MurphyAnderson
PLLC

Washington
1701 K Street NW, Suite 210
Washington, DC 20006
202.223.2620 Fax 202.223.8651

Boston
111 Devonshire Street, 5th Floor
Boston, MA 02109
617.227.5720 Fax 617.227.5767

Cincinnati
2406 Auburn Avenue
Cincinnati, OH 45219
513.784.1280 Fax 877.748.1449

www.murphypllc.com

Reply to Washington

September 21, 2010

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

Attn: RIN 1210-AB45

Re: Comments on Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act Issued July 23, 2010, Fed. Reg. Vol. 75, No. 141

To Whom It May Concern:

I represent and work with Taft-Hartley welfare benefit funds that provide welfare benefits to tens of thousands of employees pursuant to collective bargaining agreements in the retail grocery and other industries.

I write to comment on the recently issued regulations enacting Section 2719(b) of the Patient Protection and Affordable Care Act ("the Act") relating to external review of claims. My comments relate not only to the regulations themselves, but to the Interim Procedures contained in DOL Technical Release 2010-01 ("the Technical Guidance").

1. <u>The exclusion from appeals for claims involving self-insured plans must be broadened to avoid wasting plan assets on frivolous appeals</u>.

Section 2719(b) of the Act requires all non-grandfathered, self-insured Taft-Hartley health plans, among other entities, to offer an "effective" external review process for claims denials. The external review process is to be similar to review processes that include the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners ("NAIC").

Self-insured Taft-Hartley health plans have long been subject to ERISA's existing claims procedures, which already incorporate many features similar to NAIC's consumer protections, including timing requirements that must be followed by the plan in resolving claims and appeals; the participant's access to documents and information upon which the claim decision was based; the ability to submit additional information and documents for consideration by the decision-maker; and the manner and content of the notification of the decision on appeal. *See* 29 CFR 2560.502-1(h)-(j). Thus, Taft-Hartley plans have long been providing reasonable and fair claims review processes to their participants and beneficiaries.

What is new about Section 2719(b) is that it displaces the trustees of Taft-Hartley plans as the final decision-makers on claims appeals, and instead substitutes an independent review organization (IRO) as the final decision-maker, without limiting the IRO's authority to alter the terms of the plan. The regulations implementing Section 2719(b) have been written so broadly that they encourage participants to pursue external review of even frivolous claims, thereby imposing significant costs on self-insured plans.

While it cannot be gainsaid that the Act requires that the external review process be similar to those used in the private insurance market, in drafting regulations governing the external review process to be used by self-insured health plans already covered by ERISA's claims procedures, especially Taft-Hartley health plans, the Agencies should be mindful of the differences between how these health plans operate.

As currently drafted, the regulations allow a participant to appeal any adverse claim decision other than one that relates to eligibility questions. *See* 29 CFR 2590.715-2719(d)(1). The exclusion of these claims implies that the IRO lacks authority to change the eligibility requirements for the plan, but the regulations should expressly state that the IRO lacks authority to change *any* terms of the plan. The Technical Guidelines can be read to infer this, as they require plans to provide IROs with the terms of the claimant's plan "to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law." However, this important point should not be made through an inference—the regulations should make clear that IROs have no authority to change the terms of the plan, whether they govern eligibility, coverage, levels of benefits, or any other matter.

Additionally, because IROs do not have authority to change the terms of the plan, allowing appeals that do nothing more than challenge the terms of the plan would result in a waste of plan assets, not to mention the participant's time, on frivolous appeals. This is the antithesis of an "effective" external review process. Just as plans are allowed to engage in a preliminary review to screen out eligibility claims before referring them to

the IROs, they should be allowed to screen out claims that seek treatment or benefits not offered by the plan, or which challenge clear, unambiguous and lawful plan terms.

This is especially the case because a self-insured plan can only meet the requirements of Section 2719(b) in one of two ways: by subjecting itself to state law procedures from which it is otherwise exempt under ERISA's preemption clause; or by contracting with IROs accredited by the URAC or a similar nationally-recognized accrediting organization, to rotate review of the appeals.

According to URAC's website, it has accredited only one IRO in the entire state of New Jersey, where some plans I currently work with have more than 50,000 participants and beneficiaries, and only 43 IROs nationwide. I am not familiar with other "similar nationally-recognized accrediting organizations," so I have no idea how many other acceptable IROs there may be, but I wonder if it is a large enough number to constitute a sufficient pool of IROs to handle all the claims appeals that may be submitted to them. Given that the Technical Guidance requires plans to contract with three IROs to rotate the appeals, or somehow randomly select among accredited IROs, the lack of sufficient accredited IROs could severely impair the "effectiveness" of the external review if the caseload of appeals is such that the IROs cannot decide them within the relatively short period of time (45 days) contained in the Technical Guidance. This problem could be mitigated in large part by not burdening IROs with appeals that cannot, under the clear and lawful terms of the plan, be granted.

Further, the IROs I am familiar with have expertise in reviewing whether the requested treatment is medically necessary, or whether it involves experimental treatment. However, few, if any claims appeals, involve either issue. Rather, in my experience, the vast majority of claims appeals relate to eligibility and coverage issues over which the IROs have no special expertise.

While certainly there is merit in allowing participants access to an external review of plan terms that might be contrary to applicable law, in addition to claims that may be decided contrary to lawful plan terms, the benefit of such an external review process must be weighed against the costs to the plans in being required to pay the expenses involved for external review of a far larger number of potentially frivolous claims. Plans are already subject to excise taxes, as well as possible tax disqualification, where they operate inconsistently with federal law, including the Act, and this provides a powerful incentive to make sure the plan terms are not inconsistent with the law: an incentive that protects participants as much as an external review process for individual claims will provide.

Further, the unique structure of Taft-Hartley plans provides additional protections to participants even without an external review process. Taft-Hartley plans by definition are governed by a board of trustees, an equal number of which are selected by the contributing employers on the one hand, and by the unions whose members participate in the plan on the other (with the exact terms on selection of trustees being specified in a trust agreement). This board of trustees is both the plan sponsor and the administrator of the health fund. As with all plan administrators, who are ERISA fiduciaries, trustees of Taft-Hartley plans are charged with administering the plans for the exclusive benefit of members and participants.

Unlike with self-insured plans that are sponsored solely by an employer, Taft-Hartley plans are governed by an equal number of trustees who are not selected by the contributing employers. The union trustees typically have years of experience in administering health plans; they receive education and training through organizations such as the International Foundation of Employee Benefit Plans, and are well-versed in their fiduciary obligations to participants. Their independence from the contributing employers helps ensure not only that the plan terms are lawful, but that the participants' interests, not the interests of the contributing employers, are put first when deciding claims appeals. Where the trustees cannot agree on resolution of a claims appeal, they can refer the matter to an independent arbitrator for decision. Thus, in the context of Taft-Hartley health plans, there are already mechanisms in place to assure that the plans operate in accordance with applicable law and for the exclusive benefit of participants and their dependents.

By contrast, as drafted the regulations provide an incentive for a participant (or presumably a health service provider standing in the shoes of a participant pursuant to an assignment of benefits) to pursue even clearly frivolous claims through the external review process. The plans bear all the expense of the external review process, as they must contract with the IROs and pay the expenses incurred for the review. Further, the definition of "adverse benefit determination" is so broad that it includes every instance where a plan fails to pay a health service provider's bill in full, regardless of whether the lesser amount paid is because of a discount under a network arrangement or applicable of "usual, customary and reasonable" rates, or because the plan required the participant to pay a percentage of the bill under the plan's lawful co-insurance terms. Thus, a health service provider attempting to renegotiate its payment, or a participant attempting to renegotiate his or her co-insurance percentage now has the leverage of the external review to strengthen its bargaining position. Self-insured health plans may find that it makes more sense economically to pay claims outside of the clear and lawful terms of the plan rather than incur the expenses associated with the external review process. This is not the "effective" external review envisioned by Congress when enacting Section 2719(b).

I respectfully submit that the regulations need to be reworked to strike a fairer balance between a participant's right to a fair and full claims review, and a plan's right to avoid incurring needless expense to provide an external review of frivolous claims. A fair way to balance those interests would be to expand the preliminary review process to allow health plans to screen out from external review those claims that merely seek to alter the lawful terms of the plan.

2. The regulations and Technical Guidance should not preclude plans from seeking judicial review of the IRO's decision where appropriate.

The regulations provide that an IRO's decision is binding on the plan excess to the extent other remedies are available under state or federal law. 29 CFR 2590.715-2719(d)(2)(iv). Presumably, that would include a plan's right under Section 502(a)(3) of ERISA to seek declaratory or injunctive relief where the IRO has ordered the plan to provide a benefit contrary to the lawful terms of the plan.

However, the Technical Guidelines provide that where the IRO reverses a claims denial, the plan "*immediately* must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim." This language severely curtails a plan's rights under Section 502(a)(3), and should be modified. A plan should not be made to "pay now, litigate later" where it has good-faith basis to believe that an IRO has ordered it to pay a claim contrary to the lawful terms of the plan.

I appreciate your consideration of these issues. Thank you.

Very truly yours,

Joni S. Jacobs

JSJ:oc