



The  
ERISA  
Industry  
Committee

May 3, 2010

*Submitted through the Federal eRulemaking Portal:  
<http://www.regulations.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: RIN 1210-AB30

Ladies and Gentlemen:

The ERISA Industry Committee (“ERIC”) is pleased to submit these comments on the interim final regulations implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”). The interim final regulations were published by the Departments of Labor, Health and Human Services, and the Treasury (collectively, the Departments) in the *Federal Register* on February 2, 2010.

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 each group health plan. 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.

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 Interim Final Regulations**

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. The regulations implementing the MHPAEA 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. Although the recent health reform legislation aspires to reduce health costs for all Americans in the long run, in the near term it will impose a number of expensive new mandates on employer group health plans. Accordingly, ERIC's members have a vital interest in assuring that the regulations interpreting the parity requirements 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 MHPAEA requirements be affordable and administrable is consistent with a primary objective of MHPAEA: to assure that employees will continue to have access to mental health and substance use disorder benefits through employer-sponsored group health plans. ERIC recognizes that the interim regulations must strike a difficult balance: they must give effect to the statutory parity requirements without discouraging employers from offering mental health and substance use disorder benefits to their employees. ERIC offers these comments in the hope that they will assist the Departments to adjust the interim regulations where necessary to achieve the appropriate balance.

## Comments on the Regulations

### 1. The regulations should not require employers to aggregate separate plans.

The interim final regulations create an unprecedented new aggregation rule. Under this rule, if any individual is eligible to receive coverage for medical/surgical benefits under an “arrangement to provide medical care benefits,” and the same individual is simultaneously eligible to receive coverage for mental health or substance use disorder benefits under an entirely different “arrangement” maintained by the same employer, the “arrangements” are treated as a single group health plan, and the parity requirements apply to the aggregated benefits.<sup>1</sup> This mandatory aggregation rule is contrary to the plain language of the statute and constitutes an unsupportable extension of the parity requirement. The Departments should eliminate the mandatory aggregation rule from the interim final regulations, and instead should rely on the anti-abuse rule proposed in 2004, which requires the aggregation of separate plans only to the extent necessary to prevent evasion of the parity requirements.

The parity requirements apply to “**a group health plan** (or health insurance coverage offered in connection with such a plan) that provides **both** medical and surgical benefits **and** mental health or substance use disorder benefits” (emphasis added).<sup>2</sup> MHPAEA does not mandate that mental health or substance use disorder benefits be subject to the parity requirements when they are offered under a separate plan that provides no coverage for medical and surgical benefits. In contrast, however, the interim final regulations impose this requirement by ignoring the existence of separate plans, regardless of when or why the employer established the plans, and treating all benefits offered to the same individual as being provided under the same plan.

There is no basis in the statute or in its legislative history for this aggregation rule. The Departments have always permitted employers to determine how many plans they will maintain and what benefits will be offered under each plan. An employer designates the benefits that constitute a plan in the written instruments that govern the plan. Each plan has its own identifying number and is required to file its own annual report on Form 5500. Employers establish separate plans for a variety of business reasons; and the employer’s decision to designate a particular benefit arrangement as a “plan” often determines what rules apply to the arrangement. For example, a plan that covers fewer than 100 participants is not

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<sup>1</sup> 26 C.F.R. § 54.9812(e)(1); 29 C.F.R. § 2590.712(e)(1); 45 C.F.R. § 146.136(e)(1).

<sup>2</sup> IRC § 9812; ERISA § 712; PHSa § 2705.

required to be audited;<sup>3</sup> a plan that provides only welfare benefits is not required to be funded;<sup>4</sup> a plan that provides only payroll benefits such as holiday pay, vacation pay, and sick pay is not subject to ERISA;<sup>5</sup> a deferred compensation plan that covers only management and highly-compensated employees is exempt from ERISA's vesting, funding, and fiduciary requirements.<sup>6</sup> The Department of Labor has never suggested that an employer must aggregate all arrangements that cover the same individuals for purposes of determining whether and how the basic requirements of ERISA apply to the arrangements.

The Departments issued proposed regulations in 2004 that explained how an employer could identify its group health plans for purposes of applying a number of benefit mandates, including the mental health parity requirements then in effect. 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.<sup>7</sup> 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 of the proposed regulations explained that these rules provided plans sponsors with great flexibility in determining how many plans to maintain, while the anti-abuse rule limited that flexibility to the extent necessary to prevent evasion of the statutory requirements.<sup>8</sup>

In the preamble of the interim final regulations, the Departments explain that an anti-abuse rule is necessary to prevent plan sponsors from avoiding the parity requirements by providing mental health and substance use disorder benefits under a separate plan that provides no medical or surgical benefits. The Departments note that comments on the anti-abuse rule proposed in 2004 raised concerns about how employers would demonstrate that they had not established separate plans for the principal purpose of evading the law.<sup>9</sup> Rather than address these concerns by describing the criteria that the Departments would use to apply

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<sup>3</sup> ERISA § 104(a); 29 C.F.R. § 2520.104-46.

<sup>4</sup> ERISA §§ 301, 302.

<sup>5</sup> 29 C.F.R. § 2510.3-1(b).

<sup>6</sup> ERISA §§ 201(2), 301(a)(3), 401(a)(1).

<sup>7</sup> 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).

<sup>8</sup> 69 *Fed. Reg.* 78800, 78807 (Dec. 30, 2004).

<sup>9</sup> 75 *Fed. Reg.* 5409, 5417 (Feb. 2, 2010)

the anti-abuse rule, the Departments abandoned the anti-abuse rule in favor of the mandatory aggregation rule. Under the aggregation rule, all employers are presumed to have established separate plans for the purpose of evading the parity requirements, even if the employer maintained separate plans long before the parity requirements were enacted and designed them as separate plans for purposes that are manifestly benign.

The Departments have cited no evidence of abuse that would justify this irrebuttable presumption of guilt. To the contrary, large employers generally have modified their group health plans to comply with the MHPAEA parity requirements rather than drop mental health and substance use disorder coverage or move it to a separate plan.<sup>10</sup> Moreover, there is no basis in the statute itself or in the legislative history of MHPAEA for a mandatory aggregation rule. Congress presumably was aware that the Departments had defined the term “group health plan” in the 2004 proposed regulation in a manner that respected the employer’s designation of separate plans, subject to the anti-abuse rule. Congress made no effort to change this standard when it expanded the parity requirements in MHPAEA: to the contrary, it used exactly the same language it had used in the Mental Health Parity Act of 1996 to describe the arrangements that were subject to the parity requirements. As the plain language of the statute indicates, the purpose of MHPAEA is to provide parity between the financial requirements and treatment limitations that apply to medical and surgical benefits and to mental health or substance use disorder benefits offered *under the same group health plan*.<sup>11</sup>

There is no evidence anywhere that Congress intended to extend the parity requirement to plans that had not previously been subject to this requirement; and yet this is precisely the effect that the aggregation rule will have. Consider an

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<sup>10</sup> A recent survey of 70 Fortune 500 companies by Hewitt Associates indicates that employers have generally not eliminated mental health or substance use disorder coverage since MHPAEA was enacted in 2008. Hewitt Associates Press Release: “Most Employers Already Modifying Benefits to Comply with New Federal Mental Health Parity Regulations” (Mar. 1, 2010), <http://www.hewittassociates.com/Intl/NA/enUS/AboutHewitt/Newsroom/PressReleaseDetail.aspx?cid=8172>.

<sup>11</sup> See H.R. Rep. No. 374 Part 1, 110th Cong., 1st Sess. 13 (2007) (“H.R. 1424 seeks to increase access to mental health treatment by prohibiting group health plans (or health insurance coverage offered in connection with a group health plan) from imposing financial requirements (including deductibles, co payments, coinsurance, out-of-pocket expenses, and annual lifetime limits) or treatment limitations (including limitations on the number of visits, days of coverage, frequency of treatment, or other similar limits on the scope and duration of treatment) on mental health benefits that are more restrictive than those restrictions applied to medical and surgical benefits.”)

example that is quite common among large employers. The employer maintains a comprehensive group health plan that offers employees and their family members both medical and surgical benefits and mental health benefits, but no substance use disorder benefits. In recognition of the comprehensive coverage provided under the group health plan, the plan imposes significant cost-sharing requirements on participants, including a monthly contribution comparable to a premium, deductibles, and co-payments. The benefits under the group health plan comply with the MHPAEA parity requirements in all respects, including the application of these cost-sharing requirements.

The same employer also offers an employee assistance program (“EAP”) that provides treatment for substance use disorders. All employees and their spouses and dependents are automatically enrolled in the EAP program, which requires no monthly premium or other cost-sharing. Because the employer bears the entire cost of providing the substance use disorder benefit, however, the EAP program limits substance abuse treatments to one course of treatment per covered individual. The employer has determined that it is not practicable to offer a benefit covering unlimited substance use disorder treatments at no charge to its entire workforce and their families.

Under the plan aggregation rule, the one-course-of-treatment limit in the EAP is no longer permissible, since no similar limits apply under the group health plan to medical and surgical benefits in the same benefit classifications. The employer in this example has only three choices, any one of which will significantly reduce the health benefits currently available to its employees and their dependents. One choice is simply to eliminate the substance abuse disorder benefit under the EAP program. The second choice is to limit substantially all medical and surgical benefits offered in the same classifications under its group health plan to one course of treatment, a restriction that would severely diminish the value of the group health plan benefits. The third choice is to remove the provision in the EAP program limiting the substance use disorder benefit to one course of treatment, but at the same time to require employees to satisfy cost-sharing requirements comparable to those under the group health plan in order to defray the cost of the unlimited substance use disorder benefit. By forcing the employer to treat the EAP program as part of its group health plan,<sup>12</sup> the plan aggregation rule in the interim

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<sup>12</sup> We note that the interim final regulations do not apply the aggregation rule consistently. In paragraph (c)(4)(iii), Example 5, the proposed regulation concludes that an employer improperly applies a “nonquantitative treatment limitation” if it requires employees to complete counseling sessions under an EAP before the employees gain access to mental health benefits under the employer’s group health plan, but it does not apply a similar exhaustion requirement to medical and surgical benefits under the group health plan. If the EAP and the group health plan are truly considered a single plan, however, the counseling sessions should be considered part of a unified course of treatment under the (continued...)

final regulation will in effect increase the cost of group health coverage for all employees and their families, raising their monthly contributions and associated COBRA premiums to the extent necessary to pay for the additional benefit.

None of the choices we have described in the preceding paragraph advances the objective of the MHPAEA, which is to expand the availability of mental health and substance use disorder benefits. As this example illustrates, one important reason why employers maintain separate plans is so that they can match any applicable cost-sharing requirements to the scope of the benefits offered under the plan: benefits with fewer limits come with higher costs, and employers must pass some of these costs on to participants. We have used the example of a stand-alone substance use disorder benefit provided under an EAP because these arrangements are widely used;<sup>13</sup> but the same point applies to any two group health arrangements that are maintained separately and that have different employee contribution levels or other cost-sharing requirements. The Departments should not assume that employers can simply absorb any additional costs that will result when the aggregation rule forces employers to remove treatment limits or other design elements that are design to contain the cost of supplemental benefit programs funded largely or entirely by the employer.

**2. If the Departments do not rescind the aggregation rule, they should publish the rule as a proposed regulation.**

If the Departments do not eliminate the mandatory aggregation rule, they should publish it only as a proposed regulation, and not as an interim final regulation. As we have explained above, the aggregation rule represents an abrupt departure from longstanding practice, from the language of the statute, and from the Departments' prior interpretation of the mental health parity requirements. The Departments had confirmed in the proposed regulations issued in 2004 that they would respect the employer's designation of an arrangement as a group health plan. When the Departments published a request for information on the expanded parity requirements in MHPAEA, they did not ask for information concerning the definition of "group health plan" or otherwise indicate that this definition might be radically revised.<sup>14</sup> Accordingly, until the Departments published the interim final regulations in February of this year, employers had no notice that a "group health

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group health plan rather than as a precondition to receiving benefits under the group health plan.

<sup>13</sup> A 2008 National Study of Employers following ten years trends related to U.S. workplace policies and benefits shows that 65 percent of employers provided EAPs in 2008. Families and Work Institute, 2008 National Study of Employers (May 21, 2008) *available at* <http://familiesandwork.org/site/research/reports/2008nse.pdf>.

<sup>14</sup> 74 *Fed. Reg.* 19155 (April 28, 2009).

plan” for purposes of the parity rules might be anything other than the arrangement they had designated as a group health plan for all other purposes under ERISA and the Internal Revenue Code (the “Code”).

The Departments’ unexpected reversal of their position concerning the “group health plan” definition has left employers in an untenable position. They must either apply the parity requirements to artificially aggregated arrangements that have different designs and cost-sharing requirements and serve widely different purposes, or—if this solution proves impracticable—they must eliminate the mental health and substance use disorder benefits they previously provided to their employees under bona fide separate plans.

The Departments noted that while the interim final regulations treat all medical benefits provided by the same employer as a single group health plan, the rule published in 2004 (which respects the employer’s designation of separate group health plans except in cases of abuse) “remains proposed.”<sup>15</sup> We respectfully suggest that the status of the two rules is the opposite of what it should be. If the Departments believe that it is necessary to abandon the accepted definition of a “group health plan” and to adopt an unprecedented new mandatory aggregation rule, the Departments should publish the new rule as a proposed regulation so that all interested parties will have a reasonable opportunity to comment on the rule before it becomes effective.

The need for public comment is especially compelling in a case such as this one, where the new rule overturns a longstanding position on which employers have relied in designing their benefit programs, and where there is no evidence that a change in the established standard is necessary to prevent abuse. As the Departments acknowledge in the preamble of the interim final regulations,<sup>16</sup> the Administrative Procedure Act permits an agency to publish final regulations without first issuing a notice of proposed rulemaking when the agency, for good cause, finds that notice and public comment are impracticable, unnecessary, or contrary to the public interest. None of these conditions applies in the case of the mandatory aggregation rule: to the contrary, the Departments and the public will benefit from comments that identify the unintended and potentially damaging consequences of the aggregation rule. Until the Departments have gathered and considered comments on the proposed aggregation rule, the definition of “group health plan” that appeared in the 2004 proposed regulations should be the definition used in the interim final regulations.

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<sup>15</sup> 75 *Fed. Reg.* at 5417.

<sup>16</sup> 75 *Fed. Reg.* at 5419.



**3. The regulations should make clear that the aggregation rule does not apply to benefits that are a condition of employment.**

As we explained in the preceding comments, the Departments should rescind the mandatory plan aggregation rule, or should at a minimum publish it only as a proposed rule for further comment. If the Departments allow the rule to take effect in its current form, it will disrupt many longstanding benefit programs that employers have historically maintained as separate plans for important reasons having nothing to do with a desire to escape the parity requirements. When an employee's participation in a plan is a condition of employment, the aggregation rule is particularly inappropriate. Even if the Departments make no other change in the aggregation rule, we urge the Departments to exempt these plans from the aggregation rule.

For example, if an employee tests positive for an illegal substance, an employer might require the employee to undergo a course of treatment under the employer's separate program for substance use disorder benefits. An employee who refuses to participate in the substance use disorder treatment program is dismissed. The employee is also dismissed if he or she completes the treatment program, but later tests positive a second time for the same illegal substance.

The requirement that the employee participate in the program, and the rule that an employee who tests positive a second time is dismissed, are necessary features of the employer's program to maintain a drug-free workplace: these features have nothing to do with a desire to limit treatment under a group health plan. Nevertheless, under the mandatory aggregation rule, these requirements might be viewed as impermissible nonquantitative treatment limits, since no comparable requirements apply to medical and surgical benefits under the employer's group health plan. The Departments should make clear that mental health and substance use disorder programs required as a condition of employment are not required to be aggregated with programs in which employees participate voluntarily.

**4. The regulations should make clear that the parity rules do not apply to group health plans that cover only retirees.**

The expanded mental health parity requirements under MHPAEA, like the original parity requirements enacted in 1996, apply only to group health plans that cover active employees. The statute states that the parity requirements "shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees."<sup>17</sup>

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<sup>17</sup> IRC § 9831(a)(2); ERISA § 732(a); PHSA § 2721(a).

Accordingly, if an employer maintains a separate group health plan for its retirees and their family members, the retiree plan is not subject to the parity requirements for mental health and substance use disorder benefits. The interim final regulations cite the exclusion for retiree-only plans, but only as a cross reference in the paragraph describing the exception for small employers.<sup>18</sup> The Departments should amend the interim final regulations to state directly that a plan is not subject to the mental health and substance use disorder parity requirements if the plan covers no active employees, and that this rule applies regardless of the size of the employer.

The interim final regulations should also make clear that the mandatory aggregation rule does not alter the statutory exemption for plans that cover no active employees. The definition of “group health plan” in the interim final regulations appears to require an employer to aggregate a retiree-only plan with the employer’s group health plan for active employees if the retiree plan provides any mental health or substance use disorder benefits.

The interim final regulations state that plans must be aggregated if any “participant” simultaneously receives medical and surgical benefits and mental health or substance use disorder benefits under an arrangement or arrangements sponsored by the same employer. The regulation also states that all plans aggregated in this manner are considered to be a single group health plan for purposes of the parity requirements. Under ERISA, the term “participant” means “any employee *or former employee* of an employer . . . who is or may become eligible to receive a benefit” under an employee benefit plan.<sup>19</sup> Accordingly, if a group health plan that covers only retirees and their families offers both medical and surgical benefits and mental health or substance use disorder benefits, the interim final regulation appears to require the employer to aggregate this plan with any group health plan covering active employees who receive both medical and surgical benefits and mental health or substance use disorder benefits.

If a retiree-only plan is treated as if it were part of a plan covering active employees, the retiree-only plan will no longer be eligible for the exception that applies to a plan covering no active employees. This result is contrary to the plain language of the statute. Accordingly, we urge the Departments to make clear that the mandatory aggregation rule does not apply to a separate group health plan that covers only retirees and their families, even if the employer chooses to offer mental health and substance use disorder benefits under the retiree-only plan.

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<sup>18</sup> 26 C.F.R. § 54.9812(f)(1); 29 C.F.R. § 2590.712(f)(1); 45 C.F.R. § 146.136(f)(1).

<sup>19</sup> ERISA § 3(7) (emphasis added).

We also urge the Departments to clarify that the exception for retiree-only plans continues to apply for plan years beginning on or after September 23, 2010, when many of the market reforms in the Patient Protection and Affordable Care Act (“PPACA”)<sup>20</sup> become effective. PPACA amends ERISA and the Internal Revenue Code to include new sections<sup>21</sup> stating that the provisions of Title XXVII, Part A of the Public Health Service Act will apply to group health plans as if included in Title I, subtitle A, Part 7, subpart B of ERISA and subchapter B of Chapter 100 of the Code. These provisions also state that if any provision in Part 7 of ERISA or subchapter B of Chapter 100 of the Code conflicts with Part A of the Public Health Service Act, the provision in Part A of the Public Health Service Act will govern (the “conflicts rule”). PPACA eliminates the exclusion for plans that cover fewer than 2 current employees from Part A of the Public Health Service Act.<sup>22</sup> This change has caused practitioners to question whether the “conflicts rule” requires that the corresponding exclusion also be eliminated from section 732(a) of ERISA and section 9831(a)(2) of the Code.

The change in Part A of the Public Health Service Act probably was not intended to eliminate the exemption for retiree-only plans. Instead, it appears to have been a conforming change intended to reflect the fact that PPACA had amended the definition of “small employer” in the Public Health Service Act. A “small employer” had been defined as an employer “who employs at least 2 employees on the first day of the plan year.”<sup>23</sup> As amended by PPACA, however, the definition applied to an employer “who employs at least 1 employee on the first day of the plan year.”<sup>24</sup> As a result of this change, a plan that covered only one current employee was no longer exempt from the mental health parity requirements.<sup>25</sup> In contrast, however, a plan that covered *no* current employees—that is, a retiree-only plan—remained exempt from all of the mandates in Part A of

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<sup>20</sup> Pub. L. No. 111-148 (2010), § 1004.

<sup>21</sup> ERISA § 715 and IRC § 9815, added by PPACA § 1562[3](e) and (f). [PPACA § 1562 was redesignated as § 1563 by PPACA § 10107(b)].

<sup>22</sup> The exclusion for plans that cover fewer than 2 current employees had appeared in subsection (a) of PHS § 2721. PHS § 2721 was redesignated as PHS § 2735 by PPACA § 1001(4), and was subsequently redesignated as PHS § 2722 by PPACA § 1562[3](c)(12)(D). Subsection (a) of PHS § 2721/2735/2722 was deleted by PPACA § 1562[3](a)(1) and by PPACA § 1562[3](c)(12)(D).

<sup>23</sup> PHS § 2791(e)(4).

<sup>24</sup> PPACA § 1562[3](c)(16).

<sup>25</sup> PHS § 2705(c)(1), redesignated as PHS § 2726(c)(1) by PPACA § 1001(2) (“This section [*i.e.*, the mental health parity requirements] shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of a small employer”).

the Public Health Service Act, including the mental health and substance use disorder parity rules. This is so because Public Health Service Act, as amended by PPACA, continues to apply only to a “group health plan,” and this term is defined in the Public Health Service Act (as it is in Part 7 of ERISA) as “an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care . . . to employees or their dependents.”<sup>26</sup>

Even if the amendment had removed the retiree-only exemption from the Public Health Service Act, however, the “conflicts rule” does not signify that the same change should be made in the corresponding sections of ERISA and the Code. PPACA amended a number of group health mandates that existed in parallel form in the Part A of the Public Health Service Act, Part 7 of ERISA, and Chapter 100 of the Code. For example, PPACA amended the provision limiting pre-existing condition exclusions and the provision prohibiting discrimination based on health status, which had been added in substantially identical form to the Public Health Service Act, ERISA, and the Code by the Health Insurance Portability and Accountability Act of 1996.<sup>27</sup> Rather than revise the parallel provisions of the other two statutes, PPACA incorporated the revised provisions of the Public Health Service Act in ERISA and the Code, and added the “conflicts rule” in an attempt to ensure that the revised language of the Public Health Service Act would supersede the existing language of the parallel provisions.

This attempt to amend ERISA and the Code by bootstrap was not entirely successful: it resulted in the unconsidered effects and outright errors that one might expect to find in a complex and hastily-assembled bill several thousand pages long. For example, the “conflicts rule” applies to all of Part 7 of ERISA, but it applies only to *subchapter B* of Chapter 100 of the Code.<sup>28</sup> As a result, it appears that Chapter 100 of the Code now contains two versions of the portability,

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<sup>26</sup> PHS § 2791(a)(1); ERISA § 733(a)(1) (emphasis added). The use of the term “employees” in this definition is deliberate: compare ERISA § 3(1), which defines a “welfare benefit plan” as a plan to the extent that the plan provides medical care (among other things) to *participants* or their beneficiaries. The term “participant” is defined in ERISA § 3(7) to mean an employee or former employee.

<sup>27</sup> PPACA § 1201, amending PHS § 2701 [redesignated as PHS § 2704] and PHS § 2702 [redesignated as PHS § 2705]. Provisions parallel to the PHS provisions appear in ERISA §§ 701 and 702, and in IRC §§ 9801 and 9802.

<sup>28</sup> Compare ERISA § 715(a)(2) (“to the extent that any provision of *this part* [i.e., Part 7] conflicts with a provision of such part A . . . , the provisions of such part A shall apply”) with I.R.C. § 9815(a)(2) (“to the extent that any provision of *this subchapter* [i.e., subchapter B] conflicts with a provision of such part A . . . , the provisions of such part A shall apply”) (emphasis added).

nondiscrimination, and guaranteed renewability rules: the old version, which appears in subchapter A of Chapter 100 and thus is not affected by the “conflicts rule,” and the new version in the amended Public Health Service Act, which is incorporated in subchapter B of Chapter 100. The exclusion for plans that cover fewer than 2 current employees appears in subchapter C of Chapter 100. As a result, this exclusion, as it exists in the Internal Revenue Code, was not affected by the “conflicts rule”; and since the exclusion by its terms applies to all of the group health plan mandates in Chapter 100 except for the genetic nondiscrimination provisions,<sup>29</sup> it continues to apply for purposes of the mental health parity rules in subchapter B of Chapter 100.

Whatever the “conflicts rule” accomplishes or fails to accomplish, however, Congress cannot have intended to apply the “conflicts rule” to replace the exemptive provisions in Part 7 of ERISA and in Chapter 100 of the Code with the exemptive provisions in the amended and redesignated section 2722 of the Public Health Service Act. In order to see that this is so, one need look no farther than the next paragraph of the amended section 2722.<sup>30</sup> This paragraph states that the requirements of subpart II of Part A (the subpart that, as amended by PPACA,<sup>31</sup> is

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<sup>29</sup> The genetic nondiscrimination provisions are carved out of the exclusion for retiree-only plans by I.R.C. § 9802(e).

<sup>30</sup> As explained above in note 22, the amended PHS § 2721 was ultimately redesignated as PHS § 2722; the former § 2721(b) became § 2722(a).

<sup>31</sup> PPACA changed the subpart references in PHS § 2722 three times, inserting different references each time. See PPACA § 1562[3](a) (“subparts 1 and 2”); PPACA § 1562[3](c)(12) (“subpart 1”); PPACA § 10107 (“subparts I and II”). The reference in PPACA § 10107, which is the only section that uses the new post-PPACA designations of the relevant subparts, evidently is correct. Subpart II, which is captioned “Improving Coverage,” apparently is intended to include both the new coverage provisions added by PPACA as PHS §§ 2711–2719A and the prior coverage provisions redesignated by PPACA as PHS §§ 2725–2728.

PPACA struck subparts 2 and 3 of PHS Part A and redesignated subpart 4 (“Exclusion of Plans; Enforcement; Preemption”) as subpart 2—which, confusingly, immediately follows subpart II. PPACA § 1562[3](c)(2), (7), (11). PPACA § 1562[3](c)(12), (13), and (14) subsequently renumbered the exclusion, enforcement, and preemption provisions in PHS §§ 2735–2737 as PHS §§ 2722–2724, with the result that the mothers and newborns provision (§ 2725), the mental health parity provision (§ 2726), the post-mastectomy reconstructive surgery provision (§ 2727), and the provision mandating coverage of students on medical leave (§ 2728) ended up following rather than preceding subpart 2. This is evidently an error, since PHS §§ 2725–2728 have nothing to do with exclusion, enforcement, or preemption, but instead are coverage provisions. Despite the numbering errors and inconsistencies in PPACA, it seems reasonably clear that the mental health parity provisions in the Public Health Service Act are intended to apply only to nonfederal governmental plans, as they did before PPACA.

intended to include the mental health and substance use disorder parity provisions) applies *only* to nonfederal governmental plans and to health insurance coverage offered in connection with a group health plan. If this provision is deemed to be incorporated in Part 7 of ERISA and Chapter 100 of the Code, and if the “conflicts rule” requires that this applicability rule be substituted for the inconsistent applicability rules in sections 732 and 733 of ERISA and sections 9831 and 9832 of the Code, the only self-insured group health plans that will be subject to the general reform and coverage provisions of the Public Health Service Act, including the mental health parity rules, will be plans maintained by state and local governmental employers.

We request that the Departments clarify that retiree-only plans continue to be exempt from the mental health and substance use disorder parity rules notwithstanding the revisions to Part A of the Public Health Service Act. This issue has been a source of considerable confusion to employers that are struggling to understand and comply with PPACA. The issue has implications broader than the application of the mental health parity rules: if the exemption for retiree-only plans no longer applies, these plans will become subject for the first time to a variety of other group health plan mandates, including the new mandates included in PPACA. As we have demonstrated, this result is not consistent with a close reading of the amended statutes, and it cannot have been what Congress intended.

Because the changes in the applicability rules and exemptions in Part A are effective generally for plan years beginning on or after September 23, 2010, it is urgent that the Departments address this issue at once. Large employers ordinarily finalize the design of their group health plans for the next calendar year no later than June or July, so that the plans’ third-party administrators will have time to program software systems, revise administrative manuals, and train customer service representatives to administer the benefits properly. Employers also must prepare participant communications and open enrollment materials, and must create internet-based tools, to help participants understand the new benefit options and make appropriate choices concerning their family’s health coverage for the upcoming year. Many employers commence open enrollment for the upcoming year in October or earlier. It will be difficult enough for employers to make decisions and incorporate the changes required by PPACA for group health plans covering active employees and their families in time for open enrollment for the 2011 plan year. The current confusion concerning the status of retiree-only plans serves as a distraction and makes it impossible for employers to finalize the design of these plans.

**5. The effective date should be delayed for collective bargaining agreements ratified before the regulations were published.**

MHPAEA became effective for most group health plans in the first plan year beginning after October 3, 2009, the anniversary of the statute’s enactment.

However, 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).<sup>32</sup>

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 or regulatory requirements announced after the agreement is reached. 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 requirements.

MHPAEA required the Departments to issue regulations interpreting the new parity requirements no later than October 3, 2009.<sup>33</sup> In fact, however, the interim final regulations were not issued until four months later, on February 2, 2010. The interim final regulations apply for plan years beginning on or after July 1, 2010. The preamble states that the Departments will take into account good-faith efforts to comply with a reasonable interpretation of the statute for periods before the applicability date of the interim final regulations.<sup>34</sup>

The interim final regulations interpret the statute in ways that employers and unions could not have predicted. The preamble explains that many of the statutory provisions are capable of several reasonable interpretations and that the Departments were required to make policy judgments concerning which interpretation to adopt. For example, the Departments recognized that the statutory language is consistent with the view that a group health plan could apply cumulative financial requirements and cumulative quantitative treatment limitations separately to mental health and substance use disorder benefits, even though the Departments did not adopt this interpretation in the interim final regulations.<sup>35</sup>

Collective bargaining agreements that were ratified after MHPAEA was enacted on October 3, 2008, and before the interim final rules were issued on

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<sup>32</sup> MHPAEA § 512(e), as corrected by Pub. L. No. 110-460 (Dec. 23, 2008).

<sup>33</sup> Pub. L. No. 110-343, § 512(d).

<sup>34</sup> 75 *Fed. Reg.* at 5419.

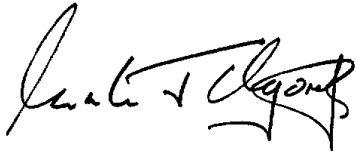
<sup>35</sup> 75 *Fed. Reg.* at 5415.

February 2, 2010, had to be negotiated in good faith reliance on the statutory language. At the time these agreements were negotiated, it was impossible for the parties to anticipate the detailed rules and policy decisions reflected in the interim final regulations. Employers and unions should not be required to reopen negotiations now in order to conform the benefits provided under collectively-bargained plans to the requirements of the interim final regulations. Instead, the Departments should issue guidance confirming that the interim final regulations do not apply to a group health plan maintained pursuant to one or more collective bargaining agreements ratified after October 3, 2008, and before February 2, 2010, until the later of (1) the first plan year beginning on or after July 1, 2010, and (2) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension agreed to after February 2, 2010). During the period before the interim regulations become applicable, the collectively-bargained plan would be required to comply with a good-faith interpretation of the statute.

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ERIC appreciates the opportunity to provide comments on the interim final regulations. If the Departments have any questions concerning our comments, or if we can be of further assistance, please let us know.

Sincerely,

A handwritten signature in black ink, appearing to read "Mark Ugoretz". The signature is fluid and cursive, with a large initial "M" and a stylized "U".

Mark Ugoretz  
President