ERIC

The
ERISA
Industry
Committee

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Re: Retiree-Only Group Health Plans

Ladies and Gentlemen:

We are writing on behalf of the ERISA Industry Committee ("ERIC") to ask the Departments of Labor, Treasury, and Health and Human Services (the "Departments") to provide additional guidance on group health plans that cover fewer than two participants who are current employees ("retiree-only plans"). Under section 732(a) of ERISA and section 9831(a) of the Internal Revenue Code, retiree-only plans are exempt from certain health mandates. In addition, the Department of Health and Human Services will not enforce these mandates with respect to non-federal governmental plans and has encouraged the states not to apply these mandates to issuers of insured plans under the Public Health Service Act.[1]

Representatives of the Departments participated in a telephone call with ERIC's members in December to discuss a number of issues that affect retiree-only plans. ERIC's members found this call very informative, and we hope that the Departments did as well. We thought that it would be helpful to outline the issues on which employers need further guidance, and to explain how we think those issues should be resolved.

[1] *See* 75 *Fed. Reg.* 34,538, 34,539–40 (June 17, 2010).

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ERIC's Interest in Retiree-Only Plans

ERIC is a nonprofit association committed to the advancement of the employee retirement, health, incentive, and welfare benefit plans of America's largest employers. ERIC's members sponsor some of the largest private group health plans in the country. These plans provide high-quality, affordable health care to tens of millions of workers and their families.

Many of ERIC's members provide comprehensive health benefits not only to active employees, but also to retired workers and their families. These retiree group health plans provide a bridge to Medicare for employees who retire before age 65. Once the retirees become Medicare-eligible, many employers continue to provide retiree group health coverage that supplements the coverage their retirees receive under the Medicare program.

Large employers do not have unlimited resources to spend on retiree health care. As American companies struggle to compete in a global economy, they labor under the burden of a health care system that is among the most expensive in the world. This burden falls much more heavily on private companies in the United States than it does on their competitors in other developed nations, where the government plays a larger role in providing health care and controlling medical costs.

The Affordable Care Act has imposed a number of expensive new mandates on employer health plans that were already struggling to cope with runaway medical costs. Many of ERIC's members are approaching, and many have already reached, the tipping point: they cannot spend more money on health care, so that every additional dollar needed to satisfy a new mandate is a dollar that must be recovered by reducing other health benefits. The statutory exemption for retiree-only plans provides welcome relief from the new health mandates, and allows large employers to continue to provide affordable health care to retirees and their families.

Beginning in 2014, the Affordable Care Act will require individuals to obtain minimum essential coverage through employer group health plans, individual insurance, or federal or state government programs. The Affordable Care Act will require large employers to offer minimum essential coverage at affordable rates to active employees in order to avoid a "free rider" penalty; there is no penalty that would compel employers to offer retiree coverage. Retirees will have access to essential health coverage through employer-sponsored plans only if employers are willing to continue to provide this coverage. While many large employers voluntarily provide comprehensive health coverage to their retirees today, they cannot continue to provide this coverage at affordable rates if they must comply with the expensive new mandates imposed by the Affordable Care Act. In order to serve the Act's objective of preserving and expanding group health coverage provided by employers, the Department must adopt a flexible, practical interpretation of the exception for retiree-only plans.

Employers Need Further Guidance Concerning Retiree-Only Plans

ERIC recognizes that the statutory exception for retiree-only plans is not new: this exception was included in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). When the exemption was created, however, most large employers' retiree group health plans already complied with HIPAA's health care portability and nondiscrimination

standards, or could easily and inexpensively be brought into compliance. Employers did not need to determine whether their retiree health plans were exempt from the HIPAA mandates, since the plans satisfied the mandates in any event.

With the enactment of expanded mental health parity requirements and the extensive new health mandates included in the Affordable Care Act, the statutory demands on group health plans have increased dramatically, with a corresponding increase in cost. Few large employers can continue to provide affordable retiree health care if they are forced to comply with these new mandates. As a practical matter, they must either qualify for the retiree-only exception or discontinue their retiree health plans. As a result, it has become crucial for employers to understand the scope of the statutory exemption for retiree-only plans, so that they can determine how to structure their plans to qualify for the exemption.

ERIC's members appreciate the guidance that the Departments have already provided concerning retiree-only plans. In the preamble to the interim final regulations addressing grandfathered plans, the Departments recognized that the Affordable Care Act did not alter the exception for retiree-only plans.[2] The Departments also acknowledged that these plans are exempt from the group market reforms enacted in the Affordable Care Act.[3]

ERIC urges the Departments to expand this guidance to provide a flexible definition of the term "plan" for purposes of the exception, and to make clear that a retiree-only plan will remain eligible to rely on the exception in the situations outlined below. This additional guidance is necessary to preserve coverage under retiree-only plans for individuals who otherwise will receive lesser coverage or no coverage at all.

1. A retiree-only "plan" is the entity designated and operated as a plan by the employer.

Large employers offer a wide variety of group health programs and other welfare benefit programs in different geographic regions to different groups of workers and their families. To reduce the volume of their annual filings, employers often include these different programs under a single "umbrella" or "wrap" welfare plan with a single plan number, and they file a single annual report on Form 5500 covering the wrap plan. As the Department of Labor and Internal Revenue Service have recognized, however, the entity designated as a "plan" for purposes of the Form 5500 filing is not necessarily the entity that functions as a "plan" for other purposes.[4]

Before an employer can determine whether it maintains a retiree-only plan, the employer must determine which of its many benefit programs constitute "plans." Employers need a definition of "plan" that they can rely on for this purpose. The definition must apply not

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[2] 75 *Fed. Reg.* at 34,539–40.

[3] *Id.; see also FAQs About The Affordable Care Act Implementation Part III,* Q&A-1 (Oct. 12, 2010).

[4] *See 2010 Instructions to Form 5500* at pp. 16–17 ("Some plan sponsors use a "wrap" document to incorporate various benefits and insurance policies into one comprehensive plan. In addition, whether a benefit arrangement is deemed to be a single plan may be different for purposes other than Form 5500/Form 5500-SF reporting.")

only to group health arrangements maintained by employers in the private sector, but also to non-federal governmental plans that are subject to the Public Health Service Act.[5] A definition of "plan" based on the Form 5500 filing entity is unworkable for purposes of the HIPAA, the mental health parity rules, and the Affordable Care Act mandates, since these mandates apply to state and local government plans that are not required to file annual reports on Form 5500. ERIC urges the Departments to adopt a definition of "plan" that does not rely on the Form 5500 filing entity, and that gives employers maximum flexibility to determine what benefit programs they will maintain as separate plans.

The Departments issued proposed regulations in 2004 that explained how an employer could identify its group health plans for purposes of applying the health plan mandates.[6] The proposed regulations respected the employer's decision to maintain separate group health plans, as long as it was clear from the governing instruments that the benefits were provided under separate plans, and the arrangements were operated as separate plans pursuant to their governing instruments. For example, under the proposed regulations, an employer could file a single Form 5500 for an "umbrella" or "wrap" plan, but could designate and operate distinct benefit packages under the umbrella as separate plans. The proposed regulations also established an anti-abuse rule, so that "[i]f a principal purpose of establishing separate plans is to evade any requirement of law, then the separate plans will be considered a single plan to the extent necessary to prevent the evasion." The preamble to the proposed regulations explained that these rules provided plans sponsors with great flexibility in determining how many plans they maintained, while the anti-abuse rule limited that flexibility to the extent necessary to prevent evasion of the statutory requirements.[7]

During informal discussions, representatives of the Departments have pointed to these proposed regulations as the basis for identifying the entity that constitutes a "plan" under the retiree-only exception. The definition in the proposed regulations is workable, provided that the Departments make clear that an employer is not deemed to "evade" any requirement of law merely because it designates the group health benefits it provides to retired workers and their families as a separate plan in order to take advantage of the statutory exemption. Instead, the "anti-abuse" provision should be limited to cases of actual abuse such as the one cited in the preamble to the proposed regulations,[8] in which an employer purports to designate the coverage of each individual active employee as a separate "plan" in order to rely on the exemption.

ERIC urges the Departments to publish guidance confirming that employers may rely on the definition in the 2004 proposed regulations to identify their retiree-only plans. The Departments have never finalized the 2004 proposed regulations, and they have applied different

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[5] The Departments operate under a Memorandum of Understanding that requires them to coordinate the administration and enforcement of provisions for which they share responsibility. *See* 75 *Fed. Reg.* at 34,539–40 *and* 64 *Fed. Reg.* 70,164 (Dec. 15, 1999).

[6] 26 C.F.R. § 54.9831-1(a)(2) (proposed); 29 C.F.R. § 2590.732(a)(2) (proposed); 45 C.F.R. § 146.145(a)(2) (proposed).

[7] 69 *Fed. Reg.* 78,800, 78,807 (Dec. 30, 2004).

[8] *Id.*

standards on different occasions to identify group health plans. For example, in informal guidance interpreting the new early retiree reinsurance program under the Affordable Care Act, the Department of Health and Human Services adopted a modified version of a similar group health plan definition in the COBRA regulations.[9] The regulations interpreting the Medicare Part D retiree drug subsidy also use the COBRA definition, although they give employers significant flexibility to aggregate or disaggregate different benefit options under the plan.[10] When the Departments issued interim final regulations interpreting the expanded mental health parity requirements, they abandoned the flexible definition and anti-abuse test set forth in the 2004 proposed regulations in favor of an unprecedented new mandatory aggregation rule.[11]

Employers face penalties up to $100 a day for each covered individual if they fail to comply with applicable health mandates. In the face of the shifting and uncertain standards for identifying group health plans, employers need assurance that they can rely on the definition in the 2004 proposed regulations to identify their retiree-only plans. The guidance should make clear that an employer may designate and operate a portion of an "umbrella" or "wrap" plan as a retiree-only plan, even though other portions of the umbrella plan cover active employees.

2. Retiree-only plans may cover Medicare-eligible disabled individuals.

Large employers often maintain separate group health plans for individuals who receive their primary health coverage from the Medicare program. The employer's health plans for Medicare-eligible individuals are specially designed to provide benefits that complement the participants' Medicare coverage. The administrators of these plans are trained to coordinate the group health plans' coverage with the participants' primary coverage under Medicare so that the participants will receive seamless care under the two programs combined.

The great majority of participants in a large employer's Medicare-primary group health plan are retirees who have reached age 65. These health plans also cover younger individuals who are eligible for Medicare as a result of disability, however. Medicare is the primary payer for a disabled individual unless the individual has employer group health coverage by virtue of the individual's or a family member's "current employment status."[12]

Large employers often treat employees who are totally disabled as if they were current employees so that they can continue to earn and receive employment-based benefits. For example, the employer might permit the disabled employee to continue to earn seniority, to continue to accrue benefits under the employer's pension plan, or to continue to participate in the employer's term life insurance program for active employees. The Department of Health and Human Services properly ignores these factors in determining whether a disabled individual has

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[9] *See* Early Retiree Reinsurance Program "Common Questions," Answer ID 100-11, *available at* http://www.errp.gov/faq_applications.shtml.

[10] *See* 42 C.F.R. §§ 423.882, 423.884.

[11] 26 C.F.R. § 54.9812(e)(1); 29 C.F.R. § 2590.712(e)(1); 45 C.F.R. § 146.136(e)(1); *see also* preamble at 75 *Fed. Reg.* 5409, 5417 (Feb. 2, 2010) (expressing concerns about the standard set forth in the 2004 proposed regulations).

[12] Social Security Act § 1862(b), 42 U.S.C. § 1395y(b).

"current employment status." Instead, under the Medicare secondary payer regulations, a disabled employee generally has "current employment status" only if the employee either is actively working for the employer (for example, during a trial work period following a period of disability) or has received disability benefits from the employer for six months or less.[13] Once the disabled individual exhausts his or her six months of short-term disability benefits, the individual is not treated as having "current employment status" unless he or she returns to work.

The Departments have issued informal guidance indicating that employers may, until further notice, treat individuals on long-term disability as former employees rather than as current employees for purposes of the exception for retiree-only plans.[14] ERIC strongly endorses this rule and urges the Departments to make the rule permanent.

An individual who is on long-term disability is, by definition, unable to work in the individual's former occupation for the employer. Employers treat disabled workers as current employees for compassionate reasons, so that the disabled workers will receive continued benefits and earn adequate retirement income during a period of disability. As we have explained above, employers include Medicare-eligible disabled workers in retiree health plans to ensure that the disabled workers' health coverage will coordinate properly with their primary coverage under Medicare. The Department of Health and Human Services has recognized in the Medicare secondary payer regulations that workers on long-term disability should not be treated as current employees unless they return to work. The Departments should adopt the same rule for purposes of the exemption for retiree-only plans.

3. Retiree-only plans may cover Medicare-eligible individuals with end-stage renal disease.

When an individual becomes eligible for Medicare on the basis of end-stage renal disease ("ESRD"), Medicare is the primary payer for the individual after the first 30 months. Medicare is the primary payer for ESRD beneficiaries regardless of whether they or their family members have current employment status. Accordingly, an individual with ESRD might receive primary coverage from Medicare even though the individual is still actively employed.

If an employee who suffers from ESRD receives primary coverage from Medicare, the employer often allows the employee (and the employee's spouse and dependents) to enroll in the employer's Medicare-primary group health plan for retirees. As explained in the preceding section, the group health coverage for retirees over age 65 is designed to coordinate with primary coverage under Medicare. Accordingly, Medicare-primary employees with ESRD generally receive more affordable, efficient, and comprehensive coverage under the retiree plan than they would receive under the employer's group health plan for active employees.

ERIC urges the Departments to make clear that individuals with ESRD will be treated as former employees for purposes of the retiree-only exception as long as they receive

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[13] *See* 42 C.F.R. § 411.104.

[14] *See FAQs About The Affordable Care Act Implementation Part III,* Q&A-2.

primary coverage from Medicare, regardless of their actual employment status. Although some ESRD beneficiaries continue to work, no purpose will be served by forcing employers to exclude these individuals from their retiree-only plans. To the contrary, ESRD beneficiaries will be disadvantaged if they are required to transfer to group health plans for active employees, since these plans are not designed to coordinate with Medicare.

4. Retiree-only plans may cover dependents who are current employees.

Large employers often employ more than one member of the same family. An employee, the employee's spouse, and one or more of the employee's children might work for the same company or for affiliated companies that are treated as a single employer under ERISA and the Code. In these cases, one employee typically enrolls as a participant in the employer's group health plan and elects family coverage; the other members of the family are covered under the group health plan as the participant's spouse and dependents. When the participant retires, the participant, spouse, and dependents receive family coverage under their employer's retiree-only plan, even though the spouse and dependents might still be current employees of the plan sponsor.

The exception for retiree-only plans applies to a plan that has fewer than two *participants* who are current employees. The term "participant" is defined in relevant part as "any employee or former employee of an employer . . . who is, or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer"; "dependent" is defined as "any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant."[15]

Read literally, the definition of "participant" would apply to each of the family members in our example: the husband, wife, and children all are employees or former employees who are eligible to receive health benefits under their employer's group health plan. In a case where only one individual is covered under the plan *as an employee or former employee,* however, it is appropriate to treat that individual as the sole "participant" in the family. The spouse and children, who receive family coverage under the plan as a result of their relationship to the participant, are properly viewed as "dependents."

As long as the participant is not a current employee, the status of the plan as a retiree-only plan should not be affected by the fact that one or more of the dependents is a current employee. Representatives of the Departments have stated in informal discussions that they agree with this analysis. ERIC requests that the Departments confirm this interpretation in written guidance. In addition to the uncertainty created by the statutory definition of "participant," ERIC notes that the Departments' guidance sometimes uses the term "participant" and "employee" interchangeably when referring to the retiree-only exception.[16] ERIC asks the

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[15] *See* 29 C.F.R. § 2590.701-2 *and* 26 C.F.R. § 54.9801-2 (incorporating the definition of "participant" by reference to section 3(7) of ERISA).

[16] *See FAQs About the Affordable Care Act Implementation Part III,* Q&A-1 ("[G]roup health plans that do not cover at least two *employees* who are current employees (such as plans in which only retirees participate) are exempt from the Affordable Care Act's market reform requirements" [emphasis added]).

Departments to clarify their position by stating that the term "participant" applies only to a person who is covered as an employee or former employee of the plan sponsor, and that the employment status of other members of the participant's family is not relevant in determining whether the plan is a retiree-only plan.

5. Retiree-only plans may cover re-hired retirees.

Large employers often permit a retiree to remain in the employer's retiree group health plan even if the retiree returns to work on a basis that would satisfy the eligibility conditions under the employer's group health plan for full-time employees. This rule promotes the efficient administration of the plans. Since it is expected that the individual will retire again in the near future, it is simpler and less disruptive to keep the individual in the retiree group health plan, rather than to go through a new enrollment procedure, issue new membership cards, and create new participation records in order to transfer the retiree and his family temporarily to the plan for active employees and then back to the plan for retired employees.

It is also to the retiree's advantage to be permitted to remain in the retiree-only plan during a period of re-employment. A retiree who remains in the retiree-only plan will retain credit for incurred medical expenses that count toward the plan's deductibles, out-of-pocket maximums, and other expense limits; a retiree who transfers to a separate plan for active employees will have to start over and pay additional expenses that count toward these limits. To the extent that the retiree-only plan and the active-employee plan use different provider networks, the retiree and his or her family will be able to continue to use the same providers if they remain in the retiree plan. Some employers have adopted provisions that assign a lower level of coverage to individuals who enroll in a retiree-only plan after a certain date, or that deny the retiree the right to re-enroll in the plan if he or she drops retiree coverage for any reason. By keeping the retiree in the retiree-only plan during a period of re-employment, the employer prevents the retiree's coverage from being curtailed or eliminated by these provisions.

The Departments should clarify that a plan does not fail to be a retiree-only plan merely because the plan provides coverage to current employees, as long as the coverage is provided by reason of their retiree status rather than their current employment status. For example, if a retiree group health plan provides coverage to employees who terminate employment after completing 10 years of service and reaching age 55, the plan should not fail to be a retiree-only plan merely because more than one retired employee returns to work and retains coverage under the plan.

The Treasury Department and Internal Revenue Service have developed rules applicable to tax-qualified retirement plans that determine when an employee has a genuine termination of employment or separation from service,[17] and those rules could be applied to ensure that individuals who are covered under the retiree-only plan are bona fide retirees. Once an individual satisfies the applicable age and service requirements and retires with coverage under a retiree group health plan, the individual should be considered a "retiree" as long as the individual retains coverage under the plan by virtue of his or her retiree status. In order to give

[17] *See, e.g.,* Rev. Rul. 69-647, 1969-2 C.B. 100; TAM 9345002 (July 13, 1993); GCM 39824 (Aug. 15, 1990).

effect to this principle, the Departments should define a "retiree-only" plan as a plan that covers fewer than two participants based on their status as current employees.

The rule ERIC has proposed is consistent with the purpose of the exception for retiree-only plans, which is to limit the application of health plan mandates to those plans that cover two or more individuals on the basis of their current employment status. If, instead, the Departments adopt a rigid interpretation of this exception that forces employers to exclude retirees from their retiree health plans as soon as the retirees return to the work force, employers' administrative costs will increase, and many rehired retirees will incur greater out-of-pocket costs or will have gaps in their health coverage. These results are not consistent with the purpose of the Affordable Care Act, which aims to reduce costs and increase coverage.

The rule ERIC has proposed would allow employers to continue to cover all rehired retirees in a retiree-only plan. If the Departments decline to adopt this proposal, the Departments should at a minimum adopt rules that accommodate particular circumstances in which rehired retirees are ineligible for coverage or would have a gap in their coverage as active employees. In the comments that follow, ERIC proposes several specific rules to address these situations.

6. Retiree-only plans may cover retirees whose work schedule makes them ineligible for coverage as active employees.

It is not unusual for a retired employee to return to work for his or her employer on a temporary or part-time basis. Often the retiree returns at the employer's request to complete a specific project, to train a successor, or to undertake some other assignment for which the retiree's prior experience is essential. In other cases the retiree's financial needs or desire to remain engaged in his or her former occupation prompts the retiree to return to work on a reduced schedule. A retiree who returns to work for a temporary, seasonal, or part-time assignment often does not meet the eligibility requirements for coverage under the employer's group health plan for active employees. In this situation, the employer permits the retiree to retain coverage under the employer's retiree group health plan.

The Medicare secondary payer rules require employer plans to pay primary to Medicare for employees who are eligible for the employer's group health plan ("GHP") coverage by reason of their "current employment status." If an employee retires and then returns to work, however, the retiree is treated as a current employee only if the retiree works on a schedule that qualifies for coverage under the employer's group health plan for active employees:

> A reemployed retiree or annuitant who is covered by a GHP *and who performs sufficient services to qualify for coverage on that basis* (that is, other employees in the same category are provided health benefits) is considered covered "by reason of current employment status" even if: (1) The employer provides the same

> GHP coverage to retirees; or (2) The premiums for the plan are paid from a retirement or pension fund.[18]

We urge the Departments to adopt the same rule for retiree-only plans. If an individual becomes eligible for retiree health coverage and then returns to work, the individual should not be treated as a "current employee" if he or she is excluded from the employer's group health coverage for current employees by an eligibility requirement that applies uniformly to all similarly-situated employees. For example, if an employer's group health plan for active employees covers only those individuals who are scheduled to work at least 20 hours a week, a retiree who returns to work for 10 hours a week should not be treated as a "current employee," and should be permitted to remain in the employer's retiree-only plan. No purpose is served by forcing the employer to exclude the individual from the retiree-only plan: the individual either will have no health coverage while he or she works part-time, or else will be forced to forgo part-time employment in order to retain his or her retiree coverage.

7. Retiree-only plans may cover re-hired retirees during a grace period.

A group health plan covering active employees ordinarily imposes a waiting period before a newly-hired employee (including a retiree who is returning to the work force) is eligible for coverage under the plan. As explained in the preceding comment, employees who are hired for temporary assignments generally are ineligible for coverage under the employer's group health plan. In addition, the waiting period under the group health plan often coincides with a period of probationary employment, during which the employer can determine whether a new hire is suitable for a job. The waiting period allows the group health plan for active employees to avoid the expense of enrolling and then disenrolling an individual who is hired for only a brief period, or whose employment is terminated at the end of a probationary period.

In order to function efficiently, the waiting period is administered in the same way for all newly-hired employees. The third-party administrator of a large employer's group health plan cannot readily determine which employees are on temporary or probationary assignments and which employees are hired (or rehired) in the expectation that they will be long-term employees. Accordingly, the administrator applies the objective rule that no employee is eligible for coverage until he or she has been on an eligible payroll for at least the requisite waiting period. At present, the duration of the waiting period is determined by the terms of the plan. Starting in 2014, however, the Affordable Care Act requires that the waiting period for all plans covering active employees (including grandfathered plans) be limited to no more than 90 days.

Both the statute and the existing regulations define a retiree-only plan as a plan that has fewer than two participants who are current employees *on the first day of the plan year*. As a result, it is clear that if a retiree returns to the work force as a full-time employee after the beginning of the plan year, the retiree's return to work will not affect the status of the plan as a retiree-only plan before the beginning of the following plan year. In some cases, however, a retiree will be rehired late in the year, so that he or she has not yet completed the waiting period under the employer's group health plan for active employees when a new year begins under the

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[18] 42 C.F.R. § 411.172(d) (emphasis added).

retiree plan. In order to avoid a gap in the individual's coverage, the retiree plan must continue to cover the individual until he or she becomes eligible for coverage under the group health plan for active employees.

In addition, even if the plan for active employees has a shorter waiting period, it will often take the administrator of the retiree-only plan at least 90 days to determine that a retiree has returned to active employment. Retirees who return to work will not necessarily attempt to enroll in the group health plan for active employees, since (as we have explained) they often receive better coverage under the retiree plan. In a large company with many different businesses, each with its own payroll and human resources department, it is no easy matter for the administrator of a retiree health plan to determine whether any participant in the plan has returned to work for the plan sponsor. ERIC urges the Departments to address these issues by providing a grace period, so that no individual will be considered a "current employee" during the longer of (1) 90 days after he or she is rehired by the employer, or (2) the duration of the waiting period imposed by any group health plan in which he or she is eligible to participate as an active employee.

8. Retiree-only plans may cover retirees who are employed by a related company that is not the plan sponsor.

An employee sometimes retires from one company and then goes to work for another company within the same controlled group. For example, an employee might retire from Company A and become covered under a retiree group health plan sponsored by Company A. The employee then is hired by Company B, a wholly-owned subsidiary of Company A. As long as Company B has not adopted the Company A retiree group health plan, the fact that the individual is a current employee of Company B should not affect the status of Company A's group health plan as a retiree-only plan.

A retiree-only plan is a plan that does not cover more than one "current employee." Under ERISA section 3(6), the term "employee" means "any individual employed by an employer." ERISA section 3(5) defines "employer" as "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan." Accordingly, a separate legal entity that does not sponsor a particular employee benefit plan for the entity's current or former employees is not an "employer" solely by virtue of its relationship to the plan sponsor.

The 2004 proposed regulations include a rule that requires related employers to be aggregated.[19] However, this rule applies only for purposes of those provisions that depend on the *average* number of employees employed by an employer, such as the exceptions for small employers in the mental health parity rules and in the excise tax for failure to comply with the health mandates. The exception for retiree-only plans is based on an absolute number of employees present in the plan on the first day of the plan year, rather than on an average number of employees, and thus is not subject to the aggregation rule. The preamble to the 2004 proposed regulations explains that the rules for determining the average number of employees, where the

[19] 26 C.F.R. § 54.9831-1(e) (proposed); 29 C.F.R. § 2590.732(e) (proposed); 45 C.F.R. § 146.145(e) (proposed).

employer-aggregation rule appears, "are not used for counting the number employed by the employer on a given day, such as the first day of a plan year."[20]

When Congress intended that related employers be aggregated for purposes of applying the health plan mandates, it made that intent clear in the statute. The statutory provisions creating the two small-employer exceptions state that companies related by common ownership or control must be aggregated and treated as a single employer.[21] The 2004 proposed regulations properly implement this statutory aggregation requirement. In contrast, the statutory exception for retiree-only plans does not include an employer-aggregation rule. Where no statutory aggregation rule applies, ERISA's standard definitions of "employer" and "employee" cited above apply by default under ERISA, and should also apply (for the sake of uniformity) under the Code and the Public Health Service Act. Accordingly, the Departments should make clear that an individual is treated as a "current employee" for purposes of the exception only if the individual is employed by an employer that sponsors the retiree-only plan.

9. Retiree-only plans may cover retirees who are reunited with their former employer through a business combination.

An individual who retires from a company and becomes covered under the company's retiree group health plan often starts a second career at a different company in the same industry. If the individual's retiree group health coverage is less expensive or more comprehensive than the health coverage (if any) offered by the individual's new employer, the individual will keep his or her retiree coverage. This arrangement does not compromise the status of the retiree health plan, since the individual is not a current employee of the plan sponsor.

If the original employer later acquires the new employer in a business combination, the worker might become a "current employee" of the original employer again, even though neither the worker nor the original employer intended this result. As ERIC has explained in the preceding comment, the two businesses will not be considered a single employer (and the individual will not be a "current employee" of the original employer) as long as the acquired business is a separate legal entity that does not adopt the retiree health plan. In some cases, however, the acquired business will be merged with the original business, although it will continue to operate as a separate division with its own benefit programs. It might take a lengthy period for the administrator of the retiree health plan even to become aware that the original business has reacquired some of its former employees as a result of the business combination. In addition, the acquired business (in order to preserve the economics appropriate to its business model) might continue to offer no group health coverage or coverage inferior to the worker's retiree coverage. In these circumstances, the status of the original employer's plan as a retiree-only plan should not be affected by the business combination.

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[20] 69 *Fed. Reg.* at 78,807 and n. 1.

[21] ERISA § 712(c)(1)(C)(i); I.R.C. §§ 4980D(d)(2)(1)(A), 9812(c)(1)(B).

Congress, the Treasury Department, and the Internal Revenue Service have recognized that there are many situations in which special employee benefit rules must be applied to mergers and acquisitions in order to avoid unintended and illogical results.[22] This is one of those situations. ERIC urges the Departments to provide that a retiree who is reunited with his or her former employer as a result of a business combination will not be treated as a "current employee" for purposes of the retiree-only exception.

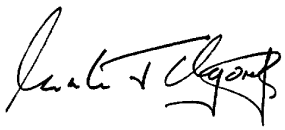
10. Any rules more restrictive than the rules ERIC has proposed should be effective only prospectively, at least a year after they are published in final form.

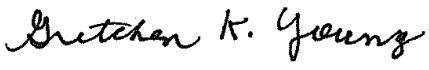
As these comments illustrate, many aspects of the exception for retiree-only plans are unclear, and large employers face a number of administrative and practical difficulties as they attempt to apply the exception to their retiree group health plans. An employer that inadvertently fails to satisfy all of the conditions necessary to qualify for the exception will face dire economic consequences. The employer either must incorporate a large number of new mandates in its retiree health plan—a solution that is likely to be prohibitively expensive—or must restructure its plan to comply with the exception. If the employer chooses to restructure the plan, it must exclude individuals who are considered to be "current employees" from coverage under the plan; if the group health plan mandates are deemed to apply to the plan until it is restructured, the broad new rules prohibiting rescissions of coverage will make it impossible for the employer to exclude these individuals retroactively. Accordingly, employers potentially face an excise tax of $100 per day for each covered individual until they are able to bring the plan into compliance with the retiree-only exception.

In recognition of these difficulties, ERIC urges the Departments to provide a generous transition period if the Departments adopt any interpretation of the retiree-only exception that is more restrictive than the rules proposed in these comments. Any more restrictive interpretation should be effective no earlier than the first plan year that begins at least 12 months after the interpretation is published in final form, following a period for public comment. For any period before the new interpretation becomes effective, the Departments should make clear that good-faith compliance with the retiree-only exception is sufficient.

Thank you for your consideration of these comments. We would be pleased to discuss this letter with you if you have any questions.

Sincerely,





Mark J. Ugoretz
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Gretchen Young
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[22] *See, e.g.,* I.R.C. §§ 401(a)(26)(E), 410(b)(6)(C), 414(a); Treas. Reg. § 54.4980B-9; GCM 39824 (Aug. 15, 1990).