The ERISA Industry Committee

May 28, 2009

via e-mail to E-OHPSCA.EBSA@dol.gov

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

Attention: MHPAEA Comments

Ladies and Gentlemen:

The ERISA Industry Committee ("ERIC") is pleased to submit this response to the request for information regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). The request was published by the Departments of Labor, Health and Human Services, and the Treasury (collectively, the Departments) in the *Federal Register* on April 28, 2009.

MHPAEA requires employers that sponsor group health plans for employees and their families to ensure that there is parity between the medical and surgical benefits and the mental health or substance use disorder benefits provided under the plans. In particular, MHPAEA requires group health plans to ensure that: (1) the financial requirements applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to medical and surgical benefits under the plan; (2) there are no separate cost-sharing requirements that are applicable only to mental health or substance use disorder benefits; (3) the treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to medical and surgical benefits under the plan; and (4) there are no separate treatment limitations that are applicable only to mental health or substance use disorder benefits.

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MHPAEA does not require any employer to offer (or to continue to provide) mental health or substance use disorder benefits under its group health plan. Instead, MHPAEA applies only to employers that elect to offer these benefits under their group health plans.

ERIC's Interest in the Request for Information

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 provide comprehensive health benefits directly to some 25 million active and retired workers and their families. ERIC has a strong interest in proposals that affect its members' ability to deliver high-quality, cost-effective benefits.

ERIC's members sponsor some of the largest private group health plans in the country. Many of these plans currently provide generous mental health benefits and substance use disorder benefits. MHPAEA and the regulations interpreting the statute will have a substantial and lasting impact on the group health plans sponsored by ERIC's members, and on the employees and their families who are covered by the plans.

ERIC's members are committed to providing high-quality, affordable health care to their employees. As American companies struggle to compete in a global economy, however, 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. Large employers feel these competitive pressures acutely. Accordingly, ERIC's members have a vital interest in assuring that the forthcoming regulations do not impose substantial new costs or administrative burdens on employers that voluntarily offer mental health and substance use disorder benefits to their employees.

ERIC's concern that the MHPAEA requirements be affordable and administrable is consistent with a primary objective of MHPAEA: to assure that employees will continue to have access to generous mental health and substance use disorder benefits through employer-sponsored group health plans. ERIC looks forward to working constructively with the Departments to achieve this goal.

Clarification of Terms and Provisions

The Departments have asked whether terms or provisions of MHPAEA require clarification in order to facilitate compliance. ERIC believes that it is important to clarify the provisions discussed below.

1. The regulations should allow employers to apply the parity requirements separately to each benefit package under a group health plan.

MHPAEA requires parity between the mental health or substance use disorder benefits provided by a group health plan and the medical and surgical benefits provided by the plan. The statute does not specify whether the parity requirement applies to the plan as a whole or to each different benefit package offered under the plan. As explained below, ERIC believes that the parity requirement will function as Congress intended only if it applies separately to each benefit package under a group health plan.

Most large employers offer group health benefits under a consolidated arrangement that functions as a single group health plan. These "umbrella" plans include a wide variety of different benefit packages that apply to different groups of employees. For example, a single group health plan might offer high-deductible health options combined with health savings accounts; low-deductible health options; regional HMOs; and Medicare supplemental options for retirees older than 65. The employees who participate in a single group health plan often work for different lines of the employer's business, in different geographic regions, or in different job classifications; and these different groups of employees might have access to widely different health options. A single group health plan might cover union-represented employees who have bargained for a particular set of health options, and might also cover non-union employees who receive a different set of health options. By combining all of these different benefit packages in a single group health plan, an employer is able to reduce certain administrative costs, such as the cost of preparing annual reports on Form 5500 to comply with ERISA or the cost of negotiating business associate agreements to comply with HIPAA.

In a situation where different health benefit packages are included in a single group health plan, it would be both unworkable and illogical to apply the mental health parity requirements to the group health plan as a whole. No single set of financial requirements or treatment limitations predominates across the entire plan. For example, no purpose would be served by comparing the mental health and substance use disorder benefits provided to a union-represented employee under a fee-for-service benefit package in Ohio with the medical and surgical benefits provided to a management employee covered by an HMO in California, even if both benefit packages are included in a single group health plan.

The purpose of MHPAEA is to ensure that the mental health and substance use disorder benefits available to an individual under the health benefit package he has elected are in parity with the medical and surgical benefits available under that benefit package. The legislative history of MHPAEA explains that "'[f]ull parity' means that an *individual* [emphasis added] receives the same health care coverage for physical illness and mental health coverage." H.R. Rep. No. 110-374, Pt. 1 at 30 (2007). The parity requirement is not intended to ensure that one individual's mental and substance use disorder benefits are equal to the medical and surgical benefits provided to a different individual who has elected a substantially different benefit package under the same group health plan.

The Departments recognized this principle when they interpreted the original parity requirements enacted in the Mental Health Parity Act of 1996. The interim regulations interpreting that statute included the following rule:

> If a group health plan offers two or more benefit packages, the requirements of this section . . . apply separately to each benefit package. Examples of a group health plan that offers two or more benefit packages include a group health plan that offers employees a choice between indemnity coverage or HMO coverage, and a group health plan that provides one benefit package for retirees and a different benefit package for current employees.

Treas. Reg. § 54.9812-1T(c); 29 C.F.R. § 2590.712(c); 45 C.F.R. § 146.136(c). ERIC recommends that the Departments adopt a similar interpretation of MHPAEA. In addition to the examples provided in the interim regulations, the MHPAEA regulations should make clear that any health options with significant differences in cost or coverage, such as high-deductible and low-deductible health options, are regarded as separate benefit packages.

2. The regulations should make clear that MHPAEA does not prohibit distinctions between different categories of treatment.

Under MHPAEA, the financial requirements that apply to mental health and substance use disorder benefits must be no more restrictive than "the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan . . . ." A similar parity requirement applies to treatment limitations. The regulations should make clear that these parity requirements apply separately to different categories of treatment, such as in-network and out-of-network treatment; inpatient and outpatient treatment; or treatment by primary care physicians and specialty care physicians.

As a cost-management tool, many employers negotiate favorable rates with particular health care providers in return for including the providers in a group health plan's preferred provider network. In order to encourage employees to use network providers, the group health plan typically covers in-network services at a higher rate than it covers out-of-network services. For example, the group health plan might cover 100% of the cost of medical or surgical treatment by a network provider, but might cover only 80% of the cost of the same treatment by a non-network provider.

The plan should be permitted to apply the same coverage distinction to mental health and substance use disorder treatment by in-network and out-of-network providers. For example, if substantially all medical and surgical services under the plan are provided by network providers and are covered at 100% of cost, the employer should not be required to treat 100% coverage as the "predominant financial requirement" under the group health plan, with the result that all mental health and substance use disorder benefits must receive 100% coverage regardless of whether they are provided by network or non-network providers. Instead of producing parity between medical/surgical benefits and mental health/substance use disorder benefits, such a requirement would mandate *preferential* treatment for out-of-network mental health and substance use disorder benefits.

It would be inconsistent with the purpose of the MHPAEA to require this preferential treatment. MHPAEA does not require that mental health or substance use disorder benefits be treated more favorably than medical and surgical benefits: it requires that the benefits be treated equally. If a plan applies different financial terms or treatment limits to in-network and out-of-network treatment for medical and surgical benefits, the same terms and limits should apply to mental health and substance use disorder benefits.

Congress explicitly recognized this principle as it considered the mental health parity legislation. The bill passed by the House of Representatives, H.R. 1424, divided benefits into four "super-categories" (inpatient/in-network; inpatient/out-of-network; outpatient/in-network; and outpatient/out-of-network) and required employers to determine parity within each category. The report of the House Committee on Education and Labor explained:

> For plans that offer mental health benefits through a network of mental health providers, the requirement for parity of benefits would be established by comparing in-network medical and surgical benefits with in-network mental health benefits, and comparing out-of-network medical and surgical benefits with out-of-network mental health benefits.

H.R. Rep. No. 110-374, Pt. 1 at 44 (2007). Although the four super-categories were not included in the final bill, there is no indication that Congress had abandoned the basic principle that parity is achieved by treating mental/surgical benefits and mental/substance use benefits in the same way.

In order to achieve the purpose of MHPAEA, the regulations should make clear that the parity requirements apply separately to different categories of treatment. Under this interpretation, in-network mental health and substance use disorder benefits will be subject to the same financial requirements and treatment limitations that apply to substantially all in-network medical and surgical benefits, and out-of-network mental health and substance use disorder benefits will be subject to the same financial requirements and treatment limitations that apply to substantially all out-of-network medical and surgical benefits.

The same principle should apply to other distinctions based on the nature of the treatment or the identity of the health care provider. For example, if a group health plan applies different financial terms or treatment limits to treatment by a primary care physician as compared with treatment by a specialty care physician, the MHPAEA regulations should permit the plan to apply the same distinction to mental health and substance use disorder treatment. A participant who visits his family doctor for treatment of anxiety or mild depression would be covered at the level applicable to a primary care physician; a participant who is treated by a psychiatrist or other specialist would be covered at the level applicable to a specialty care physician. The MHPAEA regulations should make clear that the employer is not required to determine which class of treatment—primary care or specialty care—predominates for medical and surgical benefits provided under the group health plan, and then to apply the coverage level applicable to the predominant class of treatment to all mental health and substance use disorder treatment, regardless of the identity of the provider.

3. The regulations should permit separate but equal financial terms and treatment limits for medical/surgical benefits and mental health/substance use benefits.

MHPAEA prohibits separate cost sharing requirements and separate treatment limitations "that are applicable only with respect to mental health or substance use disorder benefits." This limitation is consistent with the fundamental objective of MHPAEA: to ensure that mental health and substance use disorder benefits are not singled out for discriminatory treatment. As the report of the House Ways and Means Committee explained:

> The requirements under the bill will result in true parity in the way that physical and mental health benefits are provided under group health plans. The provisions of the

> bill are necessary to end the discrimination that exists under many group health plans with respect to mental health and substance-related disorder benefits.

H.R. Rep. No. 110-374, Pt. 2 at 12 (2007). The regulations should make clear that MHPAEA does not prohibit "separate but equal" limits that apply in the same way to medical/surgical benefits and mental health/substance use disorder benefits.

The Departments' interim regulations interpreting the Mental Health Parity Act of 1996 permitted a group health plan to apply annual and lifetime limits either by applying a single limit to all benefits in the aggregate or by applying separate limits to mental health benefits where the limits were no more restrictive than the limits applied to medical/surgical benefits. Treas. Reg. § 54.9812-1T(b); 29 C.F.R. § 2590.712(b); 45 C.F.R. § 146.136(b). For example, a group health plan that applied a $250,000 annual limit to medical/surgical benefits did not violate the parity requirement if it applied a separate $250,000 limit to mental health benefits. *Id.* Example 1. The interim regulations recognized that the separate limits did not discriminate against mental health benefits.

The provision in MHPAEA prohibiting limitations "that are applicable only with respect to mental health or substance use disorder benefits" does not prohibit separate but equal limits. Because these limits apply to medical and surgical benefits in the same way that they apply to mental health and substance use disorder benefits, they are consistent with MHPAEA's goal of promoting parity. Accordingly, the MHPAEA regulations should confirm that employers may apply separate deductibles, out-of-pocket maximums, annual and lifetime limits, and other cost-sharing requirements and treatment limitations separately to mental health and substance use disorder benefits, as long as these limits are not more restrictive than the corresponding limits for medical/surgical benefits.

4. The regulations should confirm that group health plans may continue to exclude specific mental health or substance use diagnoses from coverage.

Although MHPAEA requires parity for mental health benefits and substance use benefits offered under a group health plan, the statute does not limit the employer's ability to determine which mental conditions or substance use disorder conditions the plan will cover. MHPAEA defines mental health benefits and substance use disorder benefits as the benefits "defined under the terms of the plan." The statute also makes clear that a group health plan is not required to cover mental health conditions or substance use disorders at all. Accordingly, the statute clearly contemplates that employers will continue to determine the scope of the plan's coverage for mental health conditions and substance use disorders, just as employers determine which physical health conditions the plan will cover. The reg-

ulations should make clear that an employer may exclude particular diagnoses or groups of diagnoses from coverage under its group health plan, without demonstrating that a comparable exclusion exists for physical diagnoses.

5. The regulations should confirm that group health plans may continue to exclude specific mental health or substance abuse treatments from coverage.

MHPAEA prohibits group health plans from applying treatment limitations to mental health/substance use benefits that are more restrictive than the treatment limitations that apply to medical/surgical benefits. MHPAEA defines "treatment limitations" to include limits on the frequency of treatment, number of visits, days of coverage, "or other similar limits on the scope or duration of treatment." The regulations should make clear that MHPAEA does not prohibit a group health plan from excluding from coverage certain types of evidence-based treatments for a particular mental health condition or substance use disorder, just as the group health plan may exclude certain treatments for physical conditions.

Many employers control the quality and cost of care by excluding from group health plan coverage particular treatments that they consider to be more expensive or less effective than other available treatments for the same condition, or that they consider to be experimental. For example, a group health plan might cover most types of treatment for cancer, but might exclude autologous bone-marrow transplants from coverage. In the same way, group health plans should be permitted to exclude from coverage particular types of treatments for mental health conditions or substance use disorders.

As explained above, MHPAEA permits an employer to define the mental health benefits and substance use disorder benefits its group health plan will provide. The definition of "treatment limitations" requires parity between medical/surgical and mental health/substance use disorder benefits only with respect to limits on the frequency of treatment, the number of days of coverage, or "similar" limits: the MHPAEA does not mandate that a group health plan cover all possible treatments for a given mental diagnosis, any more than the group health plan is required to cover all possible treatments for a given physical diagnosis.

In many cases, a rule requiring group health plans to cover all possible treatments for a particular diagnosis will force employers to exclude that diagnosis from coverage entirely. For example, if an employer is forced to choose between covering all possible treatments for schizophrenia and excluding schizophrenia from coverage, many employers will conclude that they must exclude schizophrenia from coverage. A rule that forces employers to curtail their coverage of mental health and substance use disorder benefits will not serve the purpose of the MHPAEA, which was designed to expand employees' access to these benefits. Accordingly, the

regulations should make clear that MHPAEA does not prohibit treatment-based exclusions.

6. The regulations should confirm that MHPAEA does not require parity in the management of benefits.

Employers use a number of techniques to manage the delivery of health care in order to control costs and ensure that participants receive effective treatment. For example, group health plans might use prior authorization of services, concurrent review of services, treatment plans, case management, discharge planning, retrospective review, and similar methods to manage participants' health care.

The management techniques that apply to a particular condition are specific to that condition. It is not possible to conclude that a particular health care management technique or set of techniques "predominates" for the treatment of medical and surgical conditions. For example, the case management techniques that apply to a patient recovering from open heart surgery are very different from the case management techniques that apply to a patient suffering from a chronic illness such as diabetes. Similarly, particular mental health conditions or substance abuse disorders might require specific management techniques that are different from the techniques applicable to physical conditions of comparable severity. In addition, the nature of some mental health conditions and substance use disorders requires that they be managed more intensively, or over a longer period, in order to achieve a positive outcome for the patient.

It is not practicable to attempt to achieve parity in the management techniques that apply to medical/surgical benefits and mental health/substance use disorder benefits. Because techniques for managing the delivery of benefits are tailored to a particular condition (and sometimes to a particular patient), any attempt to make them more uniform will inevitably make them less effective. Accordingly, it is important for the Departments to make clear that MHPAEA does not require parity in the management of care provided under a group health plan.

MHPAEA requires parity only in the financial terms and treatment limitations that apply to mental health and substance use disorder benefits. In all other areas, the terms of the group health plan determine the conditions under which coverage is provided for these benefits. The management of benefit delivery is not a "financial term" or a "treatment limitation," and thus is not within the scope of the parity requirement. The regulations should make clear that a group health plan does not violate the parity rules if it uses different techniques for managing medical/surgical conditions and mental health/substance use disorders, or even if it applies case management techniques to one category of benefits and not to the other category.

Disclosure Requirements

The Departments have asked for information concerning the MHPAEA requirement that a group health plan make available to a participant, upon request, an explanation of the reason for any denial of coverage for mental health or substance use disorder treatment. Participants in employer group health plans governed by ERISA already receive this information automatically as part of ERISA's claims review procedures. ERIC recommends that the Departments not create any additional disclosure requirements under MHPAEA for ERISA-governed plans, since these requirements will add to the administrative burden and expense that employers must bear without providing meaningful additional protection to group health plan participants and beneficiaries.

7. The claims procedures set forth in ERISA are sufficient for determinations with respect to mental health or substance use disorder benefits.

Section 503 of ERISA and the Department of Labor's regulation at 29 C.F.R. § 2560.503-1 set forth comprehensive procedures that group health plan administrators must follow in order to resolve a claim for benefits under the plan. The administrator of an ERISA-governed group health plan must:

- automatically provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for the denial and written in a manner calculated to be understood by the participant;
- provide any participant whose claim for benefits has been denied with a reasonable opportunity for a full and fair review by the appropriate plan fiduciary;
- provide to the participant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relating to the claim;
- notify the participant in writing of the fiduciary's decision after reviewing the claim;
- if the claim is denied upon review, automatically provide a written explanation of the specific reasons for the denial, written in a manner calculated to be understood by the participant; and
- notify the participant of his or her right to challenge the denial of the claim in court.

These claim-review procedures must be set forth in writing and disclosed to all participants in the group health plan. The existing regulation also sets

forth a number of explicit requirements that must be satisfied in order to protect the rights of plan participants, including notice timing requirements, notice content requirements, and requirements for consultation with medical professionals in areas requiring medical judgment.

The protection afforded by ERISA's claim review procedures already applies to mental health and substance use disorder benefits as well as to medical and surgical benefits provided under employer group health plans. ERISA's protection extends well beyond the statutory disclosure requirement under MHPAEA: it requires that participants receive a full explanation of any denial of benefits, and an opportunity to challenge the denial through an administrative review procedure. Accordingly, it is not necessary to impose different or additional requirements under MHPAEA. Imposing new requirements would place an unreasonable burden on plan sponsors, which would be forced to comply with two sets of rules designed to achieve the same purpose.

The Departments should also make clear that a group health plan may establish separate claim review procedures for medical/surgical benefits and mental health/substance use disorder benefits, as long as the review procedures in each case comply with the requirements of ERISA. Some employers retain different organizations (for example, organizations with particular expertise in mental health conditions or substance use disorders) to review and adjudicate claims for mental health/substance use disorder benefits under their group health plans; and these organizations might apply review procedures that are different in some respects from the review procedures for medical/surgical benefit claims. As long as the claim review procedures comply with the requirements of ERISA, which are designed to protect plan participants' rights, the procedures should automatically satisfy MHPAEA.

Effective Date

The provisions of MHPAEA apply for plan years beginning after October 3, 2009. For calendar year plans, these provisions will apply beginning on January 1, 2010. The statute requires the Departments to issue regulations interpreting the statutory requirements by October 3, 2009. For the reasons explained below, ERIC recommends that the regulations include generous transition provisions.

8. Any regulation promulgated under MHPAEA should not be effective earlier than 12 months after it is published in its final form.

Large employers ordinarily finalize the design of their group health plans in June or July for the next calendar year. It is necessary to finalize the design well before the beginning of the next plan year so that the employer can communicate the plan coverage provisions to the plans' third-party administrators: once

the third-party administrators receive the final plan design, they must program software systems, revise administrative manuals, and train customer service representatives to administer the benefits properly. As explained above, a large employer's group health plan might offer a number of different benefit options in different geographic regions, so that it is necessary for the employer to coordinate with a variety of third-party vendors to ensure that the new design will be implemented and administered correctly. The employers also must prepare participant communications and open enrollment materials, and must create internet-based tools, to help employees understand the new benefit options and make appropriate choices concerning their family's health coverage for the upcoming year. Employers usually commence open enrollment for the upcoming year in October or November.

In order to finalize the group health plan design in time to accommodate these administrative requirements, employers must engage in extensive discussions, cost comparisons, and benefit analyses with their business partners. Employers also must discuss benefit needs and cost constraints with different lines of business and human resources professionals in their own organizations. These discussions are taking place now. Accordingly, a regulation released in the late summer or fall of 2009 will be far too late to provide any useful guidance with respect to the design of group health plan options for 2010.

As the Departments' Request for Information illustrates, many important terms and provisions of the MHPAEA are unclear. When the Departments publish proposed regulations, it is likely that the proposal will elicit a number of comments from the public that will require substantial revisions before the regulations become final. In the meantime, however, employers must design and administer their group health plans: they do not have the luxury of waiting until the rules are clarified and confirmed.

ERIC recommends that any regulations interpreting the MHPAEA requirements become effective no earlier than the first plan year beginning at least 12 months after the final regulations are published in the *Federal Register*. In the interim, employers should be required to comply with a reasonable, good-faith interpretation of the statutory requirements. During the period before the final regulations become effective, employers should be permitted to demonstrate reasonable, good faith compliance with MHPAEA by complying with either the proposed regulations or the final regulations; but compliance with the regulations should be a safe harbor rather than the exclusive means of compliance with the statute.

9. The definition of "collectively bargained plan" should be broad enough to ensure that the purpose of the delayed effective date is achieved.

MHPAEA includes a special effective date for group health plans maintained pursuant to one or more collective bargaining agreements. MHPAEA's requirements do not apply to collectively bargained plans until the later of January 1, 2010, or the date on which the last collective bargaining agreement relating to the plan terminates (without regard to extensions after MHPAEA was enacted). The regulations should explain which plans are considered to be "collectively bargained plans" for purposes of the delayed effective date.

A delayed effective date for collectively bargained plans is a common feature of legislation affecting employee benefits. The purpose of the delayed effective date is to allow both employers and union-represented employees to receive the benefit of the agreement they have reached through the collective bargaining process, without reopening negotiations to address new statutory mandates. When the last collective bargaining agreement expires, the parties can bargain for changes in the employees' total compensation and benefit package, taking into account the new statutory requirements.

Employers often include employees who are not union-represented in the same benefit plans that cover union-represented employees. Non-represented employees (especially hourly-paid employees) frequently are offered the same benefit options that apply to union-represented employees, or options that are substantially similar. The delayed effective date applies to the entire plan, and not only to the union-represented employees in the plan, so that the employer will not be forced to disrupt the parallel benefit structures that apply to union-represented and non-represented employees. Accordingly, when a single plan includes both union-represented and non-represented employees, it is necessary to determine whether the plan is "maintained pursuant to one or more collective bargaining agreements" for purposes of the delayed effective date.

The Employee Retirement Income Security Act of 1974 (ERISA) included delayed effective dates for collectively-bargained plans. *See, e.g.,* Pub. L. No. 93-406 §§ 211(c), 1017(c) (1974). The legislative history of ERISA explained that a plan was considered to be "maintained pursuant to one or more collective bargaining agreements" for purposes of the delayed effective dates as long as at least 25 percent of the employees in the plan were union-represented. For example, the Senate Finance Committee explained, "Where an employer has plans which involve both collective bargaining unit employees and other employees, the effective dates applicable to collectively bargained plans are to govern if (on January 1, 1974) at least 25 percent of the plan participants are members of the employee unit covered by the collectively bargained agreement." S. Rep. No. 93-1090, at 293-4 (1974); *see*

also H.R. Rep. No. 93-807, at 52 (1974); H.R. Rep. No. 93-1280, at 380 (1974) (Conf. Rep.). When Congress subsequently included a delayed effective date for collectively-bargained plans in the Tax Equity and Fiscal Responsibility Act of 1982, the Staff of the Joint Committee on Taxation concluded that test for identifying a collectively-bargained plan was the same 25-percent test that Congress had adopted in ERISA. *General Explanation of the Revenue Provisions of the Tax Equity and Fiscal Responsibility Act of 1982* at 290-91 (1982).

The Internal Revenue Service has applied the 25-percent test from ERISA in a wide variety of contexts to determine whether a plan is eligible for a delayed effective date that applies to collectively-bargained plans. *See, e.g.,* Treas. Reg. § 1.401(l)-6(a)(2)(iv) (effective date of permitted disparity rules); Treas. Reg. § 1.410(b)-10(a)(2)(iii) (effective date of amendments to minimum coverage rules); Treas. Reg. § 1.401(a)-20, Q&A-40 (effective date of Retirement Equity Act regulations); Prop. Treas. Reg. § 1.436-1(k)(*3*)(iv) (effective date of funding-related benefit restrictions); Prop. Treas. Reg. § 1.401(a)(35)-1(g)(*1*)(ii)(B) (effective date of statutory diversification requirements); Prop. Treas. Reg. § 1.411(b)(5)-1(f)(*3*)(ii) (effective date of rules concerning reduction in rate of benefit accrual); Prop. Treas. Reg. § 1.411(a)(13)-1(e)(*1*)(iii)(D) (effective date of vesting rules for statutory hybrid plans); 53 Fed. Reg. 29719-22 (Aug. 8, 1988) (effective date of proposed section 401(k) regulations).

In many of these cases, the Internal Revenue Service's interpretation of the delayed effective date for collectively-bargained plans also applied for purposes of parallel provisions in the labor title of ERISA. Accordingly, there is substantial precedent for applying the 25-percent test to determine the effective date of statutory provisions that amend both the Internal Revenue Code and Title I of ERISA. ERIC recommends that the Departments apply the same test under the MHPAEA. If at least 25 percent of the participants in a group health plan are covered by one or more collective bargaining agreements under which health benefits were a subject of good-faith bargaining, the entire plan should be eligible for the delayed effective date.

ERIC recognizes that both the Department of Labor and the Internal Revenue Service have adopted more stringent tests to identify collectively-bargained plans for purposes of certain statutory exemptions. For example, the Department of Labor has required that a plan have at least 85 percent union-represented participants in order to be exempt from regulation as a multiple employer welfare arrangement. 29 C.F.R. § 2510.3-40(b)(2). Similarly, the Internal Revenue Service has required that a plan have up to 90 percent union-represented participants in order to be exempt from the restrictive funding and deduction rules for welfare benefit funds. Treas. Reg. § 1.419A-2T, Q&A-2.

It is understandable that the Departments might wish to apply higher participation thresholds to plans that seek to rely on permanent statutory exemptions for collectively-bargained plans. ERIC believes, however, that it would be inappropriate to use these stringent tests to identify plans that are eligible for a delayed effective date, which merely postpones the application of new statutory rules. The Internal Revenue Service itself has acknowledged the policy considerations that support this distinction. Although the Service required up to 90 percent participation by union-represented employees to qualify for the permanent exemption from the welfare benefit fund restrictions, the Service concluded that the 25-percent test should apply to determine which plans were eligible for the delayed effective date under the same statutory provisions. *See* Field Service Advice Memorandum 697 (Sept. 15, 1993). The Service explained:

> [E]quitable and policy reasons support, to some extent, the taxpayer's view that the historical 25% test should be applied in interpreting the scope of [the delayed effective date for collectively-bargained plans], rather than the definition set forth in Treas. Reg. section 1.419A-2T Q & A 2. The purpose of adopting a deferred effective date for collectively bargained plans is to delay the effects of new legislation until the expiration of current collective bargaining agreements. This avoids disrupting, mid-cycle, the terms agreed to between employers and collective bargaining representatives. This purpose is arguably better served by consistently applying the same historical test, in interpreting such provisions. Such a course permits employers and unions to commit themselves to specific terms over the course of a collective bargaining cycle, provided the historically applicable test is met, with a degree of security that the intended consequences of those terms will not be changed, mid-cycle, by unforeseen legislation. By contrast, application of ad hoc, statute-specific regulatory definitions, promulgated after enactment of the subject legislation, arguably leaves employers and unions without the ability accurately to anticipate the effects of bargained-upon terms.

It is particularly important in the case of the MHPAEA that employers be permitted to rely on the customary 25-percent test to identify plans that are eligible for the delayed effective date. As explained above, employers are currently in the process of establishing the design of their group health plans for 2010. It is already too late for employers to engage in mid-term bargaining to determine how the MHPAEA requirements will apply in 2010 to a group health plan that covers union-represented employees. In the absence of guidance concerning the scope of the de-

layed effective date for collectively-bargained plans, employers have had to reach their own conclusions concerning which of their plans are eligible for the delayed effective date. Employers have justifiably relied on the consistent interpretation of similar provisions, and have assumed that a plan will be eligible for the delayed effective date if it satisfies the traditional 25%-percent test. If the Departments announce a more stringent test in regulations published later this year, employers will not have time to bargain and implement design changes in plans that they reasonably expected to be exempt from the MHPAEA requirements in 2010.

ERIC recommends that the Departments also clarify the application of the delayed effective date to plans that cover retired union members. Large employers often provide group health benefits to retired employees who were covered by a collective bargaining agreement at the time of their retirement, and who are eligible for retiree health benefits because their collective bargaining representative negotiated these benefits on their behalf while they were active employees. Although most retirees are no longer represented by the union after they retire, the benefits they receive in retirement are a direct result of collective bargaining. As a practical matter, employers often encounter significant resistance on the part of the union when they seek to alter the health benefits of union retirees. Accordingly, in determining whether a group health plan meets the 25-percent test, retired employees whose benefits were the result of collective bargaining, and who were represented by the union at the time of their retirement, should be taken into account in the same way that active members of a collective bargaining unit are taken into account.

ERIC appreciates the opportunity to provide comments in response to the Departments' request for information. If the Departments have any questions concerning our comments, or if we can be of further assistance, please let us know.

Sincerely,

Mark J. Ugoretz
President