

April 9, 2001

CC: M&SP: RU (REG-109707-97)
Couriers Desk
Internal Revenue Service
1111 Constitution Ave., NW
Washington, DC 20224

Dear Sir or Madam:

These comments are filed by the National Coordinating Committee for Multiemployer Plans (NCCMP) in response to the request for public comments on the Interim Final Rules for Nondiscrimination in Health Coverage in the Group Market solicited by the Departments of Labor, Health and Human Services, and the Treasury in the Federal Register of January 8, 2001 (66 Fed. Reg. 1378). These rules were issued to implement changes made to the Internal Revenue Code of 1986 (the Code), the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act (PHSA) by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The NCCMP is the only national organization devoted exclusively to protecting the interests of the approximately ten million workers, retirees, and their families who rely on multiemployer plans for retirement, health and other benefits. Our purpose is to assure an environment in which multiemployer plans can continue their vital role in providing benefits to working men and women. The NCCMP is a nonprofit organization, with members, plans and plan sponsors in every major segment of the multiemployer plan universe, including in the building and construction, retail food and service, and entertainment industries.

In general, the NCCMP supports the provisions of the Interim Final Rules regarding nondiscrimination in group health coverage based on health factors. We recognize the difficult task faced by the Departments in divining and carrying out Congressional intent with respect to the new nondiscrimination rules adopted in HIPAA. Although the legislative history did not provide an always clear pathway to follow and, in some cases, even offered conflicting views regarding Congressional intent, the Interim Final Rules evidence a careful balancing of competing interests and a genuinely thoughtful attempt to temper fairness with practicality. We commend the Departments for this effort, and while we might not have reached the same conclusions in all instances, we recognize and appreciate the hard work that went into the development of this guidance.

In particular, we are pleased that the Departments have clarified that the type of service requirements used by many multiemployer plans to define the minimum period of work in the industry that individuals must perform in order to be considered eligible for benefits under the plan does not violate HIPAA's prohibition against treating similarly situated individuals differently based on a health condition. These requirements of working a specified number of hours in covered employment within a fixed period of time (e.g., 250 hours in a 3-month period) have been used consistently by multiemployer plans for purposes of initial and continuing eligibility as a means to distinguish individuals performing substantial work for contributing

employers from those individuals whose connection to covered work is sporadic. These work-related requirements have never been used as a mechanism for discriminating based on health status, but rather are similar in purpose and scope to plan provisions treating full-time and part-time workers differently. So the Departments' reference to these requirements as an example of a permissible distinction in its Interim Final Rules is most welcome. Treas. Reg. §54.9802(e)(3)(ii), Example 2; 29 CFR §2590.702(e)(3)(ii), Example 2.

However, as we have reviewed the Interim Final Rules, we have concluded that implementation will require some changes for multiemployer group health plans. Most of them will not be particularly difficult to implement. But one provision raises particularly troubling concerns for us. Therefore, we strongly urge you to reconsider your approach on source-of-injury exclusions.

The Interim Final Rules provide that if a group health plan or health insurance issuer providing coverage in connection with a group health plan provides coverage for benefits for a type of injury (e.g., inpatient hospitalization), those benefits cannot be denied to a participant if the injury results from an act of domestic violence or a underlying physical or mental condition.

As you know, many plans contain source-of-injury exclusions, including exclusions for injuries that are self-inflicted, result from commission of a crime, result from failure to wear a seatbelt or occur while driving under the influence of alcohol. It is our understanding that the Rules do not preclude all source-of-injury exclusions, only those described above (i.e., exclusions for acts of domestic violence and exclusions for injuries that are related to a medical condition). We are deeply troubled, however, about the administrability of this approach because of the difficulty that plans will have in determining whether the injury resulted from a medical condition or not.

For example, assume that the plan excludes coverage for injuries resulting from an automobile accident in which the participant or beneficiary was driving while intoxicated. In the case of a pre-service claim for emergency room services (including ambulance transportation), the plan may not have enough information at the time of the accident to determine whether the injury was caused by an underlying medical condition (e.g., alcoholism or depression) or not. Who has the burden of providing that the exclusion is enforceable? May the plan assume that its exclusion is permitted unless the participant or beneficiary produces evidence of the underlying condition? At what point is that showing made? After the claim is denied? At the point that treatment is requested? In the precertification stage, can the plan deny treatment based on its exclusion or must the plan approve treatment and then later settle the question of whether or not the injury resulted from an underlying medical condition? What type of evidence will the participant or beneficiary be required to produce to show that the injury was caused by a physical or mental condition? Will a statement by a treating physician be sufficient? If not, what is the level of proof that must be offered? In deciding whether or not to enforce their source-of-injury exclusions, not only will plans have to evaluate complex underlying medical conditions, but also questions of causality involving medical judgment as well.

Although we understand and are sympathetic to the rationale for the rule you have proposed, we are concerned that, in practice, it will result in increased benefit appeals and

litigation to determine whether an injury was a result of a mental or physical condition. In the multiemployer context, trustees will be forced to spend limited plan funds to secure additional medical expertise to grapple with these questions and that process may be lengthy and expensive not only for the Fund but also for the participant or beneficiary.

Therefore, we urge you to clarify that such source-of-injury exclusions are permissible if they are related to activities that are illegal or against public policy. Although Congress clearly did not intend to allow plans to discriminate against individuals based on health factors, it is doubtful that Congress wanted to overturn common plan exclusions that force participants to bear the fiscal consequences of their illegal acts rather than spreading those costs across all plan participants.

If you have any questions, please feel free to contact me at 202-737-5315 or by e-mail at rdefrehn@nccmp.org. Thank you for your consideration.

Sincerely,

Randy DeFrehn
Executive Director