NATIONAL EMPLOYEE BENEFITS ADMINISTRATORS, INC.

NEBA

July 10, 2024

Via email to ERISAAdvisoryCouncil@dol.gov

Mark D. DeBofsky, Issue Group Chair
c/o George Pantazopoulos, Designated Federal Officer
Employee Benefits Security Administration
Advisory Council on Employee Welfare and Pension Benefit Plans
Washington, D.C. 20210

Re: Employee Welfare Benefit Plan Claims and Appeals Procedures

Dear Mr. DeBofsky:

Thank you for the invitation to submit a written statement and provide testimony to the ERISA Advisory Council ("Council") to assist in the Council's examination of employee welfare benefit plan appeals of health plan benefit claim denials. As a Third Party Administrator ("TPA") to multiemployer pension and welfare benefit plans, National Employee Benefits Administrators, Inc. ("NEBA") provides services to multiemployer health benefit plans relating to benefit claim adjudication and appeals of denied claims.

Existing regulatory guidance sets forth comprehensive standards that group health plans follow in fulfilling their responsibility to establish and maintain reasonable claims procedures and provide a full and fair review of claim denials.[1] The Council has acknowledged commentary that suggests that health plan benefit claim denials are not often appealed.

We understand that the Council is examining the reasons for low appeal rates, including whether "plan participants may lack information or an adequate understanding of the claim procedure requirements." The Council is seeking information about how claims and appeal procedures operate to inform its consideration whether "changes to regulations, to other Department guidance or education, and/or to the Department's enforcement policies and practices might make it easier for participants to navigate the claims and appeals process for a group health plan." We hope that our insight is useful to the Council as you conduct this inquiry.

[1] 29 C.F.R. §2560.503-1.

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INTRODUCTION TO NEBA

NEBA is located in Pembroke Pines, FL and has been providing TPA services to multiemployer pension and welfare benefit plans across the United States since 1994. Ms. Karin Peters first joined NEBA as a college intern and rose through the company to become NEBA's co-owner, President, and CEO. Ms. Ivelisse Berio LeBeau is NEBA's General Counsel.[2]

NEBA's plan clients are exclusively collectively bargained and primarily multiemployer. NEBA provides TPA services to both welfare and pension plans; both fully insured and self-funded health plans; both defined benefit and defined contribution retirement plans. Our clients vary in size, geographic location, and industry.

This statement and our testimony are based on our personal experience providing services to multiemployer health plan clients that have contracted NEBA to provide services relating to health benefit claim adjudication and/or appeals, as explained in more detail below.

NEBA'S SERVICES TO MULTIEMPLOYER PLAN CLIENTS

Multiemployer plans are, by definition, collectively bargained with more than one employer obligated under the terms of a collective bargaining agreement to make contributions to provide employee benefits. Each multiemployer plan has a Board of Trustees, comprised of equal numbers of union and employer representatives, which serves as the Plan Sponsor, Plan Administrator, and typically Named Fiduciary. Each plan also has a dedicated trust fund to hold employer contributions for the exclusive purpose of providing employee benefits. Each Board is tasked with managing the trust fund and developing a plan of employee benefits.

NEBA is hired by a plan's Board of Trustees to provide TPA services, including services unique to multiemployer plans, such as receiving and processing reports of covered employee work hours and employer contributions. NEBA maintains administrative records relating to the services it provides and as requested by clients. Some of NEBA's multiemployer health plan clients also hire NEBA to provide TPA services tailored to the contractual relationships that each plan's Board of Trustees has adopted as the means of providing health care benefits under their plan designs.

NEBA'S MULTIEMPLOYER HEALTH PLAN CLIENTS

The Boards of Trustees of NEBA's health plan clients have each entered into contractual relationships with different types of service providers to provide health care benefits under their

[2] Ms. Berio LeBeau previously served as a Trial Attorney in the Office of the Solicitor for the U.S. Department of Labor where she primarily worked with EBSA, and has more than 15 years of private practice experience serving as Fund Counsel to multiemployer benefit plans and representing benefit plan fiduciaries, participants, sponsors, and service providers.

benefit plans. NEBA health plan clients offer both fully insured and self-funded health care benefits. NEBA is hired to provide different types of services depending on the nature of each plan's design.[3]

Fully Insured Health Plan Clients

Some of NEBA's health plan clients provide benefits entirely through fully insured policies issued by insurance companies. NEBA's role is limited with respect to benefit claims or appeals for these types of clients, and participant experience is similar to insured group health plans.[4]

Administrative Services Only Self-Funded Health Plan Clients

Some of NEBA's health plan clients have Administrative Services Only (ASO) arrangements where participants receive benefits administered by an insurance company, but the plan takes on claims funding responsibility instead of the insurance company. Benefit claims and appeals are typically managed by the ASO carrier, and participant experience can be similar to receiving benefits through an insured plan.[5]

Shared or Joint Administration Self-Funded Health Plan Clients

Some of NEBA's health plan clients operate under shared or joint administration arrangements, where the Boards of Trustees engage different types of service providers to perform different functions needed to provide health care benefits under their plan designs. Under shared administration arrangements plans hire NEBA to adjudicate claims based on plan terms, pay claims using trust fund assets, and administer appeals of denied claims for consideration and decision by each plan's Board of Trustees, in addition to other typical TPA services. Plans hire other service providers to provide other needed services, such as access to health care provider networks,

[3] Many of our welfare plan clients offer other types of welfare benefits in addition to health care benefits, which can also be fully insured or self-funded. Plans that offer self-funded health care benefits typically also have stop loss insurance. This statement and our testimony are limited to our experience with plans that hire NEBA to provide services relating to health benefit claims and appeals.

[4] Participants in fully insured plans may still call NEBA about claims or file appeals with a Board of Trustees.

Plans that only offer fully insured health care benefits tend to not have agreements with other types of service providers, since insurance companies provide all services, in contrast to self-funded shared administration plans, as described herein.

[5] Plans with ASO arrangements tend to not have agreements with other types of service providers if the insurance company provides all services other than claims funding.

NEBA has had clients, however, with insured and ASO arrangements where appeals of benefit claim denials are referred back to the Board of Trustees. For simplicity's sake we are not including our experience with these types of clients in this statement or our testimony. NEBA's services in connection with this type of arrangement would be similar to the appeals administration services described herein for shared administration clients.

discounted pricing arrangements, reference-based pricing services, medical management review services, access to prescription drug provider networks, utilization review services, consultant services, and more. NEBA does not offer consulting, plan design, provider network access, claim re-pricing, medical management, or similar services.[6]

NEBA CLAIMS AND APPEAL ADMINISTRATION SERVICES

This statement and our testimony are limited to NEBA's experience providing health plan claims adjudication and appeals administration services for self-funded multiemployer health plan clients with shared or joint administration arrangements.

When NEBA is hired to provide claims adjudication services NEBA will program its client health plan's terms, conditions, procedures and rules into its system. Claims are typically submitted by providers electronically using standard reporting codes and systems. Certain types of claims are auto-adjudicated, as appropriate under plan terms. Claims adjusters review submitted claims and apply plan rules to adjudicate claims. NEBA provides claims adjudication services to its self-funded health plan clients on a non-fiduciary basis.

NEBA does not provide medical management review services. Claims adjusters will refer claims to each plan's medical management review company to determine whether claims are excluded from plan coverage on the basis of limitations or exclusions that require review of medical information, such as medical necessity, experimental treatment, or similar exclusions.

Each plan's contracted medical management company will also review pre-authorization requests and issue determinations. NEBA typically does not provide services related to pre-service pre-authorization requests that involve review of submitted medical information.

NEBA employees also answer phones and respond to participant and provider claim related inquiries, including about denied claims. As discussed in more detail below, NEBA assists participants and providers to informally resolve denied benefit claims when appropriate. NEBA employees are also trained to inform participants about their rights to appeal denied benefit claims. NEBA works for the Boards of Trustees of our client plans, however, and thus does not assist participants in filing appeals or provide advice on whether and how to appeal.

When NEBA is hired to provide health benefit appeals administration services NEBA will implement each plan's procedures for managing benefit appeals. Most of NEBA's client plans do not have specific requirements for participant appeals and will accept any form of writing as an

[6] Other TPA companies do offer services related to plan design, access to provider networks, claim re-pricing, medical management, consulting, and similar services. The term "Third Party Administrator" can be used to describe entities that provide lots of different types of services related to health plan administration.

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appeal of a denied benefit, such as an email, memo or letter. NEBA will typically receive a benefit appeal, will collect materials and information from the participant who is appealing and from providers who either performed services for post-service claims or from providers seeking pre-authorization for pre-service claims, will request independent medical evaluations when required, and will put together a package for the plan's Board of Trustees to use in deciding appeals. Each plan's Board is the decision maker for benefit claim appeals.

NEBA provides appeals administration services on a non-fiduciary basis. NEBA collects and prepares information following each plan's established procedures for review and decision by each plan's Board of Trustees. NEBA does not review appeals on the merits or offer recommendations on how a Board should evaluate or decide appeals.

EXPLANATION OF BENEFITS STATEMENTS (EOBs)

Plan participants are eligible for benefits as allowed under the terms of their benefit plans. Participants will typically obtain services from health care providers and the providers will typically submit claims for adjudication.[7]

Explanation of benefits statements (EOBs) are generated when claims for incurred services are submitted to a plan for adjudication. EOBs will include applicable participant cost-sharing obligations, such as deductibles, co-insurance, and co-pays, will detail payments to providers under plan terms, and will provide information about denied claims. NEBA client plans' EOBs are accompanied by disclosures and information about appeal rights, which typically track language from the claims procedure regulations.[8]

NEBA provides EOBs to participants via paper mail; many plans also make EOBs available electronically through NEBA's online member portal.[9]

EOBs are not generated for pre-service pre-authorization requests. EOBs detail how claims for incurred services are adjudicated, and pre-service inquiries are not submitted claims.

[7] Many NEBA client plans utilize provider networks, and in network providers will usually submit claims after providing services. NEBA client plans also allow participants to submit claims directly. EOBs are generated for all claims that are submitted for payment.

[8] Appeals rights language is typically written and approved by each plan's fund counsel or fund consultant.

[9] Current DOL guidance for electronic delivery of welfare plan related documents tends to make it challenging for multiemployer health plans to provide plan related documents electronically. See 29 C.F.R. §2520.104b–1(c). As discussed herein, perhaps electronic delivery of EOBs could improve the type of information provided to participants. The DOL would need to update its guidance on electronic delivery of plan related documents for welfare benefit plans, however, in a way that would allow multiemployer health plans to provide electronic welfare plan communications.

HEALTH PLAN BENEFIT CLAIM DENIALS

Given that the Council's inquiry is focused on low appeal rates of denied health plan claims this discussion is focused on health benefit claim denials.

The Council should understand, however, that, in NEBA's experience, the vast majority of health benefit claims are adjudicated and processed and paid as appropriate under plan terms. In NEBA's experience denied health plan claims represent a small minority of the total volume of processed health benefit plan claims.

We also noticed that the Council's issue statement seems to assume or imply that low appeal rates of denied health plan claims are due to participants not understanding their appeal rights or not having sufficient information about their appeal rights. Our experience, however, suggests that it is also possible that health plan claim denials are not often appealed because claims are adjudicated appropriately under plan terms, or are resolved informally without participants filing appeals, or do not result in participant financial obligation.

Informal Resolution: Missing or Incomplete or Mistaken Information

Benefit claims denied due to missing or incomplete or mistaken information can often be resolved informally without an appeal to a plan's Board of Trustees. Participants or providers will contact NEBA when claims are denied and provide missing information, correct mistaken information, or identify additional information needed to support a claim. NEBA often assists participants and providers in correcting or supplementing information to resolve health benefit claim denials.[10]

Pre-authorization requests can also be denied due to missing or incomplete information and can be resolved informally without an appeal to a plan's Board of Trustees.

Claim Denials with No Participant Financial Obligation

Some claim denials do not result in participant financial responsibility. For example, some provider network or discounted pricing arrangements have restrictions that disallow billing on

[10] Some examples: a claim is denied based on eligibility, however a participant's employer was late in reporting work hours so his eligibility was not displayed accurately at the time the claim was adjudicated. The claim can be re-processed once eligibility information is updated. A claim is denied because a participant had failed to submit an accident report form as required under plan terms. Once the required information is provided the claim can be re-processed. A claim is denied because a provider submitted incorrect coding, such as coding a preventive service as a diagnostic procedure. The provider can re-submit the claim with correct coding and the claim will be re-processed.

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certain types of claims.[11] Claims are also sometimes submitted more than once and denied as duplicate charges. Participants have appeal rights but no reason to appeal such denials.[12]

APPEALS OF BENEFIT DENIALS TO PLAN BOARDS OF TRUSTEES

Some benefit denials cannot be resolved informally. In NEBA's experience this is often because they have been properly adjudicated under plan terms. Participants, however, may still appeal benefit denials to a plan's Board of Trustees if they are not satisfied with the result.

Nature of Appealed Benefit Denials

Broadly speaking, in NEBA's experience, participants tend to appeal 1) benefit claims that were properly denied under plan terms but participants ask for exceptions or plan rule changes, and 2) benefit claims denied based on exclusions such as medical necessity. Participants also occasionally appeal cost-sharing determinations for out of network (OON) services that were properly calculated under plan terms.

Participants may appeal benefit denials even though they were properly denied under plan terms when they believe that a plan should change its rules to allow their claims or when they believe that their circumstances support an exception. For example, a plan might have limitations or exclusions on durable medical equipment, but a participant's medical team insists that certain equipment is required for the participant's treatment. The appellant might acknowledge that plan terms do not cover the claim, but request that the Board change plan rules to allow exceptions under certain circumstances such as medical necessity. Another example: a plan may have denied a dependent's claims because a participant failed to provide required information about the dependent, such as a new spouse or a new baby; the dependent would otherwise be eligible for benefits. The appellant may ask the Board to excuse the failure to timely provide information and allow late submission of the dependent's information.

Participants also appeal pre-service and post-service claim denials based on plan exclusions, asking Boards of Trustees to reconsider benefit determinations. For example, many NEBA client plans exclude cosmetic surgery, but cosmetic surgery procedures can sometimes be medically necessary. A plan's medical management company may have determined that a cosmetic surgery procedure was not medically necessary, and a claim or pre-authorization request was denied. A

[11] For example, providers often agree to provide maternity care for a bundled fee. Sometimes claims for services included in the global fee are submitted separately. The claims will be denied based on the provider agreement but participants will not have financial obligations.

[12] Please note that statistics on the number of claim denials could be misleading since systems typically do not break out the reasons for claim denials. A claim denied for lack of medical necessity and a claim denied as a duplicate or disallowed charge may appear in the same data field.

participant might appeal the denial and provide additional information asking the trustees to reconsider based on her specific circumstances.

Participants also appeal allowed OON claims where they are unhappy with their cost sharing responsibilities. Each plan has a methodology for determining the amount a plan will pay for OON services, and participants can be responsible for the remaining billed balance. Participants may appeal to the Board of Trustees for reconsideration even if the plan's OON allowance was properly calculated under plan terms.[13]

UNIONS AND INFORMATION ON APPEAL RIGHTS

Broadly speaking, in NEBA's experience, participants tend to receive information about appeal rights informally through their unions or by calling NEBA to inquire about benefit denials. Many unions have benefits coordinators who can provide information about benefit plans, including information about appeal rights. Participants also often personally know the trustees of their multiemployer health plans and will ask them about benefit denials, or will ask other union officials for information or assistance. Plan participants may also obtain assistance from other union members. As explained above, participants also call NEBA when claims are denied and NEBA will assist in resolving benefit denials and provide information about appeal rights.[14]

CLOSING THOUGHTS

We hope that this statement and our testimony is helpful to the Council in its examination of health plan benefit claim denials. As detailed above, NEBA's experience providing claims adjudication and appeal administration services to self-funded multiemployer health benefit plans suggests that most health plan claims are adjudicated and paid as appropriate under plan terms, claims that were denied based on missing or incorrect information are routinely resolved informally without appeals, and participants exercise appeal rights for denied claims if they are not satisfied with a result.

Our experience does not affect, however, our observation that current claims procedures regulations are long and detailed, and typically result in long, detailed language in Summary Plan Descriptions and EOBs that could be confusing for participants to understand and follow. The Council should consider whether the DOL should issue model language that plans could adopt

[13] The No Surprises Act provides required procedures, payment standards, and participant cost sharing for OON claims under specific circumstances, but it does not cover all OON claims.

[14] Anecdotally, most if not all appeals of benefit denials to Boards of Trustees involved at least one phone call to NEBA. Also anecdotally, members who call NEBA about benefit denials are not generally aware of their appeal rights before calling NEBA.

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with shortened or summarized appeal rights information and offer safe harbor protection for plans that use the model language.

The Council could also consider whether the DOL could offer model language for appeal rights and other disclosures specifically for electronically delivered documents that uses hyperlinks as a tool to provide shortened and easier to understand claims procedure information; the initial page could highlight key terms and information, with hyperlinks to more detailed information that participants can access as needed.[15] Plans could be offered safe harbor protection if they adopt and use electronic model language.[16]

Thank you again for the opportunity to participate in the Council's inquiry. Please let us know if there are any questions or if you would like additional information.

Sincerely,

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[15] The DOL would also need to update regulations for the electronic delivery of welfare plan documents, as the DOL recently did for electronic delivery of pension plan documents, in a way that would make it easier for multiemployer health plans to use electronic delivery of health plan communications.

[16] Please note, however, that we are not suggesting that electronic delivery of health plan communications should be required. Many participants in our client plans prefer to receive plan related information on paper via mail. We have observed, however, that Trustees of our client plans would appreciate having more flexibility for providing plan related information to participants electronically. Most of our plans already provide information electronically via NEBA's employee portal but send required plan related communications by paper mail.

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