May 14, 1999

Ms. LaNita Van Dyke
CC:DOM:COPR:R (REG-121865-98)
Room 5226
Internal Revenue Service
POB 7604
Ben Franklin Station
Washington, D. C. 20044

Dear Ms. Van Dyke:

Enclosed are comments of the National Coordinating Committee for Multiemployer Plans (the “NCCMP”) on proposed and final rules relating to the COBRA continuation coverage requirements for group health plans.

The NCCMP would appreciate the opportunity to testify on these regulations at the hearing scheduled for June 8, 1999.

In the meantime, if you have questions or need further information, please contact me at the above number or via email to nccmp@compuserve.com.

With kind regards, I am

Sincerely,

Lori Wyatt
Director

enclosure

Comments of the
National Coordinating Committee for Multiemployer Plans
to the
Internal Revenue Service
on
Proposed and Final Regulations
under the
Consolidated Omnibus Budget Reconciliation Act of 1985

May 14, 1999

The National Coordinating Committee for Multiemployer Plans (the "NCCMP") submits these comments in response to the notice of proposed rulemaking and public hearing published in the Federal Register on February 3, 1999 (64 Fed. Reg. 5237) regarding section 4980B of the Internal Revenue Code, and the continuation of coverage requirements mandated by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The NCCMP, which requests the opportunity to testify at the public hearing on these regulations to be held June 8, 1999. The NCCMP also comments on the final regulations interpreting the COBRA continuation coverage requirements published in the Federal Register that same day (64 Fed. Reg. 5160).

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. The NCCMP's purpose is to assure an environment in which multiemployer plans can continue their vital role in providing benefits to working men and women. The more than 240 Affiliate and Associate Affiliate members of the NCCMP encompass plans and plan sponsors in every major segment of the multiemployer plan universe. The NCCMP is a nonprofit organization.

In the view of the NCCMP, both the final and proposed regulations are sensible expressions of the intent of the statute, as interpreted by the courts. Moreover, they reflect an understanding -- greatly appreciated by the NCCMP -- of the way multiemployer plans differ from those maintained by a single employer. There are, however, several aspects of the rules as to which we believe clarification is needed. In some such cases, the intent of the regulation seems relatively clear. Nonetheless,

since confusion over COBRA rights has been the source of a good deal of litigation, the NCCMP believes it desirable to be explicit wherever possible.

I. Providing COBRA to Employees of Withdrawn Employers.

The NCCMP commends Treasury on the provision of the proposed regulation regarding a multiemployer plan's COBRA obligation where employers have withdrawn from the plan. In particular, we commend Treasury on Prop. Treas. Reg. § 54.4980B-9, Q&A-9, which confirms that loss of coverage due to the employer's withdrawal from a multiemployer plan is not a qualifying event for the employees involved. This principle is set forth in case law and generally acknowledged in practice. However, the issue has arisen frequently, and it will be helpful to have clear guidance readily available in the regulations.

The NCCMP also commends Treasury for rejecting the holding in *South Central UFCW & Employers Health & Welfare Trust v. Appletree Market, Inc.*, 19 F.3d 969 (April 15, 1994). Section 54.4980B-9, Q&A-10 of the proposed regulations will help multiemployer plans conserve plan assets by transferring the continuation-coverage obligation for an employer's former employees to the new plan under which the employer's similarly situated active employees are covered. It may also result in better service for those whose COBRA coverage is transferred, since they will be covered by a plan in which their former employer and fellow workers have an active interest.

The NCCMP believes, however, that one aspect of this regulation merits amplification. Under Q&A-10, a multiemployer plan is allowed to terminate COBRA continuation coverage only where the withdrawn employer provides group health coverage to a "significant number" of employees formerly covered under the plan, or starts contributing to another multiemployer plan. There may well be controversy as to what constitutes a "significant number" of employees. For example, does this refer to a relative concept, i.e., a significant *percentage* of the employees who had been covered by the old plan, even if that is a small number of people? If the "significant number" concept is to be maintained in the final regulations, the NCCMP believes that some concrete benchmark, *e.g.,* the greater of 10 employees or 10% of the employees formerly covered by the multiemployer plan, should be adopted.

In any event, the purpose for requiring new coverage of a "significant number" of employees before assumption of COBRA coverage by the new plan is required is not clear to the NCCMP. We believe the withdrawn employer should be obliged to take responsibility for its COBRA beneficiaries if it provides health coverage for *any* of its active employees. Alternatively, the regulation could specify that responsibility for COBRA participants' coverage is transferred from the multiemployer plan if active employees are transferred to any plan to which COBRA applies, *i.e.,* another plan maintained by an employer with at least 20 employees. This would draw the line in the same place as the statute, based on the apparent Congressional judgment that an

employer who has 20 employees and provides health coverage is in a position to cover COBRA beneficiaries also.

II. "Similarly Situated NonCOBRA Beneficiaries."

The final regulations use the phrase "similarly situated nonCOBRA beneficiaries," instead of referring to "similarly situated active employees" (as in the 1987 proposed regulations), or "similarly situated beneficiaries" (as in the statute). The preamble states that this phrase is shorthand for the statutory language and that "similarly situated nonCOBRA beneficiaries" are similarly situated beneficiaries with respect to whom a qualifying event has not occurred. In addition, the preamble states that COBRA qualified beneficiaries have the same rights as similarly situated nonCOBRA beneficiaries. However, in certain contexts the phrase "similarly situated active employees" is still used. For example, the regulations refer to active employees when discussing the right of qualified beneficiaries who are spouses and dependent children of covered employees to make an independent election for COBRA continuation coverage. Treas. Reg.
§ 54.4980B-6, Q&A-6.

The regulations define "similarly situated nonCOBRA beneficiaries" as follows:

> [T]he group of covered employees, spouses of covered employees, or dependent children of covered employees receiving coverage under a group health plan maintained by the employer or employee organization who are receiving that coverage for a reason other than the rights provided under the COBRA continuation coverage requirements and who, based on all of the facts and circumstances, are most similarly situated to the situation of the qualified beneficiary immediately before the qualifying event.

Treas. Reg. § 54.4980B-3, Q&A-3. It may be that the objective of the change in terminology was to provide that the rights of various categories of COBRA beneficiaries are to be measured against those of the similar categories associated with active employees, e.g., COBRA spouses and active spouses, COBRA dependents and active dependents. The rationale, however, is not explicitly set forth, and the change may well have additional ramifications. It introduces another level of ambiguity in the COBRA administrative process, by raising the question of which type of nonCOBRA beneficiary, *e.g.,* active, retired, spouse, dependent, employee on FMLA or USERRA leave, etc., is relevant to the comparison involved. We suggest reconsideration of this decision or, at a minimum, some explanation of the substantive intent and impact of the language, so as to guide in its application.

III. Elimination of Core-Only COBRA Coverage Requirement.

In general, the NCCMP supports the elimination, in the final and proposed regulations, of the requirement that plans offer COBRA qualified beneficiaries the option of electing only core coverage or both core and noncore coverage. This eliminates an extra administrative step that often provided little of value for participants. However, we do have a few suggestions in this connection.

A. The Regulations should not discourage flexibility.

The NCCMP believes it would be helpful to state, in the preamble or elsewhere, that plans remain free to offer any benefit options not mandated by COBRA. Thus, for example, a plan that wished to allow election of core medical benefit coverage (presumably at a lower cost than the full benefit package offered by the plan) should certainly be able to do so, provided that it also permits election, in the alternative, of the COBRA-mandated coverage. Some plans may want to permit employees to continue medical-only benefits, in order to protect their families from catastrophic medical bills without incurring the cost of “extras” such as dental and vision coverage. At the same time, those plans may not want to offer dental and vision coverage on a stand-alone basis, because of the high potential for adverse selection in connection with these coverages. The new option to designate “modular” plans would not achieve these objectives.

B. Transition rules.

There are no transition rules for plans that want to change from the core/noncore options to a COBRA design offering only the plan’s full benefit package. We suggest that the final regulation clarify whether a plan that chooses to eliminate the core/noncore option may do so for qualified beneficiaries currently receiving COBRA benefits, as well as for future COBRA beneficiaries.

IV. Open Enrollment Rights and Aggregation of Plans.

The proposed regulations would allow employers and employee organizations broad discretion to determine the number of group health plans that they are considered to maintain. Multiemployer plans could aggregate all health benefits into a single group health plan or disaggregate benefits into separate group health plans, for COBRA purposes, so long as the principal purpose of the treatment is not to evade any legal requirement. 54.4980B-2, Q&A 6.

The usefulness of this new flexibility is not entirely clear to us (although we have no objection to it). Why would any plan sponsor choose to have five plans for COBRA purposes, with the consequently large number of statutorily mandated COBRA choices, when a single plan would require only one choice? As noted above, where more than

one choice is desired, there seems to be no obstacle to providing those choices, independently of COBRA requirements, so long as the required COBRA choice is also an available election. Conversely, the notion that, if desired, a plan can aggregate all benefit choices into one can be thought at least partially undercut by the requirement that COBRA beneficiaries be allowed to participate fully in any open enrollment features of the plan.

Assuming that this "bundling" flexibility is retained, the NCCMP has one specific comment. We assume that a designation of a cluster of coverages pursuant to the regulation, as either one plan or more than one plan, would be solely for purposes of COBRA administration, and would not affect the health coverage program's status as a "plan" under other laws and regulations. Specifically, we assume that the deconstruction of a health coverage program into modular "plans" in the context of COBRA administration would not carry with it a requirement that separate Forms 5500 be filed for each such "plan", or require a corresponding segmentation and insulation of costs and experience under ERISA's exclusive benefit rule. Any such collateral consequences to an action a plan sponsor thinks it is taking simply to streamline COBRA administration could be extremely severe. Accordingly, we believe the regulation should explicitly state that any unbundling pursuant to the COBRA rules would be disregarded in applying other laws and regulations. If that is not the intent, the potential impact of this unbundling should be highlighted in the preamble to the final regulations.

V. Alternative Coverage Rules.

The final regulations clearly contemplate the possibility that "alternative coverage," *i.e.,*coverage "provided to a beneficiary after a qualifying event without regard to COBRA," will in some cases obviate the need to provide any COBRA election. Section 54.4980B-7, Q&A-7(b) specifically provides that a COBRA election must be provided "[i]f the alternative coverage does not satisfy all the requirements for COBRA continuation coverage, or if the amount that the group health plan requires to be paid for the alternative coverage is greater than the amount required to be paid by similarly situated nonCOBRA beneficiaries." The clear implication is that, if the alternative coverage *does* satisfy all the COBRA requirements, and does not cost more than the specified amount, no COBRA election need be provided. This is a sensible result, since, in these circumstances, COBRA coverage could only cost more for the same (or lesser) coverage.

The same Question and Answer goes on to state that, where the alternative coverage does not satisfy these criteria -- and a COBRA election is therefore given -- but the individual nonetheless rejects COBRA coverage, such individual need not be given a COBRA election at the expiration of the alternative coverage period. This too, in the NCCMP's view, is a proper and sensible result.

The NCCMP believes, however, that the regulations should deal with one additional situation – where the alternative coverage available at the time of the COBRA event *then* satisfies all the COBRA requirements, and does not cost more than the prescribed amount, but may subsequently fail one of these criteria. In that situation, the NCCMP believes that plans should be permitted, if they so choose, to give a COBRA notice only at the time of the subsequent "failure," with the offered COBRA coverage running through the remainder of the COBRA period commenced by the original COBRA event.

A participant in a multiemployer plan who experiences a COBRA event due to a lack of covered hours, for example, may be entitled to free, continuing health coverage by virtue of "hours bank" credits he has built up. The plan clearly could give a COBRA notice then, advising him that he is entitled to elect COBRA coverage for $400 per month, but that all he will get for his COBRA premium is the same coverage he is entitled to receive free by virtue of his hours bank credits. Such a participant will almost surely elect the alternative coverage, even if he understands that his hours bank credits will run out before the 18 months of COBRA coverage eligibility, and the plan will then have no ongoing COBRA responsibility (at least with respect to the COBRA event in question).

What many plans would prefer in such situations, however, is to provide no COBRA notice at the time of the event, instead permitting a COBRA election if the hours bank coverage runs out before the eighteen months of COBRA eligibility the participant could have elected. Such a participant could elect COBRA coverage for the remainder of that period, and pay for COBRA coverage only for the time that he did not already have free coverage. From the plan's standpoint, a confusing COBRA notice as to which there may be only one logical choice (rejecting COBRA coverage) would not have to be sent at the time of the initial COBRA event. Moreover, if the participant returned to active employment and regular coverage under the plan before using up his entire hours bank credit, the plan would not need to provide the election at all. From the participant's standpoint, the relatively worthless COBRA election (which clearly could have been provided at the time of the COBRA event) would be replaced by an election at a time, and for a period, when he would not already have free coverage.

The NCCMP believes that such a procedure should be permissible with respect to all alternative coverage for such period as the alternative coverage provides all the benefits of the preexisting coverage and costs no more than could be charged for COBRA coverage. A rational participant would never elect COBRA coverage over such alternative coverage if eligible COBRA beneficiaries are still able to elect COBRA coverage should the conditions change, *i.e.,* the coverage runs out, becomes more expensive than COBRA coverage, or diminishes in scope (*e.g.,* ceases to cover a COBRA beneficiary).

Thus, even where the alternative coverage is not free, the NCCMP believes that the same rules should apply. Some plans allow a participant with reduced hours, consequently no longer eligible for regular coverage, to "self pay" a part of his premium.

Provided the coverage is identical to what was provided before the reduction in hours, the NCCMP believes that no COBRA election should be required until such participant's self-pay eligibility runs out or his premium exceeds the premium for COBRA coverage.

The NCCMP also wishes to comment on the regulation's "price" trigger for requiring a COBRA election in the alternative coverage context. As noted above, Q&A-7 states that a qualified beneficiary eligible for alternative coverage must be offered the option of COBRA coverage if the plan charges more for the alternative coverage than it would charge to *similarly situated nonCOBRA beneficiaries*. We submit that this is not the appropriate standard. Rather, the alternative coverage should be treated as automatically satisfying a plan's COBRA obligations if the charge is less than what the plan would otherwise charge a COBRA qualified beneficiary, even if it is more than what active employees pay. Most multiemployer plans do not require out-of-pocket employee contributions for active workers' coverage, but many offer generous self-pay options for those whose covered service falls short of the plan's eligibility standards. Thus, a $75 monthly self-pay option may be more than the $0 an active worker must pay, but considerably less than the $400 monthly cost of COBRA coverage. As it now stands, the regulation would apparently require opportunity for a COBRA election in such situations. The notion that this is a real choice is so counterintuitive that it may be unsettling to those to whom it is presented. For those forced to communicate these two alternatives, it does not inspire confidence in the rationality of the regulations generally.

VI. Mid-Year COBRA Payment Changes.

The final regulations provide that during a determination period a plan can increase the COBRA payments made by a qualified beneficiary in only three cases: (i) where the plan has previously charged less than the maximum (102% of the applicable premium) and the increase is to an amount less than that maximum,
(ii) when the increase occurs as a result of the disability extension period, and
(iii) when the qualified beneficiary changes the coverage being received. Based at least partly on prior, public forum discussions, many in the benefits community believed that COBRA premiums could also be adjusted to reflect an increase in premiums by an HMO or insurer during a determination period, or the addition of a benefit by a self-insured fund that results in higher costs. The NCCMP suggests that the regulations address this point explicitly, hopefully to clarify that mid-year increases in costs due to higher premiums or benefit improvements may in fact be passed on to the COBRA qualified beneficiary.

VII. Providing Coverage to Qualified Beneficiaries Who Move Out of the Area.

The final regulations modify the obligation of the employer to provide COBRA continuation coverage to a qualified beneficiary that moves outside the area served by a region-specific plan. The 1987 proposed regulations required the employer to provide coverage if the employer had employees in the area to which the qualified beneficiary was moving. The final regulations eliminate this condition, and instead require the

employer or employee organization (or multiemployer plan) to permit COBRA qualified beneficiaries to elect alternative coverage that is available to other employees, and that "can be extended" to the area in question. Treas. Reg. § 54.4980B-5, Q&A 4(b). We are concerned with how this regulation might be interpreted, and request clarification.

In many cases, multiemployer plans offer a region-specific HMO and an indemnity option. The regulation could conceivably be interpreted to require offering the indemnity option to any qualified beneficiary who moves out of the HMO region-specific area, regardless of the administrative and dollar costs to the plan in doing so. We do not believe that the regulation's phrase, "that can be extended," should be interpreted to mean "regardless of the cost and difficulty," but the phrase currently has no explicit qualification in this regard.

Although indemnity plans do not contract for services on a regional basis in the same manner as HMOs, they are often administered on a region-specific basis. A regionally based plan may contract for services such as fee schedules, fraud-detection services, subrogation, and claims administration on a regional basis. Such a plan may incur significant additional expenses if forced to extend services to a participant or beneficiary who lives in a different region. It might, for example, have to purchase different fee schedules, undertake more extensive review of claims, and perhaps contract with a plan administrator in the new region in order to effectively process the participant's claims.

Similarly, many multiemployer plans contract with a national insurer or HMO to provide coverage in the geographic area serviced by the plan. The plan pays a specific rate to the insurer, PPO or HMO for use of its network. For example, a multiemployer plan that provides benefits to employees residing in New York, New Jersey, and Connecticut may contract with a PPO network to provide coverage to employees in these areas. The PPO could have networks available outside these three states, but charge a substantial additional fee to make that network available to the plan's participants and beneficiaries. The regulations could be interpreted to require that the plan be made available to COBRA qualified beneficiaries, even if the extension of the additional network would (1) cost more money and (2) make available network options that are not available to active employees.

Consequently, we believe the regulations should state that a plan (at least a multiemployer plan) is not required to make out-of-region coverage available to a COBRA qualified beneficiary if it would require the plan to incur additional, extraordinary costs, *e.g.,* an additional fee for network coverage, and would make out-of-region coverage available to the COBRA qualified beneficiary that is not currently provided to nonCOBRA beneficiaries.

VIII. Confirmation of Coverage.

The final regulations provide, at § 54.4980B-6, Q&A-3(b) and §54.4980B-8, Q&A-5, that health care providers making inquiry about coverage must be given a "complete response" about the qualified beneficiary's COBRA continuation rights. The NCCMP concurs in this admonition insofar as it requires a plan sponsor to respond completely regarding such information as it may have. (We believe that was essentially the holding of the *Nynex* decision discussed in the preamble to the final regulations.) Multiemployer plans, however, frequently receive relevant information well after such information is received by the sponsors of single employer plans. Quite apart from COBRA eligibility, multiemployer plans may have to qualify their responses to coverage inquiries because they do not yet have the information necessary to conclude that the beneficiary has coverage for the period in question. The statute itself contains no requirement of confirming coverage, and we are opposed to any purported regulatory requirement to provide more information than the plan actually has.

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The NCCMP appreciates the opportunity to submit comments regarding COBRA continuation coverage, and we look forward to presenting testimony at the hearing in June of 1999.

If you have questions or need additional information, please contact Lori Wyatt at (202) 737-315 or e-mail: nccmp@compuserve.com.