NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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DRAFT OF February 19, 2014

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 benefit structure could be a positive 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 (ACA). However, the specific provisions of the Proposed Rule unduly limit the circumstances in which the

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

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. NCCMP shares the expressed concerns of the Departments that employers should not be encouraged to drop coverage and believes that the recommended changes to the Proposed Rule will make it more likely that more employers will continue to provide coverage.

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 by ACA. The transient, project-based, mobile and seasonal employment patterns that characterize many of these industries would prevent workers from obtaining health coverage

[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.

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 key 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 Exchanges.

As recognized in the Proposed Rule, although Exchange 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 Exchanges allows employers to ensure that their employees continue to receive the same level of coverage as they did previously. 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 Exchange coverage is most attractive from an economic perspective; 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 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 Exchange 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. A summary of the analysis:

- 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 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.

[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] For 2013, the FPL for a family of four is $23, 550 and 400 times the FPL is $35,325; for an individual for 2013, 200% of FPL is $22,980.

- 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, this analysis indicates that the wrap coverage would generally not be available in circumstances where it is needed most, for lower wage industries. 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 Exchange and obtain the wrap will be confusing to employees. It would be far more transparent to be able to offer the wrap to certain employees without a requirement that they be eligible for primary coverage.

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

NCCMP shares the expressed concern of the Departments that some employers may drop coverage and, since the enactment of the ACA, has advocated for rules that would encourage employers to remain in the multiemployer plan system. While the employer penalties provide a disincentive to drop coverage, 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. 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

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

structured in a more flexible way to reflect that other factors, not the wrap, will be the major decision making factor.

Recommendations

(1) Full-Time Employees

For the reasons discussed above, the requirement that the primary plan be affordable for a majority of eligible employees makes the wrap option unavailable in situations where it may be needed most, particularly low wage industries. There are a number of alternative options that could be added to the Proposed Rule under which the wrap coverage could not be considered an integral part of a group health plan.

(a) As an alternative to the current language in the Proposed Rule, the wrap would be considered not an integral part of a group health plan if it is affordable to a majority of full-time employees **enrolled** in the primary plan. Full-time employees who are eligible for the wrap must be eligible for the primary plan.
The change from eligibility to enrollment will make wrap coverage available in a broader range of circumstances. The current rule may 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.

The nondiscrimination requirements would apply as under the Proposed Rule, including both the prohibition on differentiation among individuals based on any health factor and the nondiscrimination requirements under Code Section 105(h)(for self-funded primary and wrap coverage) or Section 2716 of the Public Health Service Act (PHSA), as incorporated by reference into the Code and ERISA, (for fully insured primary and wrap plans). In addition, as under the Proposed Rule, the wrap coverage must not impose any preexisting condition exclusion, consistent with Section 2705 PHSA (as incorporated by reference into the Code and ERISA). NCCMP agrees that these rules provide appropriate protection to employees.

[In one of the calls someone mentioned that it was possible that the wrap could be provided by a "related" plan sponsor rather than the sponsor of the primary plan, e.g., through a related multiemployer plan with a different board of trustees. Do we need to suggest a rule for such situations?]
(b) As another alternative to the current language in the Proposed Rule, the wrap would be considered not an integral part of a group health plan if it is affordable to a majority of full-time employees **enrolled** in the primary plan. Full-time 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 is similar to (b), but removes the requirement that the employee be eligible for the primary plan in order to be eligible for the wrap. As discussed above, we believe that this requirement will be confusing for employees. That is, they will be eligible for a primary plan, but it will be unaffordable, and instead they should decline the unaffordable coverage, purchase coverage on the Exchange, and obtain the wrap coverage. 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.

In lieu of this requirement, the wrap plan coverage could have to be "affordable" to the employee, i.e., provided without an employee contribution.

The nondiscrimination requirements would apply as under the Proposed Rule, including both the prohibition on differentiation among individuals based on any health factor and the nondiscrimination requirements under Code Section 105(h)(for self-funded primary and wrap coverage) or Section 2716 of the Public Health Service Act (PHSA), as incorporated by reference into the Code and ERISA, (for fully insured primary and wrap plans). In addition, as under the Proposed Rule, the wrap coverage must not impose any preexisting condition exclusion, consistent with Section 2705 PHSA (as incorporated by reference into the Code and ERISA). NCCMP agrees that these rules provide appropriate protection to employees.

(2) Part-Time Employees

The employer penalties do not apply with respect to part-time employees. Thus, consistent with those penalties, and the references to Code Section 4980H in the preamble to the Proposed Rule, it should be possible to offer wrap coverage 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 considering part-time employees in applying any affordability 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.

(3) Retirees

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 retirees. 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 affordability 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 the primary plan.

(4) Determination of Affordability

Comments were specifically requested on the standard for determining affordability under the Proposed Rule. 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 issues regarding administrability apply here. Thus, NCCMP recommends that a plan sponsor should be able to use any 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.)

[Are there any timing issues that need to be addressed?]

(5) De minimis/Inadvertent Errors

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

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 consistent 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.

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

(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

A first step in determining appropriate levels for the wrap coverage is to examine the underlying coverage that the wrap will supplement, i.e., non-grandfathered individual health insurance coverage. One might expect that, with respect to individuals that are most likely to benefit from Exchange coverage (as discussed above), the silver level plan (i.e., a 70% plan) would be most attractive. This is because cost-sharing reductions are available for qualifying individuals who purchase a silver level plan. However, current enrollment indicates that most of such individuals are interested in purchasing a bronze level plan (i.e., a 60% AV plan). [Note: This was mentioned in some of the calls. If someone has a reference that can support this, that would be very helpful.] For qualifying individuals, bronze plans can be purchased without any out-of-pocket premium. Thus, this level of coverage appears to be attractive, even though it may ultimately expose the individual to higher cost sharing once medical expenses are incurred compared to a silver plan level of coverage.

Thus, a bronze level plan is the best reference point. The basic need for supplemental coverage with respect to such a plan is to effectively increase the AV of the plan by filling in cost-sharing. Supplemental coverage could also provide additional benefits, such as coverage for out-of-network providers or benefits that are not essential health benefits or not otherwise covered by the individual market plan. Thus, for example, the supplemental plan could cover additional treatments if the underlying plan has a treatment limit on certain benefits (e.g., number of physical therapy visits). While in theory it might be appropriate to tailor the supplemental coverage to the specific individual plan, from an administrative perspective, it will be simpler to have a rule that can be applied across the board.

The preamble to the Proposed Rule references as precedent EBSA Field Assistance Bulletin 2007-04 and CMS Insurance Standards Bulletin 08–01 (the "Prior Guidance"), which was coordinated among all the Departments. The Prior Guidance relates to circumstances under which coverage is considered an excepted benefit by reason of providing coverage that is supplemental to other coverage under a group health plan. The approach suggested here is consistent with the Prior Guidance.

First, with respect to the plan that should be the reference plan for determining the supplemental benefits, the Prior Guidance addressed situations in which the excepted benefit supplemented group health plan coverage. Thus, in that situation the appropriate reference was the underlying group health plan coverage. Following the rationale of the Prior Guidance, the appropriate reference plan for the proposed wrap coverage expected benefit should be the individual market plan that is being supplemented, not the primary plan.

Second, the preamble to the Proposed Rule indicates that the 15% limitation was based on the Prior Guidance. Again, looking at the rationale of the Prior Guidance, it supports an alternative approach 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%.[7] Thus, the underlying principle of the Prior Guidance is to look at the plan that is being supplemented and determine a limitation based on the underlying plan. Consistent with that approach, any limitations of the benefits should look to the individual insurance, at the bronze level.

Finally, 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."[8] Similarly, DOL indicated that it was seeking to prevent insurers "from avoiding 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.[9]

Given the ACA's coverage requirements, these same concerns should not be an issue with respect to the wrap coverage, and should not, therefore, drive the decision-making process with respect to the parameters for the wrap coverage. In particular, the wrap coverage 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. Thus, the wrap coverage may be designed to adequately supplement non-grandfathered coverage, with the knowledge that the various provisions of the ACA itself, including the market reforms and employer penalty provisions, provide sufficient and strong safeguards to prevent against abuses of the sort that may have been possible when the pre-ACA Prior Guidance was issued.

Recommendations

[Following are various suggestions from the group that are provided here for comment and review, particularly from the actuarial side. While we can provide various alternatives, if we can whittle it down, that would be helpful.]

Based on the foregoing, the NCCMP recommends that the final rule allow the wrap coverage to be structured in such a way as to permit the wrap to fill in the gaps in coverage based on a [bronze level plan]. The estimated difference in cost between a typical multiemployer plan and a bronze plan is XX%.].

[In lieu of the requirements in the Proposed Rule, NCCMP recommends the following:

[7] "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.

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

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

[The wrap plan should be able to provide benefits so that the AV level of a bronze plan can be increased to 100% or 94% (the max for a silver plan supplemented with cost sharing reductions)or other?

[The wrap plan should be permitted to do any one of or combination of the following: fill in cost sharing, provide additional benefits that are not coverage by the underlying plan, or cover out of network providers.

[The preamble mentions FSAs or HSA limits, which are based on dollar limits – is that a possible approach?]

C. Application to Basic Health Plans

Proposed Rule

The Departments specifically request comments on how wrap coverage might supplement coverage provided under a basic health plan (BHP).

Recommendations

[Is there any interest in this approach?]

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 required 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. EAPs [any interest?]

C. 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,

[Signature]

Randy G. DeFrehn
Executive Director

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