Submitted Electronically Via Federal Rulemaking Portal: www.regulations.gov

Attention: Excepted Benefits
Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

RE: Amendments to Excepted Benefits; Proposed Rule

To Whom It May Concern:

The U.S. Chamber of Commerce (the “Chamber”) submits these comments in response to the Amendments to Excepted Benefits Proposed Rule (“Proposed Rule”) issued by the Department of Labor, the Department of Treasury and the Department of Health and Human Services (“the Departments”). As requested, these written comments are being submitted to the Department of Labor with the understanding that they will be shared with the other Departments. This Proposed Rule would amend the regulations regarding excepted benefits under the Employee Retirement Income Security Act of 1974 (“ERISA”), the Internal Revenue Code (“the Code”), and the Public Health Service Act (“PHSA”). Excepted benefits are generally exempt from the health reform requirements that were added to those laws by the Health Insurance Portability and Accountability Act (“HIPAA”) and the Patient Protection and Affordable Care Act (“PPACA”). The Proposed Rule was published in the Federal Register on December 24, 2013, by the Departments. The Proposed Rule offers possible implementation approaches for a number of different statutory sections of the PPACA, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as “ACA”).

The Chamber is the world’s largest business federation, representing the interests of more than three million businesses and organizations of every size, sector and region, with substantial membership in all 50 states. More than 96 percent of the Chamber’s members are small businesses with 100 or fewer employees, 70 percent of which have 10 or fewer employees. Yet, virtually all of the nation’s largest companies are also active members. Therefore, we are particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at large. Besides representing a cross-section of the American business community in

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terms of number of employees, the Chamber represents a wide management spectrum by type of business and location. Each major classification of American business – manufacturing, retailing, services, construction, wholesaling, and finance – is represented. These comments have been developed with the input of member companies with an interest in improving the health care system.

OVERVIEW

There are three areas of excepted benefits that the Proposed Rule addresses: dental and vision benefits, limited wraparound coverage, and Employee Assistance Programs (“EAP”). The Chamber has discrete concerns regarding each of these sections and recommends substantive and procedural changes for these provisions in the Final Rule.

I. DENTAL AND VISION BENEFITS

The Chamber appreciates the apparent effort in the Proposed Rule to assuage the discrepancies between current practices in offering employer-sponsored vision and dental benefits and the original statutory requirements of ERISA, the Code and the PHSA that created four categories of excepted benefits. However, we urge two additional modifications to this specific portion of the rule when it is finalized in order to truly and more completely reconcile practical operations with the statutory provisions.

As the Proposed Rule reiterates, the second category of excepted benefits that is exempt from specific PPACA and HIPAA health reform requirements includes limited excepted benefits which must either (1) be provided under a separate policy, certificate or contract of insurance OR (2) be offered as a non-integral part of a group health plan. We urge the Departments to make a relatively small change to each of these two options in order to allow employees to continue to benefit from generous coverage offerings and not be unintentionally subject to provisions that weren’t intended to apply to these limited excepted benefits.

A. CLASSIFYING A LIMITED EXCEPTED BENEFIT AS A NON-INTEGRAL PART OF A GROUP HEALTH PLAN

As the Proposed Rule appropriately recognizes, prior classification of an excepted limited benefit under the second option (i.e. as a “non-integral part of a group health plan”) will be problematic for employers and employees alike in many instances. Prior regulations defined an excepted limited benefit as a non-integral part of a group health plan if: (a) an employee could elect not to receive such benefit coverage, AND (b) an employee would have to pay an additional premium or contribution to receive the benefit coverage.

i. Required to Pay an Additional Premium

Many employers currently offer limited excepted benefits such as vision and dental without requiring a participant to pay an additional premium or contribution to receive the benefit coverage. Requiring employers to reduce the generosity of their benefits and require participants to pay a nominal contribution simply in order for these benefits to continue to be considered limited excepted benefits would be short-sighted and contrary to the best interest of employees.
Secondarily, since only employers offering coverage through fully-insured plans can benefit under the first option (i.e. a separate policy, certificate, or contract of insurance), this requirement would unfairly require self-insured employers and those employers who don’t offer fully-insured limited excepted benefits under a separate policy to charge participants an additional contribution amount. In recognition of this reality and “in response to concerns and to level the playing field between insured and self-insured coverage, these proposed regulations would eliminate the requirement that participants pay an additional premium or contribution for limited-scope vision or dental benefits to qualify as benefits that are not an integral part of a plan.” We strongly support this change and believe that it appropriately encourages employers to offer generous limited excepted benefits and facilitates their ability to do so.

ii. Required Opportunity to Elect Not to Receive Coverage

Although the Proposed Rule recognizes the value and importance of generous employer offerings by eliminating the second half of the requirement (the requirement that an employee pay an additional contribution or premium), in order to fully allow and facilitate the offering of generous limited excepted benefits, a second modification is needed. Clearly, if an employee would have to pay a contribution to enjoy the benefit, then an employee must have the ability to choose whether or not to elect that benefit. However, if the benefit is being offered at no cost to the employee, there is no meaningful policy or practical reason to require employers to allow participants to opt out of a benefit that will be free for them to receive. In fact in order to encourage employers to continue to offer generous limited excepted benefits and to encourage employees to take advantage of this coverage at no cost, employers should be permitted to automatically enroll all participants in limited benefit coverage that comes at no cost to them and with no payroll-deduction. Requiring employers to offer participants the opportunity to decline coverage adds operational complexities that may discourage such generous benefit provisions in the future.

This requirement poses an even more significant problem for highly unionized employers that are obligated to offer dental and vision coverage in their current form under current collectively bargained agreements. Any change to the dental and vision plans, no matter how small, would require employers to reopen union contracts that specify certain terms and conditions for the offering of these benefits. Even a change as offered in this Proposed Rule that would require a benefit opt-out for zero cost coverage would require a company to reopen collectively bargained agreements with numerous unions. As a result, simply waiving the additional contribution or premium section will not be sufficient for many employers.

Therefore, we urge the Departments to modify the first element of this test as well. Instead, we would recommend that the proposed language of Section 2590.732(c)(3)(ii) be deleted and the following language be promulgated instead:

ii. Not an integral part of a group health plan. For purposes of this paragraph (c)(3), benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan or a separate plan) if: a participant is automatically enrolled in coverage and not required to pay any additional

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contribution or premium, or a participant is required to pay an additional contribution or premium and that participant has the right to elect not to receive the coverage for the benefit.

This change will encourage employers to offer generous limited excepted benefits at no additional contribution or premium for the participant while also protecting the ability of a participant who must pay an additional amount for such a limited excepted benefit the opportunity to decline such a benefit and forego the added cost.

B. CLASSIFYING A LIMITED EXCEPTED BENEFIT AS BENEFIT PROVIDED UNDER A SEPARATE POLICY, CERTIFICATE OR CONTRACT OF INSURANCE

In order to truly satisfy the important and stated goal of the Proposed Rule, the first option to classify a limited-scope dental and/or vision benefit as limited excepted benefit must be modified so that it is available to both self-insured and fully-insured benefits.

In order to actually “level the playing field between insured and self-insured coverage,” the Chamber suggests a slight modification to the first option of the second category of excepted benefits. Just as this Proposed Rule modifies the HIPAA regulation that clarified when a benefit is not an integral part of a plan under the second option, we propose that this regulation when finalized also modify which benefits are deemed to be provided under a separate policy, certificate, or contract of insurance for purposes of defining a limited excepted benefit. If a limited excepted benefit is offered through self-insured coverage, that benefit will be deemed to be provided under a separate policy, certificate or contract of insurance provided it is administered through an entity separate and distinct from the entity administering the group health plan.

The Chamber recommends that this principle be promulgated by inserting the following language at Section 2590.732(c)(i):

(i) **In general.** Limited-scope dental benefits, limited-scope vision benefits, or long term benefits are excepted if they are provided under a separate policy, certificate or contract of insurance, *or administered by a separate entity*, or are otherwise not an integral part of a group health plan as described in paragraph (c)(3)(ii) of his section.

This simple modification would more appropriately reflect both the definition of the term “group health plan”, which under the ACA includes both insured and self-insured group health plans, as the Proposed Rule states, as well as the goal of leveling the playing field between insured and self-insured coverage.

II. LIMITED WRAPAROUND COVERAGE

The Chamber has significant questions and concerns about the Proposed Rule’s addition of a limited wraparound coverage excepted benefit. Operational questions include: how can an

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employer provide or even structure appropriate wraparound coverage without knowing the plan that their employees elect and the corresponding benefits and provider network included. While we support the concept of offering employers a variety of options and increased flexibility in benefit design and coverage choices, this proposal contains many elements that would require additional examination and extensive discussion. We urge the Departments to withdraw this provision of the rule and continue discussions with stakeholders on this topic on a separate track to ensure appropriate input and feedback.

III. EMPLOYEE ASSISTANCE PROGRAMS

Many of our member companies offer EAPs which are highly valued by their employees. Given the significant administrative, reporting and compliance work facing employers in 2015 in particular, we urge the Departments to rely on these four criteria broadly and not further specify or define these straight-forward terms in order to facilitate the offering of these programs.

The Proposed Rule suggests that certain EAPs will be considered excepted benefits provided that four criteria are met:

(1) The program cannot provide significant benefits in the nature of medical care;
(2) Its benefits cannot be coordinated with benefits under another group health plan;
(3) No employee premiums or contributions can be required for participation; and
(4) There is no cost sharing.

These criteria appear to be designed to protect employees, as well as the ability of employers to offer these programs, and ensure that EAPs are available to employees as a separate voluntarily available offering, distinct from any significant benefit such as a group health plan. The Chamber believes that the criteria sufficiently indicate that EAPs are separate and distinct from an offering of group health coverage. This definition has been sufficient for determining whether an individual is ineligible to contribute to an HSA, which would only be the case if that individual is covered under a group health plan other than a high deductible health plan. If the definition is sufficient in distinguishing EAPs from group health coverage for purposes of HSA eligibility, it should be sufficient for distinguishing from it from a group health plan.

Conversely, establishing an arbitrary definition such as a number of visits would reduce the ability of employers to design programs that benefit their employees and instead disadvantage some employees. If some parameters are deemed necessary for further specifying what constitutes significant, we urge the Departments to consider examining or limiting visits based on scope of services, instead of fixating on a discrete number of visits. Limiting the number of counseling visits would fail to consider the various reasons or issues for which an employee may seek counseling. An employee in a given year may need counseling for nutritional advice, legal problems or substance abuse because of a variety of unrelated scenarios. To limit the number of counseling visits wholesale would disadvantage an employee to whom an employer would like to provide assistance and undercut prior guidance from the IRS that would permit such aid.  

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We urge the Departments to continue to permit employers to use “a reasonable good faith interpretation” when assessing whether EAPs provide significant benefits in the nature of medical care.

CONCLUSION

We encourage the Departments to continue to work carefully, pragmatically and cooperatively with the numerous stakeholders to minimize unnecessary costs for, and burdens on, employers and provide flexibility as employers work to comply with the law. We look forward to continuing to work together in the future.

Sincerely,

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