

# SECTION OF TAXATION

## State Bar of Texas



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February 24, 2014

**VIA U.S. MAIL & FEDERAL eRULEMAKING PORTAL**  
**HTTP://WWW.REGULATIONS.GOV**

Office of Health Plan Standards and Compliance Assistance, Room N-5653  
U.S. Department of Labor  
200 Constitution Avenue NW  
Washington DC 20210

Re: Comments on Proposed Regulations Regarding "Excepted Benefits"

Dear Ladies and Gentlemen:

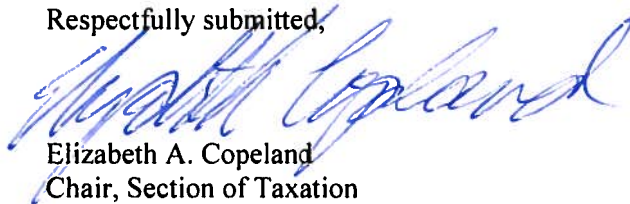
On behalf of the Section of Taxation of the State Bar of Texas, I am pleased to submit the enclosed comments concerning the definition of excepted benefits under the Employee Retirement Income Security Act of 1974, the Internal Revenue Code, and the Public Health Services Act.

THE COMMENTS ENCLOSED WITH THIS LETTER ARE BEING PRESENTED ONLY ON BEHALF OF THE SECTION OF TAXATION OF THE STATE BAR OF TEXAS. THIS REQUEST AND THESE COMMENTS SHOULD NOT BE CONSTRUED AS REPRESENTING THE POSITION OF THE BOARD OF DIRECTORS, THE EXECUTIVE COMMITTEE OR THE GENERAL MEMBERSHIP OF THE STATE BAR OF TEXAS. THE SECTION OF TAXATION, WHICH HAS SUBMITTED THESE COMMENTS, IS A VOLUNTARY SECTION OF MEMBERS COMPOSED OF LAWYERS PRACTICING IN A SPECIFIED AREA OF LAW. THE COMMENTS ARE SUBMITTED AS A RESULT OF THE APPROVAL OF THE COMMITTEE ON GOVERNMENT SUBMISSION OF THE SECTION OF TAXATION AND PURSUANT TO THE PROCEDURES ADOPTED BY THE COUNCIL OF THE SECTION OF TAXATION, WHICH IS THE GOVERNING BODY OF THAT SECTION. NO APPROVAL OR DISAPPROVAL OF THE GENERAL MEMBERSHIP OF THIS SECTION HAS BEEN OBTAINED FOR THIS REQUEST FOR ADDITIONAL GUIDANCE AND ACCOMPANYING COMMENTS AND THIS REQUEST AND THESE COMMENTS REPRESENT THE VIEWS OF THE MEMBERS OF THE SECTION OF TAXATION WHO PREPARED THEM.

1414 Colorado Street, Austin, TX 78701  
(512) 427-1463 or (800) 204-2222

We commend the Internal Revenue Service, the Department of Treasury, Employee Benefits Security Administration, Department of Labor, and Centers for Medicare & Medicaid Services, Department of Health and Human Services for permitting us to submit these comments, and we appreciate being extended the opportunity to participate in this process.

Respectfully submitted,



Elizabeth A. Copeland  
Chair, Section of Taxation  
The State Bar of Texas

**COMMENTS WITH RESPECT TO PROPOSED REGULATIONS RELATING TO THE DEFINITION OF EXCEPTED BENEFITS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, THE INTERNAL REVENUE CODE AND THE PUBLIC HEALTH SERVICE ACT**

These comments on the proposed rules entitled “Amendments to Excepted Benefits” under the Employee Retirement Income Security Act of 1974, as amended (“*ERISA*”), the Internal Revenue Code of 1986, as amended (the “*Code*”) and the Public Health Services Act (the “*PHS Act*”), as published in 78 Federal Register 247 (December 24, 2013) (the “*Proposed Regulations*”) are presented on behalf of the Section of Taxation of the State Bar of Texas. The principal drafters of these comments were Henry Talavera, Co-Chair, and Rob Fowler, Vice-Chair, of the Compensation and Employee Benefits Committee of the Section of Taxation of the State Bar of Texas (the “*Employee Benefits Committee*”). The Committee on Government Submissions (“*COGS*”) of the Section of Taxation of the State Bar of Texas and Susan Wetzel, Co-Chair of the Employee Benefits Committee have approved these comments. Stephanie Schroepfer is the Co-Chair of COGS and reviewed these comments on behalf of COGS. Substantive comments were provided by Sibyl C. Bogardus, and Riva Johnson reviewed these comments on behalf of COGS.

Although many of the people who participated in preparing, reviewing, and approving these comments have clients who will be affected by the legal principles addressed by these comments and frequently advise clients on the application of such principles, none of the participants (or the firms or organizations to which such participants belong) has been engaged by a client to make a government submission with respect to, or to otherwise influence the development or outcome of, the subject matter of these comments.

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Date: February 24, 2014

## I. EXECUTIVE SUMMARY

The following submission contains comments regarding the Proposed Regulations relating to the definition of excepted benefits for purposes of ERISA, the Code and the PHS Act and their corresponding regulations (“*excepted benefits*”).<sup>1</sup>

The following is a summary of our comments:

- A. We commend the Internal Revenue Service, the Department of Treasury, the Department of Labor and the Department of Health and Human Services (collectively, the “*Departments*”) for eliminating the requirement that participants pay a separate premium for limited scope dental, vision, long term care benefits and similar benefits provided by regulations (“*limited scope benefits*”) in order for such benefits to qualify as excepted benefits under a group health plan, but respectfully suggest that the Departments consider (i) further modifying the Proposed Regulations, (ii) issuing further guidance and (iii) allowing further comments, to address a particular matter that is potentially, adversely impacted by the Proposed Regulations. Specifically, in our view, an employer should be permitted to offer additional limited scope benefits under its “primary plan” as defined in the Proposed Regulations to the extent those benefits could be offered separately, and not just in a group health plan as defined under HIPAA (“*group health plan*”).<sup>2</sup>

We welcome and invite the opportunity to work further with the Departments on this important guidance as there is much uncertainty concerning the additional benefits, if any, that may be offered under a primary plan which is otherwise compliant with the Patient Protection and Affordable Care Act, Public Law 111-148 (124 Stat. 119 (2010)), as amended (“*ACA*”) requirements. While the Proposed Regulations were thoughtfully crafted, due to the complexity of the issues involved, we respectfully recommend certain further expansions and/or clarifications of the rules.

Pending the issuance of final regulations, we recommend that the Departments consider issuing guidance such that a group health plan offering limited scope benefits is not required to provide for an opt out opportunity in order for such benefits to qualify as excepted benefits, as long as all eligible employees are eligible to receive the limited scope benefits upon enrollment under the applicable group health plan.

- B. We also respectfully recommend that the Departments consider clarifying that excepted benefits include the following benefits, regardless of whether the applicable plans offer “significant benefits,” “substantial medical benefits” or “significant medical benefits”:
- a. Any health benefits offered as part of a bona fide wellness program that complies with the final regulations relating to wellness programs under the Health Insurance Portability and Accountability Act of 1996, as amended (“*HIPAA*”);<sup>3</sup>
  - b. Employee assistance program benefits; and
  - c. Other health benefits provided by employers to their employees that are not offered under the primary plan (collectively (“*Proposed Excepted Benefits*”));

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<sup>1</sup> The current regulations which are being modified by the Proposed Regulations are found in Treasury Regulations §54.9831-1; 29 C.F.R. §2590.732; 45 C.F.R. §146.145 (collectively the “*Current Regulations*”).

<sup>2</sup> A “*primary plan*” is defined as a plan which generally provides minimum value and is affordable for purposes of the ACA Penalty Regulations (defined below). Preamble to the Proposed Regulations, 78 Federal Register 247 at 77635.

<sup>3</sup> The regulations were published as Incentives for Nondiscriminatory Wellness Programs in Group Health Plan, 78 Fed. Reg. 106 at 33158 (June 3, 2013) (“*Wellness Regulations*”).

Provided that in the case of any of the Proposed Excepted Benefits:

- (1) An employer would be prohibited from claiming that such benefits qualify as benefits offered under the primary plan for purposes of satisfying either minimum essential coverage or minimum value coverage for purposes of any penalties under section 4980H of the Code (“*ACA Penalties*”);<sup>4</sup>
- (2) Requirements similar to those set forth in Proposed Regulations §54.9831-1(c)(vii)((1) through (D))<sup>5</sup> should be met; *provided, however*, further that benefits offered outside a primary plan not exceed 25% of the cost of such coverage determined under COBRA (or such other reasonable percentage determined by the Departments with further input); and
- (3) There would be no requirement that any such benefits be provided under a separate policy, certificate or contract of insurance, with respect to coverage supplemental to Medicare, supplemental to the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) or to Tricare or supplemental to that coverage provided under a group health plan (“*Supplemental Coverage*”).

We recommend that the term “Employee Assistance Program” (hereafter “*EAP*”) be defined as broadly as possible (and be designated an excepted benefit as noted above) so health reform rules do not discourage employers from providing additional benefits to their employees. Employers commonly provide EAP benefits for a variety of reasons that may not be adequately addressed in the employers’ medical plans, such as to address workplace conflicts and to provide assistance for employees facing family challenges. We believe that it would be beneficial for employees if the final rules support rather than thwart the provision of EAP benefits. As one example, the Departments should encourage the provision of health benefits provided by a health clinic or similar benefits established by an employer for some or all of its employees, but that cannot be provided to all employees due to geographic restrictions or cost considerations.

Regarding mental health parity provisions, we recommend allowing stakeholders a further comment period to address potential abusive situations under other applicable laws. Until then, we would recommend a doubling of the number of permissible mental health visits to 20 with some period for transition.

- C. We also respectfully recommend that the Departments consider clarifying that excepted benefits include self-insured benefits provided by an employer in lieu of or in addition to workers’ compensation benefits.
- D. We also respectfully recommend that the Departments expand permissible “wrap around” benefits under Proposed Regulations §54.9831-1(c)(vi) (“*wrap around benefits*”) to include group health plan benefits that are provided on an after-tax (*i.e.*, fully taxable), self-insured basis, along with other benefits which may be provided under a primary plan, so long as:

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<sup>4</sup> The regulations published in the Federal Register as the “Shared Responsibility for Employer Health Coverage” were finalized in 79 Fed. Reg. 29 at 8544 (February 12, 2014) (“*ACA Penalty Regulations*”).

<sup>5</sup> In this Comment, for ease of reference and because the other Current Regulations essentially duplicate the Treasury Regulations, we cite only to the Treasury Regulations further in these Comments, but we suggest that our comments apply with equal force to the other changes contemplated to the Current Regulations by the Proposed Regulations.

- (1) The wrap around coverage provides benefits in addition to those required to be provided under the primary plan and the employer does not use (or attempt to use) the provision of such benefits to satisfy (or avoid) any provision of the ACA.
- (2) The primary plan satisfies “minimum value” and is affordable within the meaning of Proposed Regulation §54.9831-1(c)(vi)(C) and the wraparound benefit cost does not exceed 25% of the cost of coverage provided by the primary plan.

Group health plan benefits that satisfy these requirements are referred to herein as “permitted after-tax health benefits.”

- E. We also respectfully recommend that the Departments clarify, with respect to permitted after-tax group health plan benefits:
- (1) The nondiscrimination requirements under Proposed Regulation §54.9831-1(c)(vi)(E) and Treasury Regulations §105(h) (“nondiscrimination rules”) do not apply to self-insured benefits, including self-insured excepted benefits; and
  - (2) There is no requirement that such excepted benefits be provided under a separate policy, certificate or contract of insurance.
- F. Because these Proposed Regulations may, if implemented, substantially and adversely impact the benefits that can be provided by employers to employees and would appear to prohibit benefits that, in our experience, are benign and commonplace, we respectfully request a hearing on these matters and/or an opportunity to discuss further these matters in person.

We believe that, if the Proposed Regulations are implemented substantially as drafted, employers’ efforts to provide medical assistance benefits to their employees will be unduly limited. Employers will be forced to eliminate valuable benefits for their employees or risk incurring significant ACA penalties, including, but not limited to, those set forth by the ACA Penalty Regulations. Employers also incur additional costs for administration when federal rules condition excepted benefit status on the programs being provided outside of the group health plan. Separation of the benefits does not protect the employees from undesirable consequences since these additional benefits are generally low-cost value adds. Creating additional administrative costs provides no enhancement of protections to the employees but rather actually incentivizes employers to eliminate benefits they would otherwise provide.

We also request that the Departments consider the guidance with respect to excepted benefits in the context of its health reimbursement arrangement (“HRA”) guidance. HRAs have been substantially classified as excepted benefits in all material respects if integrated with certain group health coverage (generally this would include benefits under a primary plan) offered by an employer. We suggest that similar guidance should apply for other benefits provided by an employer.

## II. DISCUSSION

### A. Permitting Additional Limited Scope Benefits Within The Primary Plan

#### I. Expand What Constitutes Limited Scope Benefits

We urge the Departments to expand the list of limited scope benefits permitted under a primary plan, as the Departments have the authority to authorize “such other similar, limited benefits,” as may be

specified in the Current Regulations.<sup>6</sup> We suggest that all of the benefits that can be offered as excepted benefits outside of a primary plan should be permitted within an otherwise ACA compliant plan. For example, an employer may want to offer a wellness program that is intended to be compliant with the Wellness Regulations, and which is part of the primary plan.

If an employer desires to provide additional limited benefits such as limited visits to a state of the art wellness institute or similar benefits limited in quantity or value, the Departments should permit these additional benefits, even if such benefits could otherwise be classified as essential health benefits under the ACA. Specifically, we are aware of employers that have offered “biggest loser” benefits to certain of their employees and then sent them to physician-supervised camps to help their employees lose weight.<sup>7</sup> While this specific benefit must be carefully crafted to comply with Federal tax and discrimination rules, providing such a benefit is consistent with what we perceive as a positive trend of employers earnestly and in good faith trying to improve the health of their employees in meaningful, life changing ways. We encourage the Departments to provide a road map for employers to provide these common, health-promoting and other similar additional limited scope benefits as parts of their primary plans. We encourage the Departments to permit as much as flexibility as is possible in order to foster innovation in the provision of additional health-promoting benefits under an otherwise ACA compliant primary plan.

We request the opportunity to comment further on what additional benefits may be provided under a primary plan before the Proposed Regulations are finalized.<sup>8</sup> For example, just as the Departments have provided specific guidance that a Health Reimbursement Arrangement (“HRA”) generally must be integrated into certain group health plans in order to be ACA compliant, we suggest that there are other benefits that should be permitted as integrated benefits as part of a primary plan. Due to the complexity of these issues, we urge the Departments to establish a separate longer comment period in order to properly address these complex issues and to provide a hearing or other opportunity to discuss in person these issues.

## 2. Opt-out requirement for Dental and Vision Benefits

Pending the issuance of final regulations, we suggest that a plan offering limited scope benefits should not be required to offer an opt out opportunity in order for such benefits to qualify as excepted benefits, provided that all eligible employees are eligible to receive the limited scope benefits upon enrollment under a group health plan. We perceive no harm in permitting in this expansion. In our view, requiring an opt out opportunity for limited scope benefits merely imposes unnecessary administrative and economic burdens on employers without benefitting employees.

We suggest that the Current Regulations addressing opt-outs were prepared in an entirely different context, as the primary concern of HIPAA was with limiting preexisting conditions exclusions and providing similar protections that have been addressed and are no longer pertinent concerns with respect to a primary plan. While certain group health plan laws, including laws regarding (i) health status discrimination, (ii) mothers and newborns standards, (iii) mental health parity and (iv) ACA market reforms will and should still apply to protect covered persons, we suggest that the elimination of the opt out feature for a limited scope benefit would not adversely impact HIPAA compliance.<sup>9</sup>

Since 2004, the Departments have excepted limited scope dental and vision benefits from coverage under HIPAA, so long as the benefits are either:

- i. Provided under a separate policy or contract of insurance or

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<sup>6</sup> Section 9832(c)(3) of the Code.

<sup>7</sup> While such a benefit might be able to be provided within a disease management program, the uncertainty provides a disincentive for employers to provide this additional benefit.

<sup>8</sup> See Technical Release 2013-03 (September 13, 2013).

<sup>9</sup> See sections 9802 to 9815 of the Code.

- ii. “[O]therwise not an integral part of a group health plan.”<sup>10</sup>

For purposes of the HIPAA regulations, benefits are not an integral part of a health plan if participants (1) may opt out of coverage and (2) pay an additional premium or contribution for such coverage.

In the Proposed Regulations, the Departments have eliminated the requirement that participants pay an additional premium or contribution for limited scope dental and vision benefits in order for such benefits to be deemed not integrated with a primary plan. This is a welcome change, given the disparate treatment afforded insured versus self-insured plans in this regard under the Current Regulations. However, under the Proposed Regulations, the requirement remains that employers provide health plan participants (“*participants*”) the option to opt out of such coverage.

We believe the opt-out requirement serves no meaningful purpose but rather is simply a perhaps unintentional remnant of what was previously required under the Current Regulations. While admittedly, the opt-out requirement may be satisfied by an employer preparing an amendment to its benefit plan, we believe that requiring such an amendment would impose unnecessary administrative burdens and costs for employers and participants. We suggest that participants will not be benefitted by a right to affirmatively opt out of such coverage provided as part of group health plan coverage. In practice, a participant could simply opt out merely by not taking advantage of the limited scope dental or vision coverage. We are aware of employers and insurers that have already eliminated the additional benefits from their programs instead of undertaking the additional administrative expense and tasks associated with an opt out requirement.

We suggest that requiring the opportunity to opt out of the limited scope dental or vision coverage has no meaningful correlation with whether the coverage is integrated with a group health plan -- the coverage could be integrated with an opt out alternative, or not integrated with an opt out alternative, or vice versa. Furthermore, retaining the opt-out requirement may present a trap inviting an unwary, well-meaning employer that desires to provide cost-free medical or dental coverage to its employees, to engage in an innocent “foot-fault” by failing to offer an opt out right, thereby jeopardizing the coverage’s status as an excepted benefit. We suggest that this opt-out requirement be eliminated.

## B. Significant Medical Coverage under an EAP

### 1. EAP Benefits

#### a. Summary of Proposed Regulations

As noted in the Proposed Regulations, EAPs allow employers to provide wide-ranging benefits that can improve the health and welfare of their employees. In recognition of this, the Departments issued guidance on September 13, 2013, seeking to amend the excepted benefits regulations to allow an EAP to qualify as excepted benefits so long as the EAP does not provide “significant benefits in the nature of medical care or treatment.”

The Proposed Regulations set forth the criteria for an EAP to qualify as excepted benefits, specifying that such an EAP must not:

- a. Provide significant benefits in the nature of medical care;
- b. Coordinate the EAP benefits with benefits under a group health plan, and
- c. Require employee contributions or premiums.

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<sup>10</sup> See Section 9831(c)(1) of the Code.

The Departments invited comments on, among other things, what might constitute an EAP. In a further footnote, the Departments provided two other examples of EAPs that do not provide significant benefits in the nature of medical care:

“Other examples of EAPs that do not provide significant benefits in the nature of medical care, discussed in IRS Notice 2004–50 Q&A–10 include (1) an EAP with benefits that consist primarily of free or low-cost confidential short-term counseling (which could address substance abuse, alcoholism, mental health or emotional disorders, financial or legal difficulties, and dependent care needs) to identify an employee’s problem that may affect job performance and, when appropriate, referrals to an outside organization, facility or program to assist the employee in resolving the problem; and (2) 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.”<sup>11</sup>

b. Recommendation

We recommend that the Departments eliminate the requirement that benefits under an EAP not be provided in the nature of medical care, particularly if such benefits are offered as part of a program subject to the Wellness Regulations (“*wellness program*”). For instance, in some cases employers offer primary plan coverage that in practice is declined by employees if such employees are eligible for other coverage, including, but not limited to, Supplemental Coverage (e.g., former U.S. military personnel). In such a case, under the Proposed Regulations as drafted an employer would have no meaningful way to effectively promote the overall mental or physical health of its employees as part of an EAP or formal wellness program or otherwise.

We understand that the Departments are concerned that this exception may be subject to abuse by employers and others, and we would respectfully request the opportunity to discuss further (or make further comments) with the Departments before the Proposed Regulations are finalized to develop safe harbors so that this exception not be used as a way for employers to design programs to avoid the substantive requirements of the ACA.

An employer promoting the wellness of its entire workforce might offer all such employees additional health or other benefits at no charge, such as visits to a doctor or health professional that might be unrelated or unconnected to the benefits offered by the primary plan. Such an employer might want to provide state of the art wellness/health benefits to those employees in an effort to help its employees get healthier (e.g., doctor visits to a center of excellence hospital for all employees without regard to the primary plan coverage offered by such employer, or access to free health screening). Under the current guidance, these services probably make the plan a group health plan under ACA rules, and thus, render it virtually impossible to offer such benefits other than as part of an ACA compliant group health plan. Even then, some of the ACA requirements, such as the prohibition on annual limits can pose insurmountable obstacles to the offering of wellness benefits fully paid by an employer.

We encourage the Departments to promote efforts of employers to offer health benefits to their employees in addition (or supplemental to) those provided by the primary plan. For example, if an employer wants to provide an employer provided health clinic to employees (and some but not all dependents over a certain age) some of whom live within a short distance of a worksite, this would be prohibited by ACA as an excepted benefit unless this “benefit” is designed to be fully compliant with the myriad of ACA rules. On-site and near-site clinics are cost-effective ways for an employer to address the

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<sup>11</sup> Preamble to the Proposed Regulations, 78 Federal Register 247 at 77636, fn 28.

health of its entire workforce, and their families, and to manage workplace injuries. This type of innovation should be encouraged.<sup>12</sup>

Because it is so difficult to define what benefits might constitute part of an EAP, we respectfully suggest that the Departments employ a definition that is as broad as possible. As long as the employer also provides primary plan coverage, subject to the limitations we suggest below, we recommend that the definition of EAP be materially expanded to allow for coverage which may (or may not) otherwise be provided by the primary plan, but only if the primary plan is otherwise ACA compliant and the EAP is not used as a vehicle to avoid ACA Penalties. The employer should also be prohibited from claiming that any such benefits apply for purposes of satisfying any ACA coverage and avoiding any corresponding ACA Penalties. An EAP should never be considered minimum essential coverage under the ACA (“MEC”), for example.

We believe that the other requirements set forth in Regulations §54.9831-1(c)(3)(vii)(B) through (D), are reasonable for all EAP benefits. Further, to avoid such benefits from replacing benefits provided under a primary plan, we suggest that a cap or percentage of primary plan benefits be placed on any such EAP benefits (i.e., 25% or such other higher percentage established by the Departments), applying an appropriate percentage to Proposed Regulations §54.9831-1(c)(3)(vii)(B) through (D).<sup>13</sup>

Without the exception for wellness programs, employers will be unable to offer meaningful wellness program benefits to employees who elect not to be covered under the primary plan. In addition, to allow supplemental coverage to employees who opt out of primary plan coverage, we suggest that the Departments eliminate any requirement that any such benefits be provided under a separate policy, certificate or contract of insurance, with respect to coverage Supplemental Coverage. These wellness programs are often provided by third party vendors that specialize in population health management, not through insurance carriers. Employers using this best practice approach own their data even as they change insurance carriers to maximize benefits and minimize costs.

It appears to us that there is no basis for continuing this insurance distinction in the current ACA environment. Given the requirement that any costs charged are separate from the individual’s coverage under the health plan, there should be little risk that this will be an avenue for an end run around the requirements of the ACA and we see little potential for abuse.<sup>14</sup> In fact, if tied to the health plan under ACA wellness incentives, the wellness services already must be cost neutral to the participating employees, except for personal costs like special diet foods.

Such coverage should be permitted whether using a health plan carrier or outside of a carrier relationship, such as on a self-insured basis including through a vendor. In that regard, any other potential abuses regarding discrimination may be addressed by the provisions of section 105(h) of the Code. We respectfully recommend that the Departments expressly grant broad leeway to employers to provide benefits on a self-insured basis under an EAP, subject to the requirements of section 105(h) of the Code.

If the Departments disagree with the substance of these comments, we respectfully request the opportunity to discuss and comment further, as these issues are extremely complicated and cannot be fully captured and fully briefed by single comment on excepted benefits.

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<sup>12</sup> Alternatively, employer provided health clinics could also be expressly allowed to qualify as limited wrap-around coverage.

<sup>13</sup> We suggest 25% of the cost of coverage for each such individual as a reasonable limitation with respect to the primary plan based upon the fact that employers should have significant flexibility to provide additional benefits provided that such benefits do not replace primary plan benefits. We borrow the 25% as applicable from the key employee concentration test of section 125(b)(3) of the Code.

<sup>14</sup> We also ask for a corresponding change to §54.9831-1(c)(5) of the Current Regulations to clarify that such benefits can be provided on a self-insured basis or by the same insurer notwithstanding the guidance set forth in Preamble to the Proposed Regulations, 78 Federal Register 247 at 77636, fn 13.

## 2. Significant Benefits and Mental Parity

The Departments invited comments on what constitutes “significant benefits in the nature of medical care”:

“For example, the Departments request comments as to whether a program that provides no more than 10 outpatient visits for mental health or substance use disorder counseling, an annual wellness checkup, immunizations, and diabetes counseling, with no inpatient care benefits, should be considered to provide significant benefits in the nature of medical care.”<sup>15</sup>

Many counseling and wellness programs provide a more generous approach, and in some cases, employees can access services like diabetic counseling on an as-desired basis (theoretically daily if the individual can freely initiate the contact with a coach or nutrition counselor, for example). Imposing a limit on wellness programs unduly hampers the efforts of the employer, as well as the individual, and creates a need for costly tracking of wellness contact events and ultimately restricted access. Broad leeway for wellness benefits is consistent with the overall health goals of the ACA and does not create a potential for abuse.

Finally, regarding mental health parity provisions, we recommend allowing stakeholders a further comment period to address potential abusive situations under other applicable law. In the meantime, we believe that an even higher threshold of outpatient visits for mental health and substances abuse benefits should be allowed within the exception. A higher threshold, such as 20 annual visits, will allow employers to offer an even broader scope of benefits to their employees in a way that is truly in addition to any group health plan that might be offered. We can think of no reason not to provide a liberal rule that encourages employers to provide EAPs with these types of benefits, at least until further guidance is issued regarding the impact on other laws, including, but not limited to, laws affecting mental health parity.

### C. Expand Relief for Self-Insured Coverage Designed to Opt-Out from Workers’ Compensation Laws

For the reasons set forth above, we also request that voluntary injury benefit programs (which replace workers’ compensation benefits under applicable law) (“*voluntary injury benefit plans*”) be excepted as self-insured “[w]orkers’ compensation or similar coverage.”<sup>16</sup> A description of the issues was provided to the American Bar Association on May 6, 2011, as follows:<sup>17</sup>

#### **“15. PPACA: Excepted Benefits Question**

**Question:** Is a Texas voluntary injury benefit plan that (1) provides medical and income replacement benefits solely for workplace injuries and illnesses and (2) is maintained by a Texas employer that does not subscribe to the state workers' compensation system an “excepted benefit” under Part 7 of ERISA and the parallel provisions of Chapter 100 of the Internal Revenue Code?

**Initial Proposed Answer:** Yes. Approximately one-third of all Texas employers covering over 1.5 million Texas employees do not subscribe to the Texas workers’ compensation system (“nonsubscribers”). Because Texas nonsubscriber plans provide coverage similar to workers’ compensation coverage, these plans are exempt from Part 7

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<sup>15</sup> Preamble to the Proposed Regulations, 78 Federal Register 247 at 77636.

<sup>16</sup> Code Section 9832(c)(1)(D). Alternatively, such plans could be excepted as EAP benefits to the extent the requirements above are met.

<sup>17</sup> Questions and Proposed Answers for the Department of Labor Staff for the 2011 Joint Committee of Employee Benefits Technical Session Held on May 6, 2011, Q&A 15. *See also similar discussion*, American Bar Association, Technical Session Between the Department of Health and Human Services and the Joint Committee on Employee Benefits (May 3, 2004), Q&A 5, with further discussion of HIPAA privacy rules.

of ERISA and Chapter 100 of the Code. See, ERISA Section 733(c)(1)(D) and IRC Section 9832(c)(1)(D) that exempts “workers’ compensation and similar insurance,” and their implementing regulations under DOL Reg. Section 2590.732(c)(2)(iv) and Treas. Reg. Section 54.9831(c)(2)(iv) that exempts “workers’ compensation or similar coverage.”

**Background:** The workers' compensation system in Texas is purely voluntary. (See, Texas Labor Code §406.002.) Employers in Texas may elect whether to provide state regulated worker's compensation benefits, i.e., "subscribe" to the state program. Employers who subscribe to the state regulated workers' compensation program may either pay into the state system on an insured basis or may self-insure the state provided benefits. (See Texas Labor Code §406.003.) Alternately, an employer may elect to be a nonsubscriber. Under Texas law, a nonsubscriber is not required to provide workers' compensation benefits for its employees and may be sued for any workplace injury or illness. These employers are subject to negligence liability claims (similar to general liability claims) from injured employees that can prove that their injuries resulted from the employer failing to provide a safe workplace. To limit their liability nonsubscribers provide an occupational injury plan (referred to as a "Nonsubscriber Plan") that provides medical and salary continuation benefits for Texas employees who experience a workplace injury or illness. Some Nonsubscriber Plans also provide death, dismemberment, income replacement and other forms of work-injury related benefits. However, no dependents participate in a Nonsubscriber Plan (except as a beneficiary of a death benefit provided by the plan), because only those employees who actually experience a workplace injury or illness are eligible to receive benefits. Similar to many other workers' compensation programs in other states, Texas Nonsubscriber Plans are typically self-insured, with some employers obtaining stop loss coverage for both benefits and liability exposure. A Texas Nonsubscriber Plan is solely limited to workplace injury and illnesses. Thus, like other plan sponsors who desire to provide major medical coverage for their eligible employees and dependents, a Texas Nonsubscriber Plan sponsor will also provide a separate ERISA plan providing major medical coverage for non-workplace injuries and illnesses.

**Status Under ERISA:** ERISA §4(b)(3) provides that ERISA shall not apply to any employee benefit plan if the plan “is maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws.” Various court decisions have held that Texas Nonsubscriber Plans are not maintained “solely to comply with” workers' compensation laws, and thus are not eligible for this ERISA exception that covers substantially all other state workers' compensation systems. As a result, Texas Nonsubscriber Plans satisfy the definition of an “employee welfare benefit plan” under ERISA §3(1).

**Status Under the IRC:** A Texas Nonsubscriber Plan provides, in part, health care to employees. As a result, a Texas Nonsubscriber Plan is a “group health plan” under IRC Section 5000(b)(1).

**Texas Nonsubscriber Plans are Similar Insurance / Coverage to Workers' Compensation:** Texas Nonsubscriber Plans provide coverage to Texas workers for workplace injuries and illnesses, thereby making these plans similar to workers' compensation. The phrase “solely to comply with” under ERISA Section 4(b)(3) means that the exclusive reason to maintain the plan must be to comply with the workers' compensation system of Texas. Alternatively, the phrase “similar insurance” and “similar coverage” in the excepted benefit provisions of ERISA Part 7 and IRC Chapter 100 does not require that the exclusive purpose of the Plan be to comply with the

workers' compensation system. Rather, the phrase only requires that the Plan be “similar to” or have characteristics in common with workers' compensation in order to be an excepted benefit. As noted above, Texas Nonsubscriber Plans are the functional equivalent of workers' compensation and should be exempt from ERISA Part 7 and IRC Chapter 100. Texas courts have also held that Texas Nonsubscriber Plan benefits are “non-fringe benefits” (unlike traditional major medical coverage) and that the primary purpose of such benefits (similar to workers' compensation) is to protect nonsubscriber employers from liability exposure. Rentech Steel v. Teel (Tex. App. – Eastland, August 13, 2009).”

We understand that the Departments did not provide a response to this briefing of the issues. We do not have anything more to add substantively, but we suggest that voluntary injury plans are just one of a myriad of health benefits an employer might add in addition to its primary plan. These benefits should be excepted as self-insured benefits that are similar to workers' compensation benefits.<sup>18</sup> We suggest the reasoning above continues to be applicable and that voluntary injury plan benefits provided on a self-insured basis should be treated as excepted benefits, particularly where ACA issues are not implicated.

#### D. Expand Relief for Truly Supplemental Coverage

The Proposed Regulations add a new exception for “limited wraparound coverage”, which wraps around and supplements individual policy coverage purchased by employees. To qualify, the wraparound coverage must provide benefits in addition to the primary plan, must reimburse out of network benefits under the individual policy or cover cost-sharing under the individual policy, along with the following requirements:

- i. The sponsoring employer must provide a primary plan that is affordable for a majority of eligible employees;
- ii. The cost of the wraparound coverage must not exceed 15% of the primary plan's cost of coverage; and
- iii. The wraparound coverage must not discriminate on health status or in favor of highly compensated employees.

The Proposed Regulations acknowledge that:

“Federal law is designed to encourage employers to provide group coverage for their employees.”

Preamble to the Proposed Regulations, 78 F.R. 247 at 77634. However, the carefully crafted “limited wraparound coverage” exemption set forth in the Proposed Regulations is arguably too limited, particularly given the requirement that the coverage can only wrap around certain individual coverages and the limitation to 15% of the primary plan's cost. We suggest that any limitation be based upon 25% of each such employee's cost of coverage.<sup>19</sup> We suggest these figures as a reasonable compromise that provides employers with additional flexibility without serious concern that such coverage will replace primary plan coverage. Finally, it allows for geographic variations in the cost of the primary plan (a local issue) relative to the wraparound program (which are often nationally-priced programs).

We also suggest that the purpose of encouraging employers to provide group coverage for their employees can be better served by setting forth a broader exemption for truly supplemental coverage that is in addition to any other primary plan coverage, whether or not offered through a separate insurance policy with the same insurer, and that meets the following additional criteria:

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<sup>18</sup> Or, as noted above, such plans could be exempted as EAP benefits.

<sup>19</sup> See footnote 14 above.

- 1) the benefits are either provided to participants on an “after-tax” basis on a self-insured basis and subject to taxation under section 105(h) of the Code, or are provided by a separate insurance policy by any insurer (including the primary plan insurer) that complies with Section 2716 of the PHS Act, and
- 2) such coverage will not qualify as MEC for purposes of the employer shared responsibility rules under the ACA.

The adoption of this broader definition of Supplemental Coverage will allow an employer that desires to offer executive level benefits as a supplement to do so, without any tax advantage to the recipients on a self-insured basis, but without fear that offering such coverage will “taint” its primary plan. Such an employer will still be subject to the employer shared responsibility mandate under the ACA and have the same incentives to provide minimum essential coverage to its employees. But it will not be unduly chilled from offering truly supplemental coverage to a particular group of employees.

**E. AFTER-TAX SELF-INSURED BENEFITS**

We are concerned that an employer will be effectively precluded from offering “self-insured” benefits that violate requirements analogous to section 2716 of the PHS Act (which applies to insured arrangements), without also incurring a corresponding violation of the ACA as a whole. Therefore, we urge the Departments to permit extended Supplemental Coverage, EAP and other coverage and benefits as further described in this comment on an after-tax self-insured basis. Otherwise, employers may be effectively precluded from providing any supplemental coverage that, although allowed in the past, would now run afoul of ACA without an expansion of the concept of excepted benefits. We respectfully urge the Departments to retain the only substantial alternative left for employers—the ability to provide taxable, excepted benefits on a self-insured basis to its executive level employees (such as Supplemental Coverage), without incurring an ACA violation.

**F. SUMMARY STATEMENT.**

We urge the Departments not to substantially eliminate employers’ ability to offer EAPs and other supplemental coverage consistent with our requests above. Due to the complexity of these issues, we request a hearing to discuss further in person the formulation of rules that would encourage employers to provide additional health benefits to employees without violating ACA prior to the finalization of the Proposed Regulations. Finally, we welcome the opportunity to comment further on the Departments’ efforts to address these complicated matters as the guidance on these matters is further refined and issued.