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Sent Electronically to:
www.regulations.gov
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RIN 1210-AB45

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 in its Notice of Interim Final Rules Federal Register published July 23, 2010 (Volume 75 Page 43,330), 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. We have also taken the liberty to express issues related to the Model Notices released subsequent to the Interim Regulations and which have a direct impact on plan sponsors.

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.

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 in 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 express to you several concerns arising in the recently published Interim Final Regulations and we hereby submit the following comments.

The comments presented here are 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. In speaking to TPAs throughout the U.S., we found that TPA client firms face common difficulties in understanding the many changes to the newly drafted Internal/External Claims Review Procedures. Benefit administrators need immediate guidance from you on how to administer requests for coverage, particularly as they relate to the responsibilities of employers, and this letter is meant to highlight these issues. It is our hope that our comments will provide insight on the impact the PPACA-Mandated Claims Review Procedures will bring to employer-sponsored welfare benefit plans. It is in that spirit that SPBA respectfully submits these comments for your review.

Clarify Standard Review Process

It is stated in several places in the Interim Final Regulations and Technical Release 2010-01 that plans must set out the requirements for "standard" review process. The new notice requirements add an external, second-level review process governed under state "standards" or, if no state "standards" apply, Federal "standards". Third party administrators would like the Agencies to provide additional explanations, examples and even model language on the "standards" that are contemplated. We would like to see discussion on whether the URAC standard will satisfy the requirements. Some TPAs would like to know whether a plan sponsor can establish their own "standard" and whether complying with that "standard" incorporated into its plan design would be sufficient? Additionally, TPAs would like to see guidance on whether the requirement under the existing claims regulation to provide claim determinations in the EOB also apply to the "standard" used to make the determinations; given the obvious lack of room on the EOB itself.

Clarification of Timeline

SPBA respectfully requests a clarification whether the deadline for internal appeals and external review are intended to be the same. Under the Technical Release 2010-01, claimants must be given an opportunity to file a request for external review up to 4 months (or 120 days) after receiving the internal adverse benefit determination. Under the current Claims regulations, plans must provide 180 days for the claimant to appeal an adverse benefit determination. We would like a clarification on which deadline should be followed by plan sponsor under which circumstances.

Model Notice

The Model Notices for Adverse Benefit Determinations issued in July 2010 impose new notice requirements. Failure by the plan sponsor to strictly adhere to the new notice and other requirements can result in a claimant being deemed to have exhausted the appeals process and, therefore, proceed directly to an independent external review or file a lawsuit.

However, we note that the Model Notices do not include the language required to provide a right to appeal under ERISA as required in the EOB. We would like the agencies to clearly establish whether the language should be added to the Model Notice by the plan sponsor or whether the Model Notice will be modified in the future to include this notice.

Following is the statement that TPAs place on each EOB for their client plan sponsors. Since it was not included in the Model Notice, TPAs question whether or not it is still necessary:

“If any part of your claim was denied or reduced, it was because the Plan relied on a rule, guideline, or protocol. You may request, in writing, a copy of that rule, guideline or protocol free of charge. If your claim was reduced or denied because the Plan did not have certain information, you may request in writing, free of charge, the information necessary to correct your claim and it is necessary. If you disagree with this benefit determination, you have 180 days from the date of receipt to appeal the decision. You will receive a written response to your appeal no later than 60 days after our receipt. If the Plan fails to follow its claim and appeal procedures, ignores, or denies your request for benefits and you exhaust the Plan’s internal claim procedures, you are entitled to bring civil action against the Plan under ERISA Sec. 502(a). If you have questions, contact Customer Service at (xxx) xxx-xxxx or (800) xxx-xxxx. Written requests and appeals should be sent to the address above.”

Time Change Unnecessary in Urgent Care Claims

The current DOL claims procedure regulations provided the welfare benefit plans consider urgent care claims as soon as possible taking into account the medical exigencies, but no later than 72 hours after receipt of the claim by the plan. The Interim Final Regulations place that time limit at "no later than 24 hours" after the receipt of the claim by the plan or issuer.

The change in time limitations is of significant concern to third party administrators who establish that the change is unnecessary. First, as referenced in the IFR themselves, under the existing regulation many if not most of the claims were already "handled in less than 24 hours" especially given the new technological communication developments. The new change imposes upon group health plans the additional costs associated with a 24-hour on-call staff, in some cases, as second bilingual staff person.

Secondly, while the agencies themselves recognized that plans in many cases do satisfy the 24-hour time period, if on the rare occasion they fall beyond the timeframe due to lack of information or verification of a condition, the group health plan would automatically fall into the category of non-compliance with the regulation. This non-compliance would automatically trigger their filing a self-report for non-compliance with the Internal Revenue Department. The requirement to self-report non-compliance of regulatory requirements on Treasury Form 8928 requires employers who sponsor group health plans and certain other responsible persons, such as third party administrators, to self-report and pay excise taxes when they fail to comply with various group health plan mandates. The failure to self-report will result in the imposition of penalties and interest.

The failure to report and pay penalties can range from 25 to 50 percent of the amount of the unpaid tax including interest. The result of having a regulation "on the books" that is generally already complied with, is unnecessary and puts plans in the position of paying a penalty and excise tax.

State/Federal External Review Process

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 Agencies have asked whether the Federal external review process should apply when the State external review process does not apply to all issuers in the State. It would be appropriate that, in the absence of a State external appeal, the Federal external review should be the standard.

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. The establishment of a "Chinese Wall" to avoid a conflict of interest is a well-known and well-established process successfully used in many areas of business. We think that the regulations should clarify that IROs selected by an independent Third Party Administrators, would meet the requirement of independence and satisfy that requirement.

The rules provide that State external appeals should be conducted in a "substantially similar" manner to that found in the NAIC Model Act. We strongly urge the Agencies to clarify the meaning of "substantially similar". External appeals brought regarding new treatments often result in a disagreement about whether the information is sufficient to find that the treatment is not experimental. The use of a single standard to be used by State and Federal external reviews would clarify the definition and provide guidance for group health plans and IROs about the standard they must use to evaluate a treatment plan. In our opinion, incorporating a uniform standard is desirable.

Requirement of three IRO Contracts

The Interim Final Regulations require that the welfare benefit plan make available three IROs. Further, the safe harbor guidelines of Technical Release 2010-01 require self-funded plans to either voluntarily comply with a state's external review process (if the state so allows) or comply with the Federal external review requirements set forth in the Release. Our members report and we want the Agencies to be aware that some states (we understand this to be true in the New England area for example) have so far declined to open up their external review processes to self-funded plans. As such, TPA client group health plans would not be able to voluntarily comply with the state process and, instead, would be required to follow the Federal requirements.

Under the safe harbor requirements, employer group health plans need to contract directly with at least three IROs. We request the Agency to clarify the significant confusion in the interpretation of this provision which seems to disallow third party

administrators from contracting with the IRO on the plan's behalf. If this is a correct interpretation, this will present major challenges for employers and the IRO's in contracting individually and in collecting and remitting the fees for IRO services directly between the employer and IRO. This process would be a significant disincentive for thousands of self-funded employers across the country. Because the TPA administers the claims plans for the employer, the process would also present challenges for claims administrators to coordinate the transfer of claims information for external review referrals to possibly multiple IRO organizations, depending upon which IRO an employer contracts with and each employers claims would need to be rotated among the three IROs each employer contracts with.

Under the IFR, the requirement for plans to have three IRO vendors in place prior to the need for an external review by the deadline poses an administrative nightmare. In our opinion, the Agencies should clarify this provision to allow the contracts with an IRO be made directly by the plans or through a TPA for their employer plans sponsor clients.

Request for Additional Time

Third Party Administrators are in the process of trying to decipher the changes expected under the new regulation while attempting to make the appropriate changes to group health plans required through PPACA. In many of the cases, the changes brought about by the Final Interim Regulations to plan design will take an inordinate amount of time to reprogram the entire claims adjudication system. Due to the complexity in administering these new provisions, especially due to the urgent care requirements, SPBA respectfully requests a one-year delay in implementation of the Interim Final Regulations to Sept, 23, 2011.

We further request that sufficient advance time be provided so that Third Party Administrators may provide guidance to employers to promote their understanding of their new responsibilities under the 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.

Respectfully submitted,
Society of Professional Benefit Administrators

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