

**Comments of
The National Coordinating Committee for Multiemployer Plans
to the
United States Department of Labor
Pension and Welfare Benefits Administration
on
Proposed Amendments to ERISA Claims Procedure Regulations
and Summary Plan Description Requirements**

December 9, 1998

The National Coordinating Committee for Multiemployer Plans (the NCCMP) submits these comments in response to the notice of proposed rulemaking published in the Federal Register on September 9, 1998, regarding proposed amendments to the ERISA claims procedure (63 Fed. Reg. 48390) (the Proposal). Also included is a comment on the proposed amendments to the Summary Plan Description regulations, published in the same issue of the Federal Register (63 Fed. Reg. 48376).

The NCCMP is the only national organization devoted exclusively to protecting the interests of the more than nine 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.

CLAIM AND APPEALS PROCEDURES

The unsolicited reaction to the Proposal from those working with multiemployer plans around the country who have gotten in touch with the NCCMP has been unusually intense. These comments provided by representatives of the NCCMP affiliates and other multiemployer plans relate to the anticipated impact the proposed changes in the claims/appeals regulation would have on multiemployer benefit plans.

I. Background: Special features of multiemployer plans.

Multiemployer plan benefit packages are, typically, designed by the plans trustees, rather than negotiated by the employers and union and set out in the collective bargaining agreement (CBA) itself. Large national or regional funds that cover a broad array of groups often offer a menu of benefit packages corresponding to stated contribution rates, so that local bargainers know in advance what a contribution increase will provide.

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

A. Health plan delivery structures.

Multiemployer plans have a long tradition of self-insuring for benefits. Insurance, managed care organizations and other intermediaries are also used to provide benefits when that is cost-effective and acceptable to the participants. The types of health plans offered by multiemployer health funds can be divided into four general categories:

**Traditional fee-for-service/indemnity plans
Preferred provider organization plans or networks (PPO)
Point-of-service plans (POS)
Health maintenance organization plans (HMO)**

By contrast with single employer plans, in multiemployer health funds, traditional plans and PPO plans still predominate. By providing a PPO or traditional plan, multiemployer health funds can retain control over the types of benefits provided, the amount of coverage, eligibility rules, and claims and appeals rules. Traditional fee-for-service and PPO plans often include some cost-containment features (such as utilization review and demand management).

Multiemployer funds with PPO plans purchase access to a network of providers and health care facilities that have agreed to treat plan participants at a discounted rate. The PPO does not generally have anything to do with the participants= access to care. It merely enables the plan to control its costs by virtue of the discounted arrangement. Participants may be directed to network providers, typically through the imposition of lower co-pays and deductibles, but their use of health care is not screened in advance.

Multiemployer plans with traditional self-insured indemnity health plans pay for benefits based on the allowable charge for each treatment or procedure. The health plan will set the allowable charge based on a schedule of charges it develops or purchases from an expert source. Multiemployer plans that provide indemnity benefits do not have prior access to information regarding the services that a participant will be receiving from a health care professional.

Some multiemployer plans offer managed care approaches such as HMOs and POS plans as options. However, it is still unusual to see them as the only or primary coverage format in a multiemployer plan in most parts of the country. When benefits are provided through HMOs and insurance companies, the state regulatory agency or law may set the ground rules for the first level claims procedure.

**Comments on Proposed Amendments to ERISA Claims
Procedure Regulations and Summary Plan Description Requirements**

Finally, multiemployer funds generally provide prescription drug benefits. These benefits are most frequently offered as part of a fee-for-service plan, PPO, or free-standing/carve-out plan, as opposed to being provided through an HMO.

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

B. Managed care and multiemployer plans.

The regulations presume that cost-management techniques are preventing participants and beneficiaries from accessing care. This is not the case with multiemployer plans.

Multiemployer funds do employ managed care methods to help control costs and assure that care is provided in the most effective manner. However, multiemployer funds generally use a far less intrusive kind of managed care than the HMO model that prompted many of the concerns expressed in the proposed regulation.

Multiemployer health funds with traditional and PPO plans commonly use the following cost-management features: case management, hospital precertification, concurrent review, second surgical opinion (either voluntary or mandatory) and outpatient utilization review.

In many multiemployer funds, there is no penalty associated with failing to use a managed care option. For example, case management and hospital precertification are often voluntary. In the alternative, a higher copay may be assessed for failure to obtain preauthorization.

C. Other benefits provided by multiemployer welfare funds.

Most multiemployer funds that provide health coverage also provide other types of welfare benefits, such as life insurance, short-term disability benefits, AD&D, etc. As part of a total package of benefits, multiemployer funds meet employees' needs for long-term disability income by providing an early unreduced pension through the multiemployer pension plan to qualified beneficiaries. Ordinarily, an employer's welfare fund contributions entitle its employees to the whole package of benefits, although modular options -- with or without group term life, for example -- may be available on some of the larger funds' benefit menus.

II. Principal Concerns.

Our principal concerns with respect to the regulation are the following:

The net added protections for participants and beneficiaries that the Proposal may achieve must be balanced against the increased costs to multiemployer plans.

The issues need more study and comment, to identify and deal with unintended consequences.

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

As currently structured, the Proposal is not workable, for a number of reasons discussed below.

A. The added protections for participants and beneficiaries that the Proposal may achieve need to be balanced against the increased costs to multiemployer plans.

We applaud and share the Department's objective of ensuring that benefit claims are fairly and expeditiously resolved. The function of an employee benefit plan is to get people the benefits that are their due. Multiemployer plans' trustees are especially focused on making sure their plans' participants and beneficiaries are treated fairly and respectfully, and that they understand that those operating the plan care about them as people. As elected union leaders and as employer officials who work with and know the plan participants on a personal basis, multiemployer plan trustees are directly accountable to the participants.

It is our understanding that disputes over multiemployer health plan coverage decisions are extremely rare. Experience indicates that the very great majority of multiemployer plan participants and their dependents are getting the care they need and want, with support, not interference, from their health funds.

¹Employer trustees on multiemployer funds are typically either small business owners who work side by side with their union employees (e.g., construction contractors) or labor relations officials at the employer corporations.

²There is little participant litigation against multiemployer health funds, but the few suits that are brought almost always relate either to eligibility determinations or to contests over the extent to which the plan, which has advanced the costs of treating a participant or family member injured by a third party, is entitled to reimbursement when the individual later recovers from that third party.

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

Nevertheless, the Proposal embodies a massive new mandate that will impose significant costs on multiemployer plans. Consequently, it is important that the final rules strike a careful balance between costs and administrative burden on plans and the need of participants and beneficiaries to have access to a fair and complete review of benefit claims.

While we understand and support the goals of the proposed regulation, we believe that it needs to be modified in order to be workable in the multiemployer plan context.

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

1. The Proposal would lead to costs unanticipated by the Department=s financial analysis.

The Proposal would lead to the imposition of costs on employee benefit plans that are not anticipated by the Department in its cost analysis. These costs will be discussed in detail in the following sections. Among the costs apparently not considered are the following:

Increased charges from service providers that would now need to be named as fiduciaries;

Increased fiduciary liability insurance premiums for adding additional named fiduciaries to the policy;

Assorted costs associated with the establishment of new policies and procedures for claims and appeals;

Start-up fees for revision of policies and procedures by service providers;

Significant increases in staffing to respond to new deadlines;

Revision of plan documents and SPDs;

Revision of contracts between service providers and plans;

Revision of computer systems to monitor and process claims and appeals under the revised rules;

Extra costs entailed in negotiating with state-licensed vendors to modify procedures and systems to meet more stringent ERISA requirements;

Increase in litigation due to shortening of the consideration and time of the appeal process.

Taken separately, some of these added expenses will not be overwhelming for most plans, and might be justified if they clearly purchased additional fairness for plan participants. Added up, the financial drain could be substantial for many multiemployer plans, particularly the smaller ones with limited administrative capability.

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

In non-bargained or single employer situations, it is not uncommon for that kind of cost and administrative pressure to lead the employer to give up the plan, or to buy less expensive, less expansive coverage. In multiemployer cases, the outright abandonment of health coverage or across-the-board benefit cuts are very unlikely. Instead, to find the money to pay the increased administrative costs trustees take such measures as tightening eligibility rules, increasing deductibles, adding more management of care than they have been comfortable with, and cutting back on coverages that the majority of active covered employees do not typically use. An alternative is to negotiate higher health fund contributions, which, given a relatively fixed compensation package, may be available only at the cost of lower pension contributions or wages.

What is clear is that the cumulative cost of revamping multiemployer plan operations to accommodate the Proposal will be borne, one way or the other, by the participants and beneficiaries. That argues poignantly, we submit, for taking great care to be sure the new rules will represent a net gain for them before the new costs are imposed.

B. The issues addressed in the Proposal need more careful study, and private sector input, to identify and deal with unintended consequences.

The Preamble states that since adoption of the current ERISA claims regulations, the growth of managed care delivery systems has largely transformed the relationship between patient and health care provider. The proposal defines Amanaged care delivery systems@ as Aany measures taken by medical practitioners, groups of which medical practitioners are part, insurers, or group health plans to control costs by limiting access to medical services.@

The Department then concludes that within managed care delivery systems, the separation between decisions on plan coverage and medical care has been substantially eroded. The Department states that a decision to deny coverage for an expensive medical procedure in effect denies that procedure to a participant who cannot afford to pay for the procedure on their own.

In fact, the Proposal is based on a premise that is not applicable to most multiemployer plans. Most multiemployer funds do not have a structure in place under which a denial of a benefit claim is directly equivalent to a denial of care. They may use managed care, but not in the same manner as a typical HMO. To the extent that a managed care delivery system is in place, state laws typically set standards for handling enrollees claims and appeals.

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

We urge the Department to consider a more targeted approach that can address the perceived ills of the existing claims procedures in the context in which they arise, but does not impair the effectiveness of multiemployer plans.

In addition, the proposal, as currently written, goes far beyond industry practice, state laws, Medicare+Choice regulations, proposed legislation, and the recommendations of the Presidents Advisory Commission on Consumer Protection and Quality in the Health Care Industry. A change this radical needs far more analysis and justification.

The proposed rules could have serious unforeseen consequences for the health, disability, and pension benefits of the millions of workers covered by multiemployer plans and their families. For example, the proposed rules could have the anomalous result of increasing the number of benefit denials, if appeals are left to professionals rather than addressed by plan trustees. Conversely, if plans approve benefit payments solely to avoid litigation when they make a mistake in the claims-handling process, the regulations could inappropriately increase payments to health care providers, thus driving up the cost of health care.

Moreover, while one of the stated goals of the Proposal is to promote consistency with other systems, its standards are more stringent than those called for or set by any of the following: the President=s Commission; the Medicare+Choice program; the Federal Employees Health Benefit Program (FEHBP); recent patients= rights legislation, including last year=s HR 4250; most state legislation regulating insurance

³ Under the Medicare+Choice system, Medicare managed care plans must have a grievance procedure for making determinations regarding whether an enrollee is entitled to receive services and the amount the individual is required to pay for such services. The time for reconsideration may not be greater than 60 days. Reconsideration of coverage determinations regarding medical necessity must be made by a physician with expertise in the field of medicine that relates to the condition necessitating treatment. However, the physician is not required to be independent.

Plans are required to have an expedited review process in cases where the normal time frame for making a determination or reconsideration could seriously jeopardize the life or health of the enrollee or the enrollees ability to regain maximum function. However, expedited review is only mandated if the beneficiary or his or her physician requests it. Expedited determinations and reconsideration must be made not later than 72 hours after the request for expedited review.

Several items are striking about the Medicare requirements. First, they apply only to Medicare managed care plans, not to the traditional fee-for-service payments made through Medicare Part A and B. Second, the expedited review process is triggered by a request for expedited review by the beneficiary or his or her physician -- the carrier is not required to sort the requests to identify those entitled to expedited review. Third, although independent review is required, it is not required during the plans appeal process, but is a statutory feature of the Medicare program that is conducted after the plan has made its decision on appeal. HCFA contracts with the independent outside entity to review denials.

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

company and HMO claims and appeals procedures; and the more stringent industry practices. In many cases, the proposed ERISA regulation combines the most inflexible aspects of these programs. The result: a regime that is not practicable, even if it were desirable. Many of these other systems were the result of careful study and private-sector consultation before they were implemented or recommended, and were tailored with flexibility in mind. Neither appears to be the case with the ERISA proposal.

In sum, the Proposal is not targeted to the problems it hopes to correct, and it extends beyond what the federal government is doing for its own employees, what public health programs are doing for their beneficiaries and what states are calling on insurance companies and HMOs to do for their enrollees. We recommend that these variances be studied to determine with clarity the justification for the extra demands that the Proposal would impose on ERISA plans, particularly multiemployer funds.

C. Concerns regarding the workability of the proposal.

1. The proposed regulation would increase confusion between the claims procedures under ERISA and state-law rules.

Multiemployer plans would have to follow the ERISA claims and appeals rules, whether they are self-insured, insured, or provide benefits through a managed care program. Multiemployer plans are often self-administered, run by fund-office employees. In other cases, they purchase administrative services from a variety of

⁴ The President's Commission found that states traditionally regulate the benefit structure, solvency, rates, and claims process of indemnity insurance companies doing business in the state. In addition, all 50 states have laws licensing or governing HMOs doing business in the state. HMO laws are separate from the insurance regulations.

All 50 states require HMOs to establish consumer grievance and appeals processes in order to obtain a certificate of authority to operate in the state. Not all 50 states set their standards at the same levels, however. Many state HMO laws are based on the model HMO law drafted by the National Association of Insurance Commissioners (NAIC), which requires HMOs to establish complaint procedures approved by the state regulators. The President's Commission estimates that 30 states have some specified complaint procedures that HMOs must follow and at least seven states require an expedited appeal for denials of urgently needed care.

The NAIC model HMO law requires plans to establish a first and second level grievance review process. It also requires an expedited review process where the time frame of the standard grievance procedures would seriously jeopardize the life or health of a covered person or would jeopardize the covered persons ability to regain maximum function. Under the NAIC model law, expedited reviews must be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. However, it does not require independence of the clinical peer.

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

service providers, including third-party administrators (TPAs), insurance companies (perhaps even acting as TPAs), and HMOs. At least some of these service providers may believe that state law governs their operations. Under the Proposal, ERISA rules for claims and appeals processing would often conflict with state rules. Consequently, health funds administered through a TPA, insurer, or HMO may have difficulty implementing the proposed regulations.

If the Proposal were adopted in its current form, ERISA health plans, whether insured or self-insured, would have to work with their vendors to get them to revise their claims and appeals procedures accordingly. Vendors will want start up fees to cover the costs of implementing the new procedures. To the extent that the vendor will need additional staff or other resources (to respond to benefit requests within five days, consider expedited urgent claims, etc.) on an ongoing basis, plans will be asked to pay higher ongoing fees to cover these costs.

Plans that are self-administered would, of course, incur the start-up and continuing costs directly. Indeed, some multiemployer plans may have to sacrifice self-administration and the personalized service that it offers participants, if, on their own, they are not large enough to absorb these and related new administrative costs.

- 2. Permitting only one level of mandatory appeal could degrade the quality of claims processing and would make it impractical for trustees to consider appeals, thus depriving participants of a critical opportunity for input and feedback regarding the operation and coverage of the plan. _____**

The Proposal would prohibit a plan from requiring a claimant to go through more than one level of appeal after the initial claim denial before the claimant can go to court. The Department requests comments on whether limiting the number of appeals or precluding mandatory arbitration before filing suit is necessary or sufficiently beneficial to prevent delays or unfairness in making and reviewing benefit claims.

A multiemployer plan=s board of trustees does not generally review an appeal before the plan=s professional administrator has analyzed it. A primary function of professional administration (whether in-house or under contract with a TPA, insurance company or HMO) is to review claims dispositions when requested by participants, correct those that are erroneous under established guidelines, and, for other cases, prepare the appeal for the trustees consideration including attaching an explanation of the reason for the denial and any plan documents and medical reports on which the administrator relied. The Proposal appears to prohibit this two-step review process. Instead, appeals would either be decided by the professional administrator (with no appeal to the board of trustees) or by the board of trustees

(without review by the administrator). Either result is unsatisfactory because it

**Comments on Proposed Amendments to ERISA Claims
Procedure Regulations and Summary Plan Description Requirements**

decreases the quality of the consideration given to the participant=s or beneficiary=s claim.

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

We suggest that plans should be allowed to adopt or continue a two-step process for addressing a disputed claim: (1) a reconsideration, which would ordinarily be handled at the vendor or administrator level and (2) a formal appeal, following reconsideration, to a named fiduciary. The ERISA formalities would attach at the appeal level, and only when that completed would the participant have exhausted his or her remedies and be allowed to go to court. We believe the added quality of the extra internal consideration will, in the great majority of cases, lead to final resolution of the issues much more quickly than would a more cursory review followed by litigation. Plan sponsors or contract administrators that prefer a single level of review would not be required to include reconsideration in their procedures.

a. Trustee involvement in plan administration would be discouraged by the proposed regulation.

An essential reason to permit the plan to establish an additional appeal level is the fact that many plan sponsors, including multiemployer trustees, want to be involved in the appeal process. Under the Proposal, appeal decisions would, by necessity, have to be delegated to professional plan administrators, including TPAs, HMOs, and insurers, in most cases. These administrators will deny the claimant's request for health care benefits if the plan document says to deny it. For multiemployer plans, neither an in-house nor a contract administrator has the authority to amend the plan document. Only the board of trustees may change the benefit provisions.

In many cases, claims that have been denied involve requests for benefits that are uncommon or involve a new medical procedure. If the board of trustees can consider these questions, they may wish to amend the plan document to provide for payment of the benefit. In addition, the board of trustees may use the appeal process to identify inadequate plan terms or practices and correct them. In the course of considering appeals trustees are presented with a wealth of human detail that illuminates needs and leads to plan changes. This will not occur with only one level of mandatory appeal.

b. Useful participant feedback would be inhibited.

In its economic impact analysis, the Department states that effective claims procedures can also improve health care and health plan quality by serving as a communication channel, providing feedback from participants, beneficiaries and providers to plans about quality issues. 63 Fed. Reg. 48400. We agree with this statement. However, under the proposed rules, this kind of collaborative interchange cannot occur.

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

The important feedback regarding quality of the plan, the providers, and the type of benefits provided by the health plan must go to the plan decision makers for review and action. In the case of a multiemployer plan, the decision makers are the trustees.

Under the proposed system, the comments regarding plan quality issues would go only to the first level reviewer. Due to the time constraints imposed by the regulation, only the first level reviewer will be able to hear these comments. However, in most cases, the first level reviewer will *not* be in a position to correct an erroneous past practice, clarify unintended interpretations, or even change plan language to protect participants and beneficiaries.

For example, a multiemployer plan may contract with a third party to process claims and review appeals. The plan may also have a preferred provider network (PPO), a utilization review provider, and an HMO. For the HMO, the appeals decision maker may be the HMO itself. Under the current structure, the TPA, the PPO, the UR provider, or the HMO may determine the claims and perhaps first level of appeal. However, in all cases the board of trustees makes the final decision on review. This is the level at which questions regarding the quality of the services provided to the individual, the quality of the plan=s review and the individual=s particular medical needs can be given effective consideration. This is also the level at which consistency in interpretation among the plan=s various modes of benefit delivery can best be monitored and enforced.

The plan=s contracted vendors are not necessarily going to alert the multiemployer plan trustees as to problems in their systems, or even in the design of the plan itself. That is something the trustees may have to learn from the participant or beneficiary whose appeal they have the chance to hear and consider. The need for a searching reconsideration of a plan feature, or for an inquiry into a particular vendors claims-handling methods, is much less likely to come to light if, because of the practical impediments to direct participation, the trustees are relegated to a passive role, reviewing a list of the professionals= determinations after-the-fact.

c. The quality of claims-handling could be undermined.

The great majority of health plan claims in indemnity-type plans are processed and paid by relatively low-level staff, operating within precisely established protocols that permit little or no exercise of discretion. New claims adjudication software is making it possible, in fact, for intake and first-level response to be handled by computer, with no human intervention. Except for audits and other quality assurance procedures, people authorized to exercise judgment do not enter the process until and unless a claimant requests review. At that point, many of the problems are handled by correcting errors in the diagnostic code entered by the provider or in other fairly direct

ways. Under the proposal, this first-level claims review would be the only level of

**Comments on Proposed Amendments to ERISA Claims
Procedure Regulations and Summary Plan Description Requirements**

review that a plan could require a claimant to pursue before going to court. We submit that the inadequacy of such a process is self-evident.

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

3. Delegation of fiduciary duty may increase costs.

Final review of a participant=s claim must be by an appropriate named fiduciary. Our experience is that TPAs, HMOs and insurance companies are either reluctant to accept fiduciary status on participant claims or charge extra for doing so. Due to the short time limits and the fact that there could be only one level of appeal under the proposal, vendors will have to make the final decisions in many more cases than at present, and thus will have to become named fiduciaries. This is another instance of additional plan administration cost.

4. Taft-Hartley exemption.

The Proposal would eliminate the right of multiemployer trustees to decide all health and disability appeals at regular quarterly meetings.

The Department may have assumed that trustees would just meet more often, perhaps through subcommittees, to hear and decide appeals within the shortened time limits. However, given the cost and disruption of travel solely for this purpose, it would not be practical to continue in-person meetings, except perhaps for small local plans. Whether conference call meetings are adequate substitutes is an open question. However, even getting together on a regular basis by phone to consider appeals could be problematic under the currently proposed 30-day decision deadline.

At least for multiemployer plans where the final decision maker is the board of trustees or some subset of them, the 30-day deadline should be revised to permit appeals to be considered at regularly-scheduled monthly meetings, with the decisions be sent out, in final form, within 3 - 5 business days after that. This would enable the trustees to establish fixed dates and times for conference-call meetings well in advance, and give the plans= professionals an opportunity to write up the trustees= decisions, and circulate them for review in appropriate cases, following each meeting.

5. The proposed changes will necessitate significant revision to plans= contracts with administrators and other service providers. _____

The Proposal would necessitate revision of all contracts between multiemployer health plans and service providers who are in any way involved in the design and administration of claims, and will likely result in significant fee increases. Plan service providers will charge additional fees both for administering a more

complicated claims and appeals system and to assume additional fiduciary

**Comments on Proposed Amendments to ERISA Claims
Procedure Regulations and Summary Plan Description Requirements**

responsibility. In addition, plans may see increased costs in their fiduciary liability insurance premiums, for adding additional named fiduciaries to the policy.

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

Amendments will be required for plan documents and summary plan descriptions, and new procedures will have to be designed and installed, all at a cost for development, document preparation and administrative staff training. To the extent that these procedures have consequences for the arrangements between plans and their service providers, further contract amendments and negotiations with the vendors will be needed.

The various contract changes could open a Pandora's box of liability and indemnification issues.

6. The systems changes necessitated by the Proposal should be coordinated with other looming demands on multiemployer health plan systems.

Ultimately, most multiemployer plans or plan administrators will need significant systems work in order to conform to the procedures and to document their compliance. Presumably it may be possible, with sophisticated enough programs and powerful enough computers, to identify urgent claims, track progress against deadlines, link documentation to decisions, generate and mail appropriate and timely notices, etc. Major insurance companies and HMOs may already have such systems, or may have them under development for business reasons in any event. Few multiemployer plans are in that position.

In fact, many multiemployer plans *and the service-providers most active in the multiemployer market* are already having difficulty finding vendors to help them through the current Year 2000 crisis. Waiting right after that, with an anticipated 2001 implementation target, are the uniform Electronic Data Interchange standards for health plans, proposed this past spring by the Health Care Financing Administration (HCFA). Whatever the fairness or wisdom of additional procedural demands, the systems challenges may be insuperable for many multiemployer plans.

7. Independent medical review would be difficult to administer and would increase plan costs.

The Proposed regulations would provide that, in deciding appeals of any adverse benefit determination involving a medical judgment, the fiduciary decision maker must consult with a physician or other licensed health care professional who has appropriate training and experience in the relevant field of medicine. Appeals involving a medical judgment would include determinations about whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, as well as, perhaps, the classification of

treatments or conditions as mental or physical Health care professionals consulted

**Comments on Proposed Amendments to ERISA Claims
Procedure Regulations and Summary Plan Description Requirements**

for an appeal must be independent of any health care professional who participated in the initial adverse benefit determination.

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

This provision will increase plan costs, and could make it difficult to comply with the new deadlines. Also, its ambiguity will stimulate litigation over the process, a wasteful enterprise from any perspective.

- a. Qualified medical input should be required.

The NCCMP agrees that claims appeals raising medical issues deserve the review and input of qualified medical professionals. However, we believe that the proposed requirement that this review be by a health care professional who is independent of any health care professional who participated in the initial determination goes beyond the bounds of practicality and beyond what is needed for fairness. Instead, to assure that appeals are considered by appropriate disinterested professionals, we suggest that the regulation require that the review be performed by a qualified medical professional who is neither the person who made the initial decision nor a subordinate of that person.

- b. Independent is an inappropriate standard because it is too broad and would expose plans to litigation.**

The use of the term independent, particularly with no definition, will throw the question into the courts at least as often as it helps resolve clinical issues. Currently, medical reviews are performed in many circumstances. For example, many multiemployer plans retain a TPA to process claims and prepare materials necessary present appeals to the board of trustees for a decision. The TPA's medical director (or the plan's contracted utilization review company, insurer, or HMO's medical director) often provides the board of trustees with an expert opinion regarding the medical condition that is the subject of the claim. The ultimate regulation should validate these mechanisms for obtaining medical input.

Without clarification of this type, the benefits community would have no support in deciding such questions as: is the plan's medical director who advises on the claim barred from advising on the appeal? If the medical director's employee advises on the claim, is the medical director barred? If the plan uses a company/consultant, is the supervisor of the employee who initially passed on the claim, or a member of a medical panel employed or retained by the same company, barred?

Indeed, would any medical consultant hired by the plan be independent for these purposes? How often could the plan retain an individual physician before she is no longer independent? If a medical reviewer is later determined by a court not to be sufficiently independent, does that authorize reopening of all prior appeals in which

**Comments on Proposed Amendments to ERISA Claims
Procedure Regulations and Summary Plan Description Requirements**

the person or company was engaged? Or would plans have to use medical reviewers designated, in each instance, by claimants?

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

Our suggestion: enable plans to use qualified medical professionals who are, or work for, the plan's medical director or the medical professionals used by their outside vendors, to decide on claims and to advise on appeals, as long as the appeals advisor is not the subordinate of the person who made the initial decision. As fiduciaries, the trustees have a duty to engage qualified advisors who will assure that fair consideration is given to claims on appeal.

c. External review should not be mandated in a regulation. _____

We infer that the Department is attempting to combine two principles: medical judgments at the plan level should be made by medical professionals and ultimate review should be by an external, an independent professional entity. This type of independent review may work if an external board that is established by law and publicly monitored (such as in the Medicare system). Indeed, this is the type of external review contemplated by the President's Commission. However, a mandate for external review requires legislation. The Proposal's attempt to blend the two by requiring that independent review be conducted inside the health plan is not an effective substitute.

8. Definition of claim.

Under the proposed rule, a **claim** is a request for a plan benefit(s), made by a claimant or his or her representative that complies with a plan's claims procedure. Plans have always treated applications for *payment* of benefits as claims. Now, "claims" will also include a request for a coverage determination (e.g., whether the participant or beneficiary is covered under the plan), a request for preauthorization or approval of a plan benefit, and/or a request for a utilization review determination.

a. Coverage v. eligibility determination.

Regardless of the specifics of multiemployer health plan eligibility rules, virtually all of the plans share one administrative characteristic. The beginning and end of an employee's multiemployer plan health coverage are both determined *retrospectively*. Until a plan has received the employer contributions and reports on employees covered service for a period, it cannot determine who has established or lost eligibility during that period.

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

Since the deadline for these employer filings may be ten days to a month after the close of the reporting period, a family's health coverage may be in effect before either the employee or the plan knows about it. To mitigate this, some plans build a delay, or lag period, into their eligibility rules so that coverage does not start until a month or two after the period in which the person earned enough service to become eligible. For example, if the measuring period is the calendar quarter and there is a one-month lag period, someone who first meets the eligibility test in the quarter ending March 31 will have coverage starting May 1. In addition, it is common for plans to append claims received on behalf of people whose eligibility has not yet been confirmed.

Due to the retrospective nature of eligibility in multiemployer plans, it may be difficult to resolve a request for an eligibility determination within the time frames established for health claims. Consequently, we recommend that the ultimate regulation authorize a narrow exception for multiemployer plan claims and appeals that raise eligibility questions, allowing up to 45 days to resolve the question if the information is not readily available to them before that. To speed up the process, participants could submit data confirming their eligibility before it would become accessible through the plan's ordinary procedures.

b. Medical exigencies should be defined.

The proposed regulation would require multiemployer plans to evaluate the medical exigencies of a situation when determining how quickly a response is necessary. If this term is used, it should be defined.

9. The plan should be able to dispute a physician's opinion that a claim is urgent.

An ERISA plan should be able to dispute a physician's contention that a claim is urgent. A physician may state that a claim is urgent, in an attempt to circumvent the plan's utilization review process. For example, a chiropractor may claim that, in his or her opinion, the claimant would suffer severe pain that could not be adequately

⁵ **Urgent care**, under the Proposal, would be any claim for medical care or treatment that could not be decided under the normal time frames because delay could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If a physician with knowledge of the claimant's medical condition determines that the claim meets either urgent care standard, the plan would be bound by the physician's decision. Otherwise, whether a claim is urgent would be decided by an individual acting on behalf of the plan applying the judgment of a reasonable individual who is not a trained health professional.

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

managed without chiropractic care of a type that would entitle the practitioner to a special payment level. This bare, self-serving statement should not be enough to compel the plan to short-circuit its normal procedures.

We do not dispute the need for swift action when a decision by the plan is necessary for the patient to receive needed urgent attention. Rather, we suggest that plans should not be compelled to defer to the participant=s health care professional in every instance, regardless of the reasonableness of the assertion or the circumstances in which it is made.

10. The Department should include the *access* standard for an urgent care claim in regulation, not just in the preamble _____

The Preamble to the proposed regulation states that urgent care means claims for *access to services*, as opposed to after-the-fact *payment for services*. We suggest that the Department make clear in the regulation itself that a claim involving urgent care refers only to claims where the plan=s decision will, by its nature, control the individual=s *access to services*.

As the drafters of the Preamble recognized, there is no need to treat a claim as urgent and move it to the front of the line for appeals when services have already been rendered, or would be rendered regardless of the plan=s determination. As neither the Code of Federal Regulations nor most commercial publications collecting ERISA regulations publish the Preamble, this principle belongs in the text of the regulation itself.

11. Indemnity claims should be excluded from the urgent care category.

⁶In multiemployer plans, experience suggests that differences of opinion over the urgency of a procedure are most likely when the practitioner is particularly entrepreneurial or the treatment proposed tends to be controversial, as with chiropractors, dentists specializing in TMJ, physicians with unorthodox cancer treatments and the like. These are the claims that merit especially careful attention, for the protection of the patient as well as the plan.

**Comments on Proposed Amendments to ERISA Claims
Procedure Regulations and Summary Plan Description Requirements**

We recommend that indemnity claims be excluded from the urgent care criteria. When an indemnity claim is made, the participant or beneficiary has already received the care to which he or she is entitled. Therefore, there is no need to process the claim quickly in order to assure access to care. Thus, such claims should be expressly excluded from the definition of urgent care.

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

However, we do not object to including claims for treatment of urgent conditions in the urgent category if the plan=s terms require advance approval for coverage of that treatment, even under an indemnity plan. And it would not be unreasonable to treat as urgent a provider=s request for advance confirmation that the plan will pay for an expensive procedure, if the criteria for urgency are otherwise met. The threshold above which a provider=s advance request for assurance of payment should be set fairly high, say, \$5,000 or more (indexed).

Also, it should be made clear that this does not give individual providers an *a priori* forum for contesting the plan=s payment levels and other procedures, including payment standards for out-of-network services. Rather, the ability to get an urgent advance ruling, subject to ERISA claims review formalities, on a plan=s payment decision should be aimed at giving the claimant guidance on whether he or she will be covered, under the terms of the plan, for the proposed procedure. The person=s current physician or hospital should not be encouraged to refuse care because of dissatisfaction with the level of reimbursement that the plan authorizes for that procedure. Allowing easy access to litigation, in advance, over payment levels could easily have that effect.

12. The definition of urgent care@ should be simplified.

We also note that the Department has combined the urgent care definitions from several sources, including Medicare and the NAIC model law, with the prudent layperson standard advocated by the President=s Commission and proposed health coverage legislation for payment of emergency claims by health plans.

We suggest that including the prudent layperson standard in the claims and appeals process is unworkable. In addition, it may be improperly dictating the terms under which an ERISA health plan makes benefit payment. Further, we suggest that since the definition is inconsistent with the Urgent@ standard for claims and appeals procedures in other areas, it may cause confusion and inconsistent plan administration.

⁷ The Consumer Bill of Rights and Responsibilities issued by the President=s Commission advocated that consumers have the right to access emergency health care services when and where the need arises. The Commission found that health plans should provide payment when a consumer presents to an emergency department with acute symptoms of sufficient severity, including severe pain, such that a prudent layperson@ could reasonably expect the absence of medical attention to result in placing that consumer=s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

**Comments on Proposed Amendments to ERISA Claims
Procedure Regulations and Summary Plan Description Requirements**

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

13. **Providers on their own behalf should not be allowed to contest the amount of payment through the plans claims and appeals process B this should be reserved for participants and beneficiaries.**

The Proposal would provide that a plan could not stop or limit a representative (which could include an attending physician or family member) from acting on behalf of the claimant. The regulation would eliminate the current requirement that the claimant be duly authorized by the participant. The Department indicates that an individual=s attending physician would generally be treated as a representative of a claimant. This provision has the potential to severely disrupt plan administration and increase costs.

Authorization to pursue a claim on behalf of a claimant is a significant right and responsibility. Authorization to pursue that right is important to the plan, the provider, and the participant, and the requirement of authorization should not be removed.

Currently multiemployer health plans do not permit a health care provider or facility to represent a claimant with respect to a claim or appeal unless the provider or facility is duly authorized. Duly authorized providers or facilities may represent the claimant in the plan=s internal appeal procedure. However, even if it allows a health care provider or facility to be duly authorized to act on the *participant*=s behalf, a plan might not permit participants to assign their benefit claims to providers, in general or in specific circumstances. Thus a provider may not be permitted to sue the health plan directly to recover its charges for health care provided to the plan participant or beneficiary.

- a. **Typically, the duly authorized requirement is easily satisfied.**

Becoming duly authorized is not ordinarily a significant barrier to a participant or beneficiary pursuing a claim or appeal under a multiemployer plan. In general, the only requirement to become duly authorized is that a claimant sign a form informing the plan administrator that a specific individual or facility is authorized to discuss the claimant=s right with the plan, to receive individually identifiable health care information from the plan, and to provide the plan with all information necessary to complete the claim.

In fact, we support issuing standards for what duly authorized means, to assure that the standard does not become a hurdle for plan participants and beneficiaries. This could include specific instances when a provider is deemed to be authorized, without completion of the standard documentation, if the patient is unconscious and

**Comments on Proposed Amendments to ERISA Claims
Procedure Regulations and Summary Plan Description Requirements**

unaccompanied by a family member or someone else in a position to approve the provider=s actions on behalf of the individual.

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

b. The interests of claimant and health care provider may be inconsistent.

The health care provider should not automatically be the patient's representative because the interests of the claimant and the health care provider or facility may be inconsistent. Consequently, the plan should not be required to recognize the provider as a representative unless the claimant has authorized the representation.

Every multiemployer plan administrator and counsel with whom we have been in contact raised this issue as one of significant concern. They discussed several problems with provider appeals. First, there may be two different providers requesting authorization for different treatment. How would the plan determine which provider is authorized to pursue the claim on behalf of the participant? For example, we have seen circumstances in which a hospital requests precertification of a hospital stay. At the same time, a physician requests authorization for treatment to be performed on an outpatient basis. The plan agrees with one provider, not the other. In that case, the participant would receive the care, but another provider would be able to pursue an appeal on the participant's behalf, without the participant's authorization.

Second, the claimant often receives all the health care requested. However, the health care provider or facility and plan may disagree with the manner in which the bills are paid. The provider may appeal the health plan payment amount, even though the participant has received the treatment and services. If the proposal regulation permits providers and facilities to appeal payment disputes, the plan will be handling a massive number of payment and contract disputes.

For another example, a plan may have a negotiated rate for payment of preferred providers in the plan's network. The contract may provide for arbitration to resolve any payment disputes between the plan and provider. The proposal would permit the provider to use the plan's appeals procedure instead of the contract's negotiated arbitration procedures.

Plans that pay based on a schedule of allowable charges (usually traditional fee-for-service/indemnity plans) often receive complaints from physicians or facilities that the plan schedule is too low. These complaints have nothing to do with whether the participant receives health care -- care has already been received. Providers often seek to appeal these charges. The Proposal would require plans to hear appeals from providers about the amount of their fee, long after the participant has received the needed health care.

**Comments on Proposed Amendments to ERISA Claims
Procedure Regulations and Summary Plan Description Requirements**

14. The new requirement that the plan acknowledge a request for benefits that is not a formal claim should be deleted or revised. _____

The Proposal creates a new rule that would apply when a claimant requests a benefit without following the plan's claims procedures. Under this rule, if a claimant (or his or her representative) makes a benefit request that fails to comply with the plan's claims procedures, the plan administrator must notify the claimant of the failure and of the procedures that must be followed. This rule applies to all ERISA plans, not just health plans.

For pension, disability, and non-urgent health care benefit requests, this notice must be given within a reasonable time period, not to exceed 5 days. For urgent care benefit requests, the notice must be provided within a reasonable time period, not to exceed 24 hours.

Under this rule, the time period is triggered when the claimant (or his or her representative) asks any one of several entities for benefits: For multiemployer plans, the entities would include the board of trustees, or any member of the board of trustees, or the organizational unit (or any employee in the unit) customarily in charge of these employee benefit matters. For plans in which the benefits are provided or administered by an insurance company, insurance service, third-party contract administrator, HMO, or similar entity, the entity is the person or organizational unit (or any employee in the unit) with the authority to preapprove, approve, or deny benefits under the plan, or any officer of the entities

15. Burden on individual trustees.

We realize that this rule closely tracks the current regulation. However, the current regulation does not impose an acknowledgment rule. Multiemployer plan trustees should not be responsible for acknowledging receipt of a claim or a request for benefits, unless the trustee is acting in an official capacity.

Most multiemployer plan trustees are not performing trustee actions during their regular jobs. They are union or employer officials who have volunteered to oversee the plan. In their capacity as a union or employer representative, they may have casual contact with union members/employees, who may mention a claim to them. It would not be appropriate to have a period for acknowledging a benefit request begin running based on a casual conversation with a trustee at the workplace. It should be adequate for the trustee to tell the individual to direct his or her claim to a representative of the plan who is responsible for handling claims.

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

a. Reduction or termination in health benefits.

If a group health plan approves a benefit or service to be provided for a specified or indefinite period of time, any reduction or termination of the benefit or service before the end of the period would be an adverse benefit determination and would trigger the notification rules for group health plans. If urgent care is involved, the plan administrator would have to provide notice of the determination *in advance* of the reduction or termination and give the claimant or the claimant=s representative time to appeal and obtain a determination on review *before* the benefit is reduced or terminated.

This provision would not apply to plan amendments or plan termination. Thus, any decisions about the amount or type of benefits provided by the plan to participants generally, rather than to an individual participant, would not be affected. Rather, this provision appears to be designed to address situations in which the plan reviews benefit determinations retrospectively . For example, if a participant obtains approval of a 5-day urgent-care hospital stay, and, upon admission, the plan determines that the participant requires only a 3-day stay, the plan administrator could have to provide notice of this determination in advance of the reduction in the approval.

This language could be read to require advance notification before a plan can correct a mistake made in approving coverage or treatment, as opposed to applying medical judgments regarding the necessity of care in particular situations.

We request clarification that a correction of a mistake, for example, in confirming the person=s coverage under the plan, is not a reduction or termination of benefits that triggers this provision. Trustees have an obligation to correct mistakes and enforce the terms of the plan document. If correction of a mistake is considered a reduction or termination of benefits that triggers a notification requirement, it may impair the ability of the trustees to make prompt correction of mistakes, and, thus, stop or prevent payments that are not authorized by the terms of the plan.

16. Access to documents.

The Proposal would allow claimants, upon request, reasonable access to and copies of all documents, records, and other information relevant to the claimant=s claim for benefits. These documents must be provided even if they were not used by the plan in deciding the claim.

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

We are concerned that the scope of the document production that must be made available during the appeal process exceeds both the scope of documents generally available under ERISA (documents that govern the plan) and the scope that would be available in litigation. For this reason, and because this would require the plan to perform a file search independent of the document review on which the claim determination was based, this definition seems exceedingly broad. We recommend that, at the review and appeal stage, the disclosure requirement be limited to documents that were considered by the decision-maker in acting on the claim.

In addition, the proposed regulation would require plans to disclose proprietary fee schedules and protocols. Trustees may not have the legal right to do so. In a court proceeding, trade secrets of this type can be protected with suitable confidentiality orders. We doubt the Department has the authority to craft and impose such protections through regulation, or that they would be enforceable by the plan against a party that misused the information. We suggest that, instead of disclosure of proprietary data, a plan be required to provide a sworn affidavit describing it with particularity sufficient to explain why and how it was dispositive and identifying the party who would have the authority to release the information. If the parties later go to court the source materials can be examined, if relevant, under protected circumstances.

17. Five-year retention and production of claims.

We oppose any requirement that a plan administrator retain and produce health claims (and all documents and records relating to the claims) for five years, categorize claims with regard to diagnosis and treatment, inform claimants who receive an adverse benefit determination that they are entitled to access and copy other participants claims in the event of litigation, and provide a statement to that effect.

In the event of litigation, the disclosure obligations of the parties should be governed by the relevant discovery rules. Requiring disclosure by the plan would ultimately result in the violation of the privacy of participants. Plans often retain such materials in electronic or other formats. Therefore, redacting to protect the privacy of the individual would not necessarily be feasible or appropriate. However, a court could insure the protection of individual participants if such document were required in the course of discovery.

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

Finally, plans have no obligation to organize benefit claims and appeals based on whether the claim involves the same diagnosis and treatment as a subsequent claim. A plan may or may not have a system for cataloging appeals. If there is one, it may be based upon the identity of the union or employer of the participant or by other demographic information. It may also be organized in accord with the plan document provisions in question, such as eligibility criteria, type of plan benefit, or type of exclusion. For example, a plan may retain copies of decisions in appeals involving the plan=s exclusion for cosmetic surgery. However, plans would not retain copies of appeals involving a diagnosis and treatment relating to cosmetic surgery because that is not the decisive factor in the appeal. Organization of these records should be left to the discretion of the board of trustees.

The trustees already have the obligation to administer the plan in accord with ERISA. Making the trustees produce copies of appeals will do nothing to assist them in administering the plan appropriately, but would add administrative costs and burdens. It also undermines the authority of the trustees previously established in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

III. Specific Considerations of Concern to Multiemployer Health and Pension Plan That Provide Disability Benefits.

Multiemployer health and pension plans both provide disability benefits. Health plans may provide AD&D and weekly disability benefits. Pension plans provide pensions based on disability.

In general, disability benefits are payable after a waiting period. For example, weekly disability benefits are payable generally after an 8 day waiting period (for illnesses). Disability pensions may have a significantly longer waiting period. Many of these claims are linked to public benefits, such as workers= compensation or social security disability.

The proposed regulations do not consider the waiting periods or other terms and conditions of disability benefits. These terms and conditions have no relation to health benefits and there is no need for uniformity with health benefits. Consequently, we urge the Department to maintain separate rules for disability benefits.

In addition, the proposed regulation is not clear as to what standards would apply to disability benefits. For example, if disability benefits are provided through a multiemployer pension plan, would the pension standards or disability standards apply? The Proposal refers to disability benefits, disability claims, and disability plans.

Comments on Proposed Amendments to ERISA Claims Procedure Regulations and Summary Plan Description Requirements

IV. Effective Date.

Multiemployer plans are financed by fixed-rate contributions negotiated with contributing employers. Those contributions pay both for benefits and for all expenses of plan administration. Recognizing this, if compliance with a statutory change will cost money or compel changes in employee benefits that may be covered by a bargaining agreement, in virtually all instances -- statutory or regulatory -- the effective date for collectively bargained plans is set at the first day of the first plan year beginning after expiration of the longest running of the current bargaining agreements. Often there is a cutoff, typically three years, after which the new rules go into effect even if one or more bargaining agreements have longer to run.

The Proposal would, as indicated, create significant costs for multiemployer health plans, and administrative challenges that could lead some plan sponsors to consider mergers or significant revisions in the nature of benefits. It would also require substantial changes in arrangements with plan vendors, as well as restructuring of plans= internal procedures. These are matters on which multiemployer plans may not be prepared to take final action without assistance or guidance through the collective bargaining process.

In the Proposal, a delayed effective date is specified for non-Taft-Hartley collectively bargained plans. It appears that the general i.e., immediate effective date would apply to Taft-Hartley plans. This is wholly inconsistent with prior legislative and regulatory practice, and puts multiemployer plan trustees in an untenable position with respect to implementation. We urge the Department to correct this in the final regulation.

V. Conclusion.

Based on the foregoing, the NCCMP strongly supports that the effort to assure timely and fair consideration and review of health plan participants claims. We also believe, however, that the consequences of individual new requirements must be thought through carefully, and, where appropriate, those requirements should be modified to avoid serious disruption of health coverage and substantial, unanticipated costs for multiemployer plans.

We urge the Department to hold public hearings on this Proposal, to explore these issues, and request the opportunity to testify at those hearings.

**Comments on Proposed Amendments to ERISA Claims
Procedure Regulations and Summary Plan Description Requirements**

SUMMARY PLAN DESCRIPTION

The proposed amendments to the Summary Plan Description regulations include an update to the standard language covering the PBGC plan termination guarantees for single employer defined benefit pension plans, in proposed revised section 2520.102-3(m)(3). An updated standard description is also needed for the PBGC=s separated benefit-guarantee program for multiemployer pension plans.

If you have any questions or would like more information on any of the above comments, please contact Robert Landau of the NCCMP=s professional staff at (202) 737-5315.