

**Testimony of the
National Coordinating Committee
for Multiemployer Plans (the “NCCMP”)
Before the
Department of Labor
on
Proposed Claims Regulations**

February 17, 1999

Thank you for this opportunity to testify regarding the Department’s proposed Claims Regulations. I am Robert Landau, from the law firm of Feder & Semo, and I speak on behalf of the National Coordinating Committee for Multiemployer Plans, the NCCMP, and its chairman, Robert Georgine.

As you know, Mr. Georgine was a member of the President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry, and he supported the Commission’s recommendations to strengthen health care consumers’ rights, including the Consumers’ Bill of Rights. In large measure, the Department’s Proposed Regulation seeks to mandate many of the Commission’s recommendations, and for that we commend the Department.

The NCCMP represents several hundred of the 3,400 multiemployer welfare plans around the country, ranging from small local plans with only a few hundred covered lives to large national plans with several hundred thousand covered lives.

As you consider finalizing the Regulation, there are two unique features of multiemployer plans that I hope you will keep in mind:

1. Multiemployer plans — both large and small — are designed to meet the health care needs of their participants and to provide benefits, not deny them. The labor and management trustees of these plans see it as their fiduciary duty to provide benefits and to design a plan of benefits, which maximizes benefits from available contributions. That includes overturning claims payers and interpreting ambiguous plan provisions in favor of the participant.
2. Consistent with this mandate, very few multiemployer health plans require prior authorization as a condition of obtaining health care.

Thus, it is critically important that the Department clarify that processing claims for **payment** — rather than providing **access to care** — does not constitute a claim or appeal for “urgent care.” Mr. Hagen will elaborate on the importance of this distinction.

With these features in mind, the balance of our comments focus on two of our most significant concerns: the need to sustain trustee involvement in appeals, and preserving the integrity of the claims and appeals process for participants and beneficiaries.

Role of Trustees in Appeals

The Proposed Regulation would effectively cut trustees out of the appeals process. We urge the Department to modify the final Regulation to permit more than one level of appeal and to allow **90 days** to process a final appeal in matters of payment when health care has already been provided. This would allow trustees adequate time to collect all relevant data and to confer on appeals. Multiemployer plan trustees are very sympathetic to participants and beneficiaries, and the current time frames give both the appellant and the trustees enough time to gather relevant facts, research the issue, confer with consultants and counsel when necessary, and come to a correct decision. Shortening the time to decide appeals reduces the information that can be collected from outside sources. Appeals that must be quickly decided before all the necessary information has been collected and analyzed means either that appeals will be routinely denied or some appeals will be incorrectly granted.

If you require that appeals be decided within 30 days, trustees will no longer be able to decide appeals because they would have to be on call continuously or at least every 15 days. Trustees will be forced to delegate appeals to a company which will be more callous to participants, in part because it doesn't work side-by-side with them. Department officials counter that if multiemployer plan trustees are inclined to grant appeals, participants would obviously postpone filing a lawsuit in order to present their cases to the trustees. This supposes that participants or trustees would be content with an erroneous first appeal decision, and that betting plan assets on participant lawsuits is a low-risk proposition. We disagree on both counts.

Multiemployer plans depend on the confidence of their participants and contributing employers. If appeals are wrongly decided, it will jeopardize the plan's credibility and its support. Nor do we want to bet on how many participants and beneficiaries will sue their plans instead of waiting for the trustees' decision. Lawsuits are costly, and

will not likely produce a faster results. The additional time we ask for is worth a better result.

If trustees cannot decide appeals, critical lines of communication between patients and trustees will be severed. The Department has acknowledged the value of participant input in providing quality health care. Deciding appeals provides trustees with critical feedback about the way claims are decided, how the plan is being administered, how the plan should be amended to better suit the needs of participants and their families, and gives the trustees a means of monitoring the quality of care. Professional claims payers do not necessarily share these same objectives; so trustee involvement in the appeals process keeps open a critical line of communication between the patients and the trustees.

We urge the Department to give multiemployer plan trustees the latitude to consider appeals with an adequate period to collect and analyze needed information after a proper administrative review.

Preserving the Integrity of the Claims and Appeals Process

There are several instances in the Proposed Regulation in which the providers may usurp for their own interest the claims and appeals process intended for participants and their families. We urge the Department to remove these mandates from the final Regulation.

First, the Proposed Regulation would prevent a plan from requiring a patient's written authorization to deal with the plan. We are concerned that, without a patient's written authorization, plans could be forced to act in conflict with the patient's wishes. Written authorization requirements can be designed so they are easily satisfied by the patient, regardless of their condition or age.

Second, we are concerned that the extremely vague definition of a "claim" makes almost anything anyone says into a claim. Medical procedures can be very expensive, and requiring the submission of a written claim before paying claims is not unreasonable. If plans have unreasonable procedures that unduly complicate the process of filing a claim, go after them; but don't destroy the multiemployer plan systems that work for patients.

Third, the proposed criteria for making a claim are so loose that even a conversation with a trustee could later be deemed a claim. Allowing patients or their doctors to file a claim simply by calling a trustee is a prescription for delays, mistakes, frustration, and lawsuits. The proposed regulation would put responsibilities on persons who are not

equipped or qualified to receive claims or appeals. If trustees are saddled with the responsibility for communicating claims and appeals, we will surely lose these volunteers — especially management people — as trustees. Fax machines and e-mail make direct communication with the proper plan official easier than ever.

Fourth, we oppose allowing providers to decide unilaterally when claims and appeals are “urgent.” We would prefer that providers advise the plan when, in their view, a claim is “urgent” but that should not be binding on the plan, as it too easily allows potentially self-interested providers to force plans to make hurried decisions, deflecting attention from truly urgent claims.

Fifth, we urge the Department not to adopt an expanded pre-trial discovery rule that would require plans to provide appellants with copies of related decisions, whether or not the plan relied upon them. The rule is totally impracticable. Multiemployer plans do not catalog decisions by all the criteria that may impact on an appeal. Each case must be evaluated based upon its own facts and circumstances. Furthermore, medical science is constantly evolving, so the decision in a 2-year old case may not be relevant for a current case. Providing even redacted documents may raise confidentiality issues, especially in small plans.

In the interest of time we have coordinated our testimony with the other panelists. We support the comments of Carol Lombardi for the Entertainment Funds regarding their objections to the 5-day rule for incomplete claims, and the problems associated with requiring consultation with an independent health care professional. We also support the views of Mr. Hagen from the Local 1199 National Benefit Fund regarding the need to distinguish between a claim for services and a claim for payment after services have been provided, and the potential costs of accelerating payment of claims.

Thank you for this opportunity to discuss our concerns, I would be glad to respond to any questions you may have.

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If you have any questions or would like more information, please call the NCCMP office at (202) 737-5315. [Document #DOL-132]