



Society of Professional Benefit Administrators

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July 25, 2011

Sent Electronically to:
www.regulations.gov
E-OHPSCA2719.EBSA@dol.gov
EBSA 2010-0019-0002

Dear Mr. Sir or Madam:

The Society of Professional Benefit Administrators submits this letter as a response to the Request for Comments issued by the Departments of Labor, Treasury and Health and Human Services in its Notice of Interim Final Rules Federal Register published on June 24, 2011 along with related guidance including Technical Release 2011-02 with respect to the Internal and External Review Requirements under the Patient Protection and Affordable Care Act (PPACA) that outline the claims procedures imposed on group health issuers and group health plans.

The Society of Professional Benefit Administrators ("SPBA") is the largest national association representing independent third party administration firms who are responsible for the administration of the employee benefits of nearly forty percent of all United States covered workers. SPBA represents 80 percent of the firms which make third party contract administration of employee benefit plans their primary line of business. Third party administrators ("TPA"s) provide continuing professional outside claims and benefit plan administration guidance for employers and benefit plans. TPAs very often become the "employee benefits office" for the covered workers of many small employers with under 100 employees. The average TPA client employs some degree of self-funding and clients range from Taft-Hartley union/management jointly-administered plans, customized plans for single employers of all sizes, and cost-effective plans designed for related groups of employers in trade associations and other multiple employer configurations.

As noted in our comments in September 2010, we commend the Departments for responding to the various concerns raised by Third Party Administrators in conjunction with the agency's amendment and re-issuance of interim final regulations governing Internal Claims and Appeals and External Review processes. We commend the effort by the Departments of Treasury, Labor and Health and Human Services to amplify the protections under the existing ERISA claims procedures and on their foresight in seeking information from private industry on the impact this change will have on employer plan sponsors and plan participants. On behalf of third party contract administration firms, the Society of Professional Benefit Administrators wishes to address the following concerns arising in the recently published Interim Final Regulations and we hereby submit the comments presented as representative of the broadest possible spectrum of TPAs that advise employer plan sponsors on and administer employee benefit plans for large and small employers, with and without unions, in every state.

The amendments to the July 2010 interim final regulations regarding employer group health plans have addressed numerous issues raised through comments to the federal regulatory agencies. Among the issues are:

Timeframe for notifying claimants of benefit determinations for urgent care claims.

The amended regulation reverts to the original rule consistent with the DOL's existing ERISA claim procedure regulation to provide notice of urgent care claim determinations as soon as possible, taking into account the medical exigencies involved, but no later than 72 hours after receipt of the claim. The 72-hour rule is applicable only if the plan defers to the attending provider over whether the claim involves a matter of "urgent care".

The requirement for including diagnosis and treatment codes in adverse benefit determination notices.

The amended regulation eliminates the requirement to automatically provide the diagnosis and treatment codes. Instead it substitutes a requirement that the plan or issuer provide notification of the opportunity to request the diagnosis and treatment codes and their meanings in all notices of adverse benefit determinations and a requirement to provide the information upon the request. This amendment clarifies that a plan or an issuer may not consider a request for such diagnosis or treatment information to be for an internal appeal or an external review.

The requirement to provide culturally and linguistically appropriate notices.

This provision was amended to establish a single threshold for the group and individual markets that will be set at 10% or more of the population residing in the claimant's county and literate only in the same non-English language. This threshold is based on U.S. Census Bureau survey data. When satisfied, the amended regulations will require plans to provide oral language services, such as telephone hotline assistance, that answer questions in the applicable non-English language and provide assistance with filing claims and appeals; to provide upon request a notice in the applicable non-English language and include in the English versions of all notices, a prominently displayed statement in the applicable non-English language indicating how to access the language services provided by the plan. However, some plans report that they still consider this requirement to be difficult in terms of finding the correct county that the plan participant resides. Additionally, we request clarification and examples of the term "culturally" and the requirement that a plan provide culturally appropriate notice.

The scope of claims eligible for external review.

We noted in our previous comments, that TPAs throughout the country found that TPA client firms face difficulties in finding Independent Review Organizations to resolve coverage disputes as required in the original regulations. These requirements and timelines needed clarification which the agencies have now addressed. Namely, the requirement that agencies now establish that health claims eligible for external review by IROs should be focused on medical judgment matters rather than "any" adverse benefit determination.

The requirement that the plans contract with a specified minimum number of IROs to conduct external claim reviews on rotating assignments and to incorporate an independent, unbiased methods for selection of IROs still provides a difficult problem. The Agencies correctly surmised that ERISA-covered self-funded group health plans will likely be the most affected by the External Review requirements contained in the Interim Final Regulations. The requirement that the benefit plan enlist the services of three IROs be contracted by the benefit plan. T.R. 2010-01 provided that DOL and IRS would not take enforcement action against a group health plan that either complied with the standards set forth in the technical release or voluntarily complied with a state external review process. The new guidance, T.R. 2011-02, modifies the prior enforcement policy to state that to be eligible for the enforcement safe harbor, self-insured plans will be required to contract with at least two IROs by January 1, 2012 and with at least three IROs by July 1, 2012 and to rotate assignments among them. However, a self-insured plan also may use an alternative process to meet the standards regarding random assignments to IROs as long as the plan adequately documents how the alternative process constitute random assignment. Third Party Administrators continue to believe that it will be difficult to contract with two IROs and will find it difficult to meet the requirement of contracting with three IROs by the July 1, 2012 deadline. We recognize that this amended guidance is significantly preferred to the original regulatory requirements. Due to the complexity in administering these provisions, especially due to the fact that IROs are difficult to evaluate and contract with in a short timeframe, SPBA respectfully requests a one-year delay in implementation of the IRO requirement of three IROs Interim Final Regulations to July 1, 2013.

The regulations provide that the State external appeal process ensure against Internal Review Organization's (IRO) conflicts of interest. SPBA generally supports this rule, and adds that Third Party Administrators are uniquely situated to serve as the entity to select and contract with IROs so that group health plans can avoid conflicts. We think that the regulations should clarify that IROs selected by an independent Third Party Administrators, would automatically meet the requirement of independence and satisfy that requirement.

Clarification of the requirement that the IRO external review decisions are binding. The amended regulation clarifies that the binding nature of the IRO determination does not preclude the plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision denying the claim. The regulation added a provision stating that the plan or issuer must provide any benefits pursuant to the final external review decision without delay, regardless of whether the plan or issuer intends to seek judicial review of the IRO's decision. We request that a model notice establishing that benefits are provided but reserving the opportunity to seek judicial review be established to clarify to plan participants that this is a right reserved to welfare benefit plans.

In addition to the issues raised above, Third Party Administrators seek clarification regarding the requirements of EOBs that are provided and viewed by claimants online. We seek clarification on whether the requirements established above apply equally whether the claimants receive paper notifications or whether the claimants are reviewing their claims online. Further, in response to the tough economic climate, many employers are moving to providing monthly EOBs to participants since postage costs have increased. Other than for urgent care claims, we would like to receive confirmation that monthly EOBs would also provide satisfactory compliance to the amended regulations.

SPBA appreciates the opportunity to express our comments on this issue. It is respectfully requested that the recommendations cited above be considered in the final regulations. SPBA welcomes the opportunity to work closely with the Agency on these and other matters to craft regulations that will foster our common goal of enhanced consumer protection, without impairing the ability of employers to maintain a workable claims adjudication process.

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