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U.S. Department of Labor
Office of Health Plan Standards and
Compliance and Assistance
Employee Benefits Security Administration
Room N-5653
200 Constitutions Ave., NW
Washington, DC 20210
Attention: RIN 1210-AB45

Re: RIN 1210-AB45

To Whom It May Concern:

These comments are in response to the Amended Interim Final Rules Relating to the Internal Claims and Appeals and External Review Process, RIN 1210-AB45 (the "Amended Rules"), and are presented on behalf of four of the largest multiemployer health plans in the entertainment industry: the Directors Guild of America – Producer Health Plan ("DGA – Producer Health Plan"), the Motion Picture Industry Health Plans ("MPI Plans"), the Screen Actors Guild – Producers Health Plan ("SAG – Producers Health Plan") and the Writers Guild-Industry Health Fund (WG-Industry Fund") (collectively, the "Plans"). Together, these Plans provide health benefits to over 250,000 participants and their dependents.

The Plans are multiemployer plans established by collective bargaining agreements pursuant to Section 302(c)(5) of the Labor Management Relations Act (the "LMRA"). As required by the LMRA, each of these Plans is governed by a Board of Trustees composed of equal numbers of union-appointed and employer-appointed trustees. Those trustees establish eligibility criteria and the level of benefits provided to participants in accordance with the mandate of both the LMRA and the Employee Retirement Income Security Act ("ERISA") §404(a) that they act strictly for the exclusive benefit of the plan's participants and beneficiaries.

The Plans generally agree with the Amended Rules and the additional guidance and clarifications provided. The Plans enthusiastically support the elimination of the requirement that adverse benefit determination notices contain diagnosis and treatment codes. The new

provision requiring notice of the availability of those codes and the requirement to provide the codes upon request, appropriately balances the serious privacy concerns of health plans with the information access concerns of patients.

In addition, the Plans are in favor of reducing the scope of claims subject to external review to those involving medical judgment and encourage the Departments to implement this limited scope permanently. There is no value for participants or plans in having a third party who specializes in medical determinations review matters other than those involving medical judgment. This is especially true in the multiemployer context where plan determinations often involve plan document and collective bargaining agreement analysis and legal interpretation. Participants already have internal appeal rights as well as the right for external review by the courts, where if participants prevail, they may be entitled to attorneys' fees. Courts are specialized in legal analysis so there is no value to an external review. In contrast, an external review where medical judgment is involved makes sense. There, judgments are generally based on established standards of care, and an external review would provide a check on the application of those measured standards by an experienced professional.

Based on our agreement with the premise that external review is not appropriate for matters involving plan document interpretation and legal analysis, the Plans ask that the Departments not extend external reviews to matters that involve rescissions in the multiemployer plan context. Our position is based on three main points:

- The Patient Protection and Affordable Care Act ("PPACA") does not specifically require external review of rescissions.
- In the multiemployer plan context, rescissions are eligibility determinations which the Departments have already recognized are not subject to external review.
- Eligibility determinations by the Plans involve extensive review and analysis of plan documents and collective bargaining agreements, legal interpretations of those documents, as well as specialized knowledge of the industry where the participant is employed. Because the decisions are not based on "medical judgment", they are not appropriate for external review.

The remainder of our comments will focus on these issues.

PPACA Does Not Require that Rescissions Be Subject to External Review

Under PPACA, Section 1001 (amending Section 2719 of the Public Health Service Act (42 U.S.C. Section 300gg)), the external review process requires:

> ''(b) EXTERNAL REVIEW.—A group health plan and a health insurance issuer offering group or individual health insurance coverage—
>
> > ''(1) shall comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or
> >
> > ''(2) shall implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process described under paragraph (1)—
> >
> > > ''(A) if the applicable State has not established an external review process that meets the requirements of paragraph (1); or
> > > ''(B) if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process described in paragraph (1)).

This section does not mandate external review for rescissions. The Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners cited in this section also does not dictate that rescissions be subject to external review. In fact, it limits external review to issues involving medical judgment.

Given that PPACA does not require external review of rescissions, we request that the Departments reconsider this mandate, especially in the context of multiemployer plans, where any retroactive terminations of coverage result from eligibility determinations which involve detailed interpretation of plan documents and collective bargaining agreements, and legal analysis.

Rescissions of Coverage in the Multiemployer Plan Context Are Not Appropriate For External Review Because They Are Eligibility Determinations Which The Departments Have Already Recognized Are Not Subject To External Review

As contemplated by the LMRA, contributions to the Plans are made by employers who are signatories to collective bargaining agreements and are made on behalf of employees

working under those agreements.[1] The Plans in turn provide comprehensive health care benefits to the employees of these companies. Eligibility requirements for the Plans are predicated on either the number of hours worked or compensation earned by individuals doing work covered under the respective collective bargaining agreements.

As is typical for multiemployer Taft Hartley plans, the Plans rely on self-reporting from employers. This makes the Plans susceptible to manipulation and fraud by companies who report hours for work on behalf of individuals who did not actually perform or get paid for the work, or occasionally the Plans encounter reporting on fictitious projects. In addition, reportings to the Plans may contain inadvertent errors due to misunderstandings or simple administrative errors. Another common issue relating to reporting for these Plans is the allocation of compensation where an individual serves many roles on a project. For example, an individual may be a writer and producer of a short film, and they are reported to also have an acting role. The individual is compensated $20,000 for the project and just enough of that is reported to the SAG Plan to qualify the individual for coverage. However, upon audit the SAG Plan learns that the individual was the highest paid performer on the project and earned more than four times the amount as the lead actors on the film. Further investigation reveals that the acting role of the individual was extremely minor, with just a few seconds of on-camera time, in contrast to the lead actors who appeared throughout the project. This may raise questions as to the legitimacy of the value assigned to the individual's acting services, and the SAG Plan would investigate whether the reporting was legitimate or whether compensation was manipulated solely for the purpose of qualifying the individual for benefits. Another example of a typical issue a plan may face is an employee reported as working in a particular classification, but an audit reveals that the classification may not have been accurate. For instance, hours are reported to the DGA Plan for a "unit production manager". Whether the individual actually performed work in this classification, however, involves detailed analysis of his or her responsibilities, best suited for the DGA Plan Trustees and staff, who are highly experienced in the entertainment industry.

To ensure that the Plans are receiving proper contributions and providing benefits to the intended beneficiaries of the Plans, as well as complying with obligations and restrictions under the LMRA and ERISA, each Plan engages in strict audit programs to review whether contributions and the resulting eligibility are proper (referred to as "authenticity" programs). Each Plan has staff dedicated to this process which involves performing audits to review whether the actual work was performed, that the individuals received compensation for the work, and that the work was covered by an appropriate collective bargaining agreement. However, because of

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[1] Those employers include all of this country's major motion picture and television producers, as well as thousands of other producers of entertainment programs, commercials, and those who provide related services to the entertainment industry.

the thousands of reportings and the amount of time it takes to conduct these authenticity reviews, the Plans have no choice but to rely on and honor the reportings made by the signatory employers until an audit can be conducted, with the expectation that the employers are meeting their contractual obligations and only making reportings where proper. Thus, coverage is often extended prior to the Plans having the opportunity to verify the authenticity of the underlying contributions.[2]

As noted, inappropriate contributions to the Plans are sometimes the result of fraud or intentional misrepresentation. Under PPACA, the Plan may retroactively rescind coverage in those circumstances.[3] As the process detailed above reveals, these rescissions only occur as a result of eligibility determinations. The July 23, 2010 interim final rule on internal claims and appeals and external review specifically recognized that eligibility determinations are not subject to external review. 75 Fed. Reg. 43336. Thus, the resulting retroactive termination should also not be subject to external review.

Terminations of coverage by the Plans based on ineligibility can be distinguished from what the anti-rescission rule is meant to address – the "overly broad and unfair" retroactive terminations of coverage based on unintentional misstatements of fact on coverage enrollment questionnaires as discussed in 75 Fed. Reg. 37188, 37193. Multiemployer plans do not require enrollment questionnaires to determine whether to provide coverage. Rather, coverage is provided once eligibility is established through an ongoing stream of contributions for individual participants. Given the volume of contributions, the Plans have no choice but to rely on employer representations until an audit is conducted. In contrast, insurers requiring enrollment questionnaires have the opportunity to review a single individual's enrollment application and

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[2] On August 27, 2010, the National Coordinating Committee for Multiemployer Plans ("NCCMP") submitted a letter to U.S. Department of Labor which detailed the unique concerns the anti-rescission rules pose for multiemployer plans. We will not summarize those arguments here, but encourage review of that letter which helps illustrate the corresponding problems of subjecting these matters to external review. We would also like to reiterate our agreement with the position articulated in the August 27th letter that retroactive rescissions of coverage by a multiemployer Taft-Hartley plan to comply with its obligations under ERISA and the LMRA should not be considered a rescission under PPACA.

[3] Often the misreportings involve administrative errors or misunderstandings by the employer. The Plans are now prohibited from rescinding coverage in those situations under PPACA, but we note our continued concern as articulated in the NCCMP's August 27th letter that providing coverage under those circumstances is contrary to the LMRA and its restrictions on Taft-Hartley plans that require payments be made per a written agreement and on behalf of "employees". LMRA § 302 (c)(5)(B).

verify the information prior to approving the initial enrollment. In addition, in insured markets retroactive terminations are often a defense to paying a claim, whereas for the Plans, any termination occurs solely as a result of a determination of ineligibility due to reportings that are not in compliance with the Plan documents.

Finally, it is important to note that as trust funds, multiemployer plans hold assets in trust for intended beneficiaries. Any improperly paid benefits inappropriately distributes, to an unintended recipient, trust assets that are being held in trust for other participants. The trustees of multiemployer plans have a fiduciary obligation to remedy these improper distributions. Insurers, on the other hand, are not acting under fiduciary mandates when retroactively terminating coverage.

Eligibility Determinations By The Plans Are Not Appropriate For External Review Because They Involve Plan Document and Collective Bargaining Agreement Analysis And Legal Interpretation

In addition, external review of these determinations is inappropriate because of the major role of plan document, collective bargaining agreement analysis and legal interpretation that is required. Under PPACA's new anti-rescission rule, in cases where a plan decides to retroactively terminate coverage, it means that the plan has made the determination that fraud or an intentional misrepresentation has occurred. The process of rendering that decision requires a plan to engage in legal analysis. The limitation of the scope of external review to matters involving medical judgment underscores the improper role of external review by an independent review organization for these type of legal matters. Neither participants nor plans would benefit from an additional level of review from a party that is not familiar with the industry, the plans, the relevant collective bargaining agreements, or the legal analysis required in determining eligibility issues and evaluating whether fraud or misrepresentation occurred. Thus, this added step would only lead to additional costs and delays in final resolution of disputes with no benefit to either party. Of course, our position in no way limits an individual's right to pursue judicial review under these circumstances as currently allowed under ERISA.

In the alternative, if the Departments do not remove multiemployer plan eligibility determinations that lead to terminations of coverage from the purview of external review, we request clarification that the scope of external review be limited to the single issue of whether there was fraud or an intentional misrepresentation. As already noted in the Interim Final Regulations at 75 Fed. Reg. 43336, a plan's eligibility determinations are not subject to external review. Thus, even in the context of a review of rescissions, a plan's determination that the participant was not eligible for coverage should be accepted by the external reviewer and not subject to scrutiny. The only issue the external reviewer may decide is whether retroactive termination was warranted because of fraud or intentional misrepresentations. If not, a plan must only reinstate the retroactively terminated coverage, but should not be required to continue

coverage for someone it has deemed ineligible due to misreportings. Moreover, since plan determinations are entitled to deference, a plan's determination that fraud occurred should also be given deference and the burden should be on the participant to prove that no fraud occurred.[4]

We are grateful for the opportunity to comment, and are available to answer any questions or provide any additional information that may be helpful in evaluating our comments.

Very truly yours,

Bush Gottlieb Singer López
Kohanski Adelstein & Dickinson
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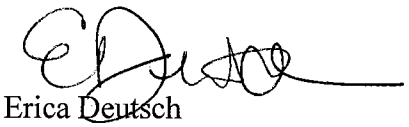

Erica Deutsch

[4] See, Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101 (1989)