EMPLOYERS COUNCIL
ON FLEXIBLE COMPENSATION

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February 21, 2014

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 (CMS-9946-P)

Sent electronically to http://www.regulations.gov

Dear Sir or Madam:

The Employers Council on Flexible Compensation ("ECFC") recognizes the enormity of the task before the Department of Labor, Internal Revenue Service, and Department of Health and Human Services ("Departments") in implementing the Affordable Care Act ("ACA"). The ACA charts new territory, necessitating the development of many new and extremely technical regulations. ECFC's more than 150 members include employers who sponsor employee benefit plans, including health flexible spending arrangements ("FSAs"), as well as insurance, accounting, consulting, and actuarial companies that design or administer employee benefit plans. ECFC member companies assist in the administration of cafeteria plan and health benefits for over 33 million employees and dependents.

ECFC appreciates the opportunity to submit comments on the Departments' Proposed Rule, "Amendments to Excepted Benefits" (*Federal Register,* December 24, 2013). Below ECFC offers its comments. We would welcome the opportunity to discuss our initial recommendations further. Should you have any questions, please do not hesitate to contact John R. Hickman at 404-881-7885 or email at john.hickman@alston.com.

Sincerely,

Natasha L. Rankin
Executive Director

COMMENTS AND RECOMMENDATIONS

1. **Clarification of Application of Excepted Benefits Rule to Stand-Alone Self-Funded Dental or Vision Only Plans**

Issue: Under the HIPAA regulations, limited-scope vision and dental benefits are considered excepted benefits if they are either: (i) provided under a separate policy, certificate, or contract of insurance, or (ii) are otherwise not an integral part of a group health plan. 26 C.F.R. § 54.9831-1(c)(3)(ii), 29 C.F.R. § 2590.732(c)(3)(ii), and 45 C.F.R. § 146.145(c)(3)(ii). Benefits are not an integral part of a group health plan if: (i) participants have the right to elect not to receive coverage for the benefits, and (ii) if a participant elects to receive coverage for the benefits, he or she must pay an additional premium or contribution for that coverage. 26 C.F.R. § 54.9831-1(c)(3)(ii)(A) and (B), 29 C.F.R. § 2590.732(c)(3)(ii)(A) and (B), and 45 C.F.R. § 146.145(c)(3)(ii)(A) and (B). In the Proposed Rule, the Departments would eliminate the requirement under the HIPAA regulations that participants pay an additional premium or contribution for limited-scope vision or dental benefits to qualify as non-integral (and therefore as excepted benefits). It is still unclear; however, whether dental not offered in connection with a major medical plan or that is provided automatically without charge is an excepted benefit.

Comment/Recommendation: We urge the Departments to clarify that self-funded stand-alone dental or vision only plans are also excepted benefits.

There is no question that fully insured limited scope vision or dental benefits are excepted benefits regardless of whether other group health coverage is offered. Likewise, we believe, that limited scope vision or dental benefits offered on a stand-alone basis should be excepted benefits as well (i.e., regardless of whether an employer offers other group health coverage). Notwithstanding the Departments' stated goal of equalizing the treatment of limited scope vision and dental coverage (whether self-funded or fully insured) the literal language leaves some ambiguity on this issue which the Departments can clarify. For the following reasons we feel that such clarification is appropriate.

First, this would ensure that that limited scope insured and self-funded benefits are treated in the same manner. Fully insured dental or vision plans provided by a stand-alone dental or vision carrier are excepted benefits by virtue of their separate contract with the insurance carrier. The financial funding arrangement for coverage should not impact whether the substantive benefits qualify as excepted benefit coverage. Limited scope vision or dental coverage should be exempt whether self-funded or fully insured. The funding distinction should not be significant for purposes of determining excepted benefit status. The Departments stated in the Proposed Rule that they intended to "level the playing field between insured and self-insured coverage," and this clarification would further that goal.

In addition, we urge the Departments to clarify that stand-alone limited scope dental and vision plans (whether self-funded or fully insured) are excepted benefits because they are *per se* "not an integral part of a group health plan." Stand-alone limited scope dental and vision plans are not integral to group health plans because they are, by definition, separate from any group health plan coverage. Requiring participants to opt out of stand-alone dental and vision coverage, while preferable to the previous rule requiring a separate contribution, arguably has no effect on the separate and distinct status of such coverage. Because the limited scope dental or vision plan is already separate from the group health plan because of its stand-alone status, it is difficult to see what additional purpose the opt-in requirement serves. Because this requirement is an administrative burden on plan sponsors, ECFC urges the Departments to clarify that limited scope dental and vision plans are automatically considered excepted benefits.

2. **Availability of Health FSAs to Employees without Access to Employer-Provided Health Coverage**

Issue: Under the current HIPAA rules, benefits provided under a health FSA are only excepted for a class of participants if other group health coverage (not limited to excepted benefits) is made available for the year to that class of participants. 26 C.F.R. § 54.9831-1(c)(3)(v)(A), 29 C.F.R. § 2590.732(c)(3)(v)(A), and 45 C.F.R. § 146.145(c)(3)(v)(A).

Comment/Recommendation: We urge the Departments to take this opportunity to eliminate the so-called group health plan "footprint" requirement and expand the health FSA exception so that health FSAs are allowable for employees even if there is no group health plan coverage offered to them through an employer (either because the employer does not offer group health coverage, or does not offer group health coverage to that particular class of employees).

First, employers who do not offer group health plan coverage (or do not offer it to a particular class of employees) may wish to enable their employees to receive the benefits of a health FSA. The ability to pay for some healthcare expenses on a tax-advantaged basis may be particularly important for employees who do not have access to the tax benefits of an employer-sponsored major medical plan (e.g., because their employer may not offer such coverage or because the employee may be subject to a waiting period or is otherwise not yet eligible for coverage).

In addition, the landscape has changed substantially since the pre-ACA period when the FSA exception was first adopted. Unlike when the FSA regulatory exception was first added, there is no longer a concern that employers would try to mask substantive group health coverage as an FSA excepted benefit. There is no longer a concern that FSA coverage would be offered by employers as a substitute for group health coverage. Under the ACA, as codified in 26 U.S.C. § 125(i), salary reductions for health FSAs are capped at $2500, so FSAs cannot provide substantial benefits to substitute for group health coverage. Moreover, under the FSA exception "maximum benefit" requirement (26 C.F.R. § 54.9831-1(c)(3)(v)(B), 29 C.F.R. § 2590.732(c)(3)(v)(B), and 45 C.F.R. § 146.145(c)(3)(v)(B)), employer contributions cannot exceed $500 or, if greater, two times the employee salary reduction contribution. Since passage of the ACA, it has become abundantly clear that Health FSAs cannot serve as a replacement for (or be confused with) group health coverage. We urge the Departments to allow employers to provide all employees, not just those offered group health coverage, with this benefit.

This change would also benefit employees of small employers and part time workers, who are less likely to benefit from the employer shared responsibility provisions under 26 U.S.C. § 4980H because of their employment classification or the size of their employer. The Bureau of Labor Statistics ("BLS") has documented that large employers provide significantly more generous compensation to their employees than small or medium sized employers. For instance, the National Compensation Survey found mean hourly earnings of $24.30 for employers with more than 500 employees, compared to mean hourly earnings of $16.80 for employers with 1-49 employees.[1] Similarly, the BLS found that civilian full-time workers made almost twice that of their part-time counterparts per hour ($21.08 compared to $11.34).[2] The income disparity is likely much greater in practice, given the difference in hours worked between full-time and part-time workers. Thus, employees who are less likely to benefit from the employer shared responsibility requirements receive, on average, significantly less compensation than their full-time counterparts employed by applicable large employers. In the Proposed Rule, in the context of wraparound benefits, the Departments noted that the Proposed Rule aimed to prevent benefit designs in which "low-income workers receive fewer primary benefits than high-income workers." This modification to the FSA rules would also achieve that goal, as it would equalize the playing field between low-income and high-income workers with respect to tax advantaged healthcare spending.

3. Technical Clarification for Proposed Limited Scope Wraparound Excepted Benefit

Issue: In the Proposed Rule, the Departments propose a new limited scope wraparound excepted benefit. Technically, given the structure and character of this "supplemental" benefit and the proposed requirements for such coverage, this new benefit should be characterized as excepted benefit coverage under the fourth category of excepted benefits (section 2791(c)(4) of the PHS Act, section 733(c)(4) of ERISA, and section 9832(c)(4) of the Code) rather than under the second category (section 2791(c)(2) of the PHS Act, section 733(c)(2) of ERISA, and section 9832(c)(2) of the Code). Thus, the regulations under 26 CFR 54.9831–1(c)(5); 29 CFR 2590.732(c)(5); 45 CFR 146.145(c)(5) should be amended (incorporating by reference subsequent Department guidance under FAB 2007-1).

Comment/Recommendation: As noted by the Departments in the Proposed Rule, the second category of excepted benefits generally consists of coverage that is limited in scope and separate and distinct (i.e., "not an integral part" of) from an employer's group health plan. The limited scope wraparound coverage differs from coverage traditionally excepted under the second (and even third) category of excepted benefit because benefits under the new Proposed Rule are specifically designed to be offered alongside and "wrap-around" other health coverage. However, the new proposed wraparound coverage can only be offered to individuals eligible for coverage under an employer's group health plan; thus, the coverage is "similar supplemental coverage provided to coverage under a group health plan." To limit possible confusion and misunderstanding, this coverage is more properly categorized as an excepted benefit under the fourth category of excepted benefit. Such placement would also make applicable (by direct reference) existing and subsequent regulation of the limited scope wraparound coverage consistent with other (c)(4) regulation.[3] The Departments have regulatory authority for such interpretation since the limited scope wraparound coverage is clearly "supplemental" to the coverage provided by the employer under its group health plan.

4. Application of Excepted Benefits Rule to Wellness Programs

[1] Bureau of Labor Statistics, National Compensation Survey: Occupational Earnings in the United States, 2007, Table 28, *available at* http://www.bls.gov/ncs/ocs/sp/nctb0325.pdf.

[2] Bureau of Labor Statistics, National Compensation Survey: Occupational Earnings in the United States, 2007, Table 2, *available at* http://www.bls.gov/ncs/ocs/sp/nctb0299.pdf.

[3] *See* EBSA Field Assistance Bulletin No. 2007–04 (available at *http://www.dol.gov/ebsa/pdf/fab2007-4.pdf*); CMS Insurance Standards Bulletin 08–01 (available at *http://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa□08□01□508.pdf*); and IRS Notice 2008–23 (available at *http://www.irs.gov/irb/2008-07□IRB/ar09.html*).

Issue: In the Proposed Rule, the Departments proposed that employee assistance programs which, among other factors, do not "provide significant benefits in the nature of medical care or treatment," be considered excepted benefits.

Comment/Recommendation: We urge the Departments to explicitly state that wellness and disease management programs that do not provide "significant benefits in the nature of medical care" are also excepted benefits.

The Proposed Rule provided that employee assistance programs ("EAPs") which meet certain requirements and do not "provide significant benefits in the nature of medical care or treatment" are considered excepted benefits. Wellness programs share many of the same features of EAPs, which would also make them appropriate for the category of excepted benefits. Like EAPs, wellness programs are complementary programs to group health coverage that may affect a person's physical or mental health, but are not sources of significant medical coverage. In addition, they also tend to be offered free of charge to employees and provided through third-party vendors (characteristics of EAPs which the Departments noted in the Proposed Rule).

In addition, the Departments have indicated that wellness programs that meet certain criteria do not provide significant benefits in the nature of medical care. If the Departments already consider wellness programs not to offer "significant benefits" in the nature of medical care, we urge them to take the next step and label wellness programs as excepted benefits. For example, in a footnote in the Proposed Rule, the Departments stated that "a wellness program that provides a wide-range of education and fitness services (also including sports and recreation activities, stress management, and health screenings) designed to improve the overall health of the employees and prevent illness, where any costs charged to the individual for participating in the services are separate from the individual's coverage under the health plan," is an EAP that does not provide significant benefits in the nature of medical care. In addition, in IRS Notice 2004-50, wellness plans were included in the list of coverage that does not disqualify an individual from contributing to a health savings account under 26 U.S.C. § 223(c)(1)(A). According to this guidance, a wellness program does not provide significant benefits in the nature of medical care or treatment and is thus not a health plan.

ECFC also urges the Departments to include wellness programs as excepted benefits so that employees will not be prevented from receiving Health Insurance Marketplace tax credits and/or premium subsidies merely because their employer includes them in a wellness program. While wellness programs may not have received as much attention as EAPs, we urge the Departments to consider that clarification in the wellness program context is just as significant.