

Comments of the
National Coordinating Committee for Multiemployer Plans
to the
United States Department of Labor
Pension and Welfare Benefits Administration
on
Request for Information on Claim Procedures for Plans

July 31, 1998

The National Coordinating Committee for Multiemployer Plans (“NCCMP”) is pleased to submit these additional comments in response to the Department of Labor’s request for information regarding claims/appeals regulation (29 C.F.R. § 2550), which was published in the Federal Register on September 8, 1997 (62 Fed. Reg. 47262).

The NCCMP is the only national organization devoted exclusively to protecting the interests of the nearly ten 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.

The following comments are based on information recently provided by NCCMP members relating to the enormous impact anticipated changes in the claims/appeals regulation would have on multiemployer employee welfare benefit plans.

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I. SUBSTANTIVE CONCERNS

A. The Proposed Regulation Will Remove Multiemployer Trustees From the Appeals Process

The anticipated regulation fails to take into account the actual functioning of multiemployer plans with regard to appeals. For many plans, quarterly meetings are the only opportunity for multiemployer plan trustees to give full and fair review of claims denials. Changing the appeals process may fundamentally change the manner in which multiemployer plans function – and could result in less due process for participants and beneficiaries.

From the point of view of a participant, one of the great advantages of multiemployer plans is that one half of the trustees are always employee representatives. In the single employer and non-collectively bargained world, there is no such employee representation. Insurance companies and solely employer sponsored health care plans often have a financial interest in denying benefit claims. In the multiemployer world, no such financial interest exists. Thus, participants in multiemployer plans are assured that in the review of their claims they will have employee appointed trustees participating in the decision making process.

Some multiemployer plans designate specific trustees to rule on appeals while others have the entire board of trustees hear appeals. During their quarterly meetings, and as a result of the appeals heard, the trustees are alerted to plan provisions that may require clarification or change. Plan professionals inform us that those trustees hearing appeals are provided detailed information regarding the nature of the appeal, the plan provisions in question, and any appropriate medical records and/or history. This procedure ensures consistency in the review of appeals and the interpretation and application of plan provisions. A requirement that in effect compels appeals to be acted on without trustees' consideration will eliminate this productive process by eliminating meaningful trustee input. It will force multiemployer plan trustees to use others (administrative staff or service providers) to make immediate appeals determinations.

Additionally, compelling urgent and nonurgent appeals to be decided without trustees' consideration will ultimately hurt participants and their families. Under the current environment many appeals committees engage in spirited discussion of the benefit plans, how they function, and how unanticipated facts and circumstances are not adequately addressed by the plan of benefits. Trustees learn about the benefit plans and become invested in the plans' adequacy. Compelling immediate appeals decisions will eliminate that process.

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The proposed time frame for making appeals decisions is considerably too short for multiemployer plans. Multiemployer plan trustees do not work for one employer. They typically each work for a different company. Therefore, thirty days may not be enough time to coordinate trustees' review and consideration of all pertinent documents. Multiemployer plan trustees are uniquely situated to interpret the plan and apply it to individual appeals. The anticipated regulation will unnecessarily rush that process—requiring, in some cases, the denial of appeals that should be granted or the approval of appeals that should be denied because they cannot be fully analyzed in the limited time. Either will increase plan costs—the first in litigation costs, the second in benefit costs.

**B. Most Appeals Are For Payment Rather Than
the Provision of Medical Services**

The proposed regulation should be amended to take into account the difference between a denial of services and a denial of payment for services already rendered. In plans that do not restrict access to care, a disputed claim and the appeal usually pertain to whether the services are covered by the plan—not whether needed medical services will be provided. In such situations the health and well being of the patient are not at issue—only how quickly the providers (or the patient) will be reimbursed. The proposed regulation should make a distinction between claims/appeals for health services that may be rendered, and the claims/appeals for services already rendered, just as the anticipated regulation distinguishes between urgent and nonurgent claims/appeals.

**C. The Proposed Regulation Should Make Clear That the Plan May
Delay Action Until the Fiduciary Has Received All Pertinent
Information**

Under the proposed regulation, no decision on a claim or appeal is required until all necessary information has been provided. Final regulations should make clear that the plan fiduciary is not required to decide a claim or appeal until the fiduciary receives all information deemed pertinent by the fiduciary. Our experience with multiemployer plans indicates that patients do not always submit all information necessary to properly decide a claim or appeal, and obtaining additional medical records can substantially delay the plan's decision.

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**C. The Patient Should Have The Burden of Establishing
That a Claim or Appeal is “Urgent”**

Given the volume of claims that large multiemployer plans process each day, it would be impracticable for the claims processor to know whether a claim must be processed under the forthcoming “urgent care” time lines. To minimize the need for a body of litigation to establish what conditions require expedited review, we suggest that the patient (including the medical care providers) should have the responsibility for designating the “urgent” claim or appeal. In addition, if necessary, the patient should be responsible for proving that the medical condition required processing as an “urgent” claim or appeal. In circumstances where the requested services have been provided, the final regulation should make clear that there is no “urgent” claim or appeal.

**D. Transferring Fiduciary Responsibility For Appeals
Will Increase Plan Costs**

It is likely that the proposed regulation would significantly increase fees paid by plans to third party administrators (“TPAs”) and other service providers. If appeals decision making is taken away from the trustees (because, as a practical matter, the trustees cannot decide appeals in the time frame required), others must step into this role. Trustees are responsible for drafting plan provisions and are uniquely qualified to interpret their plans. Moreover, as employees and employers in the industry, trustees are intimately familiar with the health concerns of their plan participants. The proposed regulation could result in claims being decided by individuals who are not as familiar with the plan or the industry.

Further, the time constraints could preclude administrators from developing a “record” which may favor a participant. Participants will therefore be “on their own” in making their appeal, without the help of the trustees or the administrator. Finally, some TPAs have contractual arrangements that attempt to limit their acceptance of fiduciary responsibility relating to the fund. To the extent that TPAs assume additional fiduciary responsibilities, there will obviously be an increase in the price they charge the plan. This price will be borne by all participants.

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II. PROCEDURAL CONCERNS

A. Implementation Will Require Additional Time

The effective date of the proposed regulation should be significantly delayed for multiemployer plans to provide time for integration of the new appeals procedures with contracted vendors. The anticipated regulation will necessitate amendments to all contracts with providers and will likely result in significant fee increases. Fiduciary authority will likely need to be delegated; and, plan amendments will have to be adopted in order to delegate such authority. Amendments to Plan Documents and Summary Plan Descriptions will be needed and new procedures will need to be adopted. Claims payment and utilization review systems will need to be analyzed, reviewed and brought into conformity with the new procedures. Because many, if not most, multiemployer plan boards of trustees have only one quarterly meeting remaining in 1998, there is simply not enough time for all of the above to occur prior to the end of this year.

**B. The Proposed Regulation Should Accommodate
Monthly Meetings to Consider Appeals**

The proposed regulation should allow the plan to defer action for one month on a nonurgent appeal if the appeal arrives less than 10 days before a regularly scheduled monthly meeting to review claims and appeals. Without adequate time to analyze the appeal, a full and fair review will be almost impossible.

**C. The Proposed Regulation Would Not Prevent an Additional Layer
of Review to Provide Trustee Review of a Denied Appeal**

The Department should clarify that the regulation will not prevent a plan from requiring an additional level of review, to allow trustees to review a denied appeal. In some contexts, the denial of an appeal should entitle a person to initiate a lawsuit against the plan. However, in the context of multiemployer plans, the value of enabling trustees to hear appeals cannot be overstated.

Accordingly, the regulation should clarify that multiemployer plans can provide for a second layer of review by the plan's trustees. This could be stated in the preamble to the final regulation.

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D. Pension Claims and Appeals Time Frames Will Remain Status Quo

The final regulation should reflect that the shortened time frames for claims and appeals apply only to health claims and appeals—and not to claims and appeals relating to pension benefits.

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