverage to rely upon a determination at the time of enrollment, or at the beginning of the applicable plan year, that the employee is not a full-time employee. The wraparound coverage could continue to be offered even if the employee's status changed during the plan year. We also recommend that the final rule clarify that seasonal employees are eligible for limited wraparound coverage, because this is a group for whom such coverage is likely to fill a very important gap.

### *Recommendation concerning retirees*

We recommend that the final rule eliminate the requirement in the Proposed Rule that would only permit a plan to offer limited wraparound coverage to a retiree if the employer sponsoring the plan or contributing to a plan is in compliance with IRC Section 4980H.<sup>5</sup>

We agree that retirees and their dependents should be eligible for limited wraparound coverage. In general, this will affect pre-Medicare retirees. This group is already at risk for loss of employer-sponsored coverage. The availability of subsidized coverage in the Marketplace enhances incentives for employers to drop retiree health coverage. Allowing plan sponsors to offer a limited wraparound coverage to individual insurance will help ensure that retirees can obtain the same level of health care coverage they had while actively employed.

There are no policy or legal reasons for requiring that as a condition of receiving a limited wraparound benefit, the employer that sponsors the plan or contributes to the plan is in compliance with IRC Section 4980H. In general, there is no legal obligation to provide retiree health coverage (unlike the obligations associated with full-time employees under 4980H), and the Proposed Rule should not add new requirements not imposed by the employer penalty rules. In addition, the pressures associated with whether retiree health coverage is offered, including such issues as compliance with Financial Accounting Standards Board (FASB) rules, are significantly different from pressures that affect whether an employer provides coverage to active employees. Finally, there are no penalties under IRC Section 4980H associated with retiree coverage, so offering a limited wraparound benefit to retirees would have no pernicious effects on coverage for full-time active workers.

### *Recommendation relating to employers without full-time employees*

The Departments should clarify that any 4980H-related requirements are considered to have been met in instances in which the employer has no full-time employees. This circumstance will arise for:

- Retirees (and their dependents) participating in a stand-alone Voluntary Employees' Beneficiary Association (VEBA);
- Retirees (and their dependents) whose past employer does not sponsor or participate in the wraparound plan or any related health plan (so-called "orphan retirees" whose employers are no longer in business or for other reasons are not contributing employers to or sponsoring the plan during the pilot years); and

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<sup>5</sup> 26 CFR §54.9831-1(c)(3)(vii)(D)(1)(i); 29 CFR §2590.732(c)(3)(vii)(D)(1)(i); 45 CFR §146.145(b)(3)(vii)(D)(1)(i)

- Employees (and their dependents) of a plan sponsor or participating employer that does not employ full-time employees.

d. **Multi-State Plan (MSP)** 26 CFR §54.9831-1(c)(3)(vii)(D)(2); 29 CFR §2590.732(c)(3)(vii)(D)(2); 45 CFR §146.145(b)(3)(vii)(D)(2)

In general, our comments on the MSP option parallel our comments above, where applicable. For example, for the reasons stated above, the requirement that employers offer coverage under Section 4980H(a) or (b) should not apply if the employer is participating in a multiemployer plan. The employer penalty rules stand on their own and should not be incorporated indirectly here, even with modifications.

We have three additional recommendations that relate specifically to the MSP option.

*Recommendation relating to design and approval by OPM*

In order to preserve flexibility in the design of wraparound coverage, we recommend that the Departments eliminate the requirement that wraparound coverage be designed and approved by OPM. While the preamble contemplates that MSP issuers will be the entities that offer such wraparound coverage, the wraparound plan could also be provided on a self-insured basis. Plan sponsors would have less flexibility to design wraparound plan for their particular pool of participants if the coverage had to be designed and approved by OPM.

*Maintenance of effort requirement – “substantially the same” contributions*

The Proposed Rule requires employers of individuals eligible for limited wraparound coverage offered in conjunction with MSP coverage to 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 preamble indicates that the Departments are considering providing that whether contributions are “substantially the same” is determined based on a percentage, with 80 and 90 percent given as examples.

- Provide discretion to OPM to determine whether the MOE “substantially the same” threshold has been met

We recommend that OPM be given discretion to determine whether or not the MOE threshold has been met by each employer. The overall objective of the Proposed Rule is to allow individuals to maintain approximately the same health benefits that had previously been received under a group health plan through a combination of MSP (or individual market coverage) and the wrap. While using cost as a surrogate for value frequently works, differences in demographics, differences in the number of family members to be covered, regional health cost differences and similar factors make cost only a flawed measure of value for this purpose. We believe that OPM should have the flexibility to take those other factors into account when making a judgment as to whether or not an employer has met its MOE responsibilities in a particular year.

- Alternatively, provide a lower threshold than 80 percent

As an alternative to giving OPM discretion as described above, we recommend that the minimum percentage used to determine a plan's MOE should be lower than 80 percent. Lowering the MOE is important to reflect the fact that multiemployer plans currently offer comprehensive coverage to a broader eligibility group than current Marketplace plans. A minimum percentage equal to 60% of an employer's 2014 employee health care costs, we believe, would more accurately account for the difference in annual employee health care costs between 2014 and later years and enable employers to avoid any such limitations and restrictions in crafting a wrap benefit.

If a specific flat minimum percentage of 60% is considered to be too low for MOE determination purposes, the minimum percentage used to determine a plan's MOE could still be adjusted below 80% based on the risk represented by the portion of the employer's total workforce population electing wrap benefits compared to the national workforce, for example, in a manner similar to the method that it is anticipated will be used to calculate the 4980I excise tax. Such minimum percentage could also be adjusted below 80% by taking into account the fact that an employer whose employees are receiving primary health coverage under an individual plan or a Multi-State plan in the Marketplace and supplemental wrap benefits through a single employer or multiemployer plan will be surrendering all or a significant portion of the Federal (and state) income tax deduction it is now entitled to receive for the full cost of providing health coverage under a single employer or multiemployer plan. In practice, this foregone Federal income tax deduction could be taken into account by reducing the employer's 2014 employee health care cost by the highest marginal Federal income tax rate theoretically payable in 2014 by most employers so that, if an employer spent a total of \$1,000,000 in 2014 on health care for its employees, it would be considered to have net employee health care costs of \$650,000 in 2014 when measuring its MOE in future years.

We also believe that the agencies should take into account the fact that an employer which has agreed to provide wrap benefits to all or a portion of its employees will likely have some employees that are eligible for Medicaid and, as a result, will have no health care expense for those employees going forward. Thus, the MOE of that employer in future years should be calculated by first determining as the cost of coverage in 2014 divided by the number of employees in 2014 compared to the cost of health care coverage for those employees (including the shared responsibility payment) in a particular future year divided by the number of non-Medicaid participants in the employer's plan. This methodology would also enable the employer and its plan to automatically adjust for any large increase or decrease in the number of its employees participating in its plan during that year.

#### *Recommendation relating to 2014 as the base year*

The Proposed Rule includes requirements that either require an offer of coverage to a substantial portion of full-time employees in 2014 or measure the employer's contributions to such coverage relative to what the employer contributed in 2014. To the extent that any such requirements are retained in a final rule, we recommend that plan sponsors be allowed to use 2013 or 2014 as the reference year. It is possible that some employers may have made fewer offers of coverage in 2014 because Marketplace coverage was first available in 2014. The possibility of also using 2013 as the reference year could expand the number of employers and plans that could take advantage of the opportunity to offer wraparound coverage.

#### *Recommendation related to inclusion of 4980H penalties in employer contribution amounts*

The Proposed Rule requires employers of individuals eligible for limited wraparound coverage offered in conjunction with MSP coverage to 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 employer's annual aggregate contribution toward primary and limited wraparound coverage during a pilot year should include any payable assessments owed by the employer for any month during that year under Section 4980H since these penalties, in effect, help to finance premium tax credits and cost-sharing subsidies received by the employer's full-time employees and their dependents when they purchase individual insurance through the ACA marketplaces.

- e. **Pilot Program with Sunset** 26 CFR §54.9831-1(c)(3)(vii)(F); 29 CFR §2590.732(c)(3)(vii)(F); 45 CFR §146.145(b)(3)(vii)(F)

The Proposed Rule would provide that limited wraparound coverage may be offered as excepted benefits to coverage that is first offered no later than December 31, 2017, and that ends on the later of the date that is three years after the coverage is first offered or the date on which the last collective bargaining agreement relating to the plan terminates after the date wraparound coverage is first offered.

We recommend that the program be a permanent one, because it is important to assure that employees, employers, and unions that are bargaining over health care benefits have certainty as to the applicable regulations. However, if it is necessary to make this rule a pilot program, we request a change in the dates.

Specifically, we recommend that the three-year period (or applicable collectively bargained period) begin with respect to limited wraparound coverage first offered no later than *December 31, 2018*. The reason for this recommendation is twofold. First, many collective bargaining agreements are already in existence. These agreements may not have a "reopener" which allows changes to the agreement. Even if there is a reopener, there may not be a practical ability to exercise it – either on the part of labor or management. Consequently, parties that have entered into longer CBAs would not have the ability to use the pilot program. Second, there is a start-up time necessary to design these benefits. There may also be significant development time for the Multi-State Plan option, including obtaining approval from the Office of Personnel Management (OPM). Consequently, the longer start-up period would allow additional time for these steps to be taken.

We appreciate the opportunity to make these comments. Furthermore, we welcome any questions or requests for clarification you may have.

Respectfully submitted,



Randy G. DeFrehn  
Executive Director