September 7, 2011

Hon. Douglas Shulman  
Commissioner  
Internal Revenue Service  
1111 Constitution Avenue, N.W.  
Washington, DC 20224  

Re: Comments on Interim Final Regulations for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Process under the Patient Protection and Affordable Care Act

Dear Commissioner Shulman:

Enclosed are comments on interim final regulations for group health plans and health insurance issuers relating to internal claims and appeals and external review process. These comments represent the views of the American Bar Association Section of Taxation. They have not been approved by the Board of Governors or the House of Delegates of the American Bar Association, and should not be construed as representing the policy of the American Bar Association.

Sincerely,

William M. Paul  
Chair, Section of Taxation

Enclosure

cc: Emily McMahon, Acting Assistant Secretary (Tax Policy), Department of the Treasury  
William Wilkins, Chief Counsel, Internal Revenue Service  
J. Mark Ivery, Senior Advisor to the Secretary and Deputy Assistant Secretary for Retirement and Health Policy, Department of the Treasury  
Jeffrey Van Hove, Acting Tax Legislative Counsel, Department of the Treasury  
George H. Bostick, Benefits Tax Counsel, Department of the Treasury  
Alan N. Tawshunsky, Deputy Division Counsel/Deputy Associate Chief Counsel (EmployeeBenefits), Internal Revenue Service
ABA SECTION OF TAXATION
COMMENTS ON INTERIM FINAL REGULATIONS FOR
GROUP HEALTH PLANS AND HEALTH INSURANCE ISSUERS
RELATING TO INTERNAL CLAIMS AND APPEALS AND
EXTERNAL REVIEW PROCESSES
UNDER THE
PATIENT PROTECTION AND AFFORDABLE CARE ACT

REGULATION IDENTIFIER NUMBER (RIN) 1210-AB45

These comments ("Comments") are submitted on behalf of the American Bar Association Section of Taxation and have not been approved by the House of Delegates or Board of Governors of the American Bar Association. Accordingly, these Comments should not be construed as representing the position of the American Bar Association.

Principal responsibility for preparing these Comments was exercised by Jane E. Armstrong, Christine M. Daly, Erin E. DeCecchis, John H. Eggertsen, Matthew J. Eickman, Seale Pylate, and Doug Ritterskamp of the Committee on Employee Benefits of the Section of Taxation. The Comments were reviewed by Mark A. Bodron, Committee Vice Chair, and by John L. Utz, former Committee Chair (2010-2011). Comments were further reviewed by Roberta Casper Watson and James R. Raborn of the Section’s Committee on Government Submissions and by Thomas R. Hoecker, former Council Director (2010-2011) for the Employee Benefits Committee.

Although the members of the Section of Taxation who participated in preparing these Comments have clients who might be affected by the federal income tax principles addressed by these Comments, no such member or the firm or organization to which such member belongs has been engaged by a client to make a government submission with respect to, or otherwise to influence the development or outcome of, the specific subject matter of these Comments.

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Date: September 7, 2011
EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act of 2010\(^1\) and the Health Care and Education Reconciliation Act of 2010\(^2\) (collectively, the “Affordable Care Act” or “ACA”) implement significant new health care reforms including new requirements for internal claims and appeals and external review processes for group health plans and health insurance issuers who provide group or individual health insurance coverage.

These Comments relate to the interim final regulations (the “Regulation”),\(^3\) issued July 23, 2010, by the U.S. Department of the Treasury, the Internal Revenue Service, the U.S. Department of Labor (“DOL”), and the U.S. Department of Health and Human Services (collectively, the “Departments”), and DOL Technical Release 2010-01 (the “Release”),\(^4\) issued August 23, 2010, regarding section 2719 of the Public Health Safety Act (the “PHS Act”),\(^5\) which relate to internal claims and appeals and external review processes for group health plans and health insurance issuers providing group or individual health insurance coverage.

In response to the invitation from the Departments for comments, we recommend that the Departments revise the Regulation to:

1. Clarify that a claim filed under a group health plan before the relevant Applicability Date (Applicability Date is defined below in Section I.A.) for the plan that has not yet been resolved as of the Applicability Date may be resolved in accordance with the plan’s claims procedure in effect prior to the Applicability Date or, if the plan so chooses, in accordance with the new procedures set forth in the Regulation.

2. Provide that if a group health plan that is a grandfathered plan ceases to provide grandfathered plan coverage for plan years beginning on or after September 23, 2010: (i) for purposes of the Regulation, the loss of grandfathered plan status will be effective (y) in the case of a change that is deemed material, 90 days after the date on which such change takes effect, and (z) with respect to all other changes, the first day of


\(^{3}\) 75 Fed. Reg. 43,330 (2010). For convenience, these Comments generally cite to the sections of the Regulation that were issued by the U.S. Department of the Treasury and Internal Revenue Service as “Interim Final Regulations.” Temp. Reg. § 54.9815-2719T. Such citations are intended to include, and these Comments are also intended to apply to, the corollary sections of the Regulation issued by the DOL, 29 C.F.R. § 2590.715-2719, and U.S. Department of Health and Human Services, 45 C.F.R. § 147.136.


the next following plan or policy year; and (ii) the Regulation will apply to claims filed after the loss of grandfathered plan status becomes effective.

3. Modify the “deemed exhaustion” standard for the internal claims and appeals processes to provide that procedural failures that do not prejudice the rights of the claimant will not trigger the deemed exhaustion standard, which is consistent with the standard developed under case law.

4. Clarify that the requirement to provide continued coverage pending the outcome of an internal appeal is limited to the approved ongoing course of treatment that is the subject of the pending claim and ceases once the internal review process has ended.

5. Clarify that a plan may rescind coverage and recoup benefits paid when the claim involves fraud or the claimant made an intentional misrepresentation of material fact.

6. Coordinate how, or clarify whether, a rescission of coverage for an ongoing course of treatment is considered an “adverse benefit determination” that would start the internal review process all over again.

7. Clarify that the scope of adverse benefit determinations eligible for the Federal external review process is limited to medical determinations and that no legal determinations (i.e., not just eligibility decisions) are subject to the Federal external review process.

8. Clarify that the safe-harbor requirement for a self-insured group health plan to “contract with at least three” independent review organizations may be satisfied by a third party administrator for the group health plan, in lieu of the group health plan.
COMMENTS

BACKGROUND

The subjects of these Comments are the Regulation and the Release, which interpret the Affordable Care Act requirements relating to internal claims and appeals and external review processes for group health plans and health insurance issuers offering group or individual health insurance coverage.\(^6\) These requirements are incorporated by reference into the Internal Revenue Code of 1986, as amended (the “Code”), by section 9815 of the Code, and into the Employee Retirement Income Security Act of 1974, as amended (“ERISA”),\(^7\) by section 715 of ERISA.\(^8\)

We commend the Departments’ regulatory and outreach efforts in providing comprehensive and thoughtful regulations and other guidance to assist employers in their efforts to comply with the provisions of the Affordable Care Act, especially those requirements that became effective during 2010.\(^9\) We hope these comments advance the Departments’ ongoing process of developing guidance that applies these new requirements in a manner that is clear, fair, and as practical as reasonably possible.

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\(^6\) PHS Act § 2719, as added by ACA § 1001(5).


\(^8\) 29 U.S.C. § 715. Section 9815 of the Code and section 715 of ERISA were added by subsections (e) and (f), respectively, of section 1563 of the ACA, entitled “CONFORMING AMENDMENTS.”

\(^9\) In addition to the various interim final regulations, model notices, the three DOL Technical Releases (2010-1 (Aug. 23, 2010), 2010-2 (Sept. 20, 2010), and 2011-01 (Mar. 18, 2011)), and other guidance issued by the Departments, we applaud the DOL’s webcast series regarding plan sponsor compliance with the ACA.
I. CLARIFY THE APPLICABILITY DATE FOR CLAIMS

A. Summary

With respect to group health plans, other than grandfathered health plans, and health insurance issuers offering group health insurance coverage, the Regulation is effective for plan years beginning on or after September 23, 2010 (the “Applicability Date”). The internal claims and appeals and external review requirements under section 2719 of the PHS Act do not apply to grandfathered health plans. However, the Regulation does not provide an Applicability Date, and no such date is expressly provided under the companion regulation concerning status as a grandfathered health plan, if and when a group health plan ceases to be a grandfathered plan.

B. Recommendations

- We recommend that the Departments revise the Regulation to clarify that a claim filed under a group health plan before the relevant Applicability Date for the plan that has not yet been resolved as of the Applicability Date may be resolved in accordance with the plan’s claims procedure in effect prior to the Applicability Date or, if the plan so chooses, in accordance with the new procedures set forth in the Regulation.

- We recommend that the Departments revise the Regulation to provide that if a group health plan that is a grandfathered plan ceases to provide grandfathered plan coverage for plan years beginning on or after September 23, 2010: (i) for purposes of the Regulation, the loss of grandfathered plan status will be effective (y) in the case of a change that is deemed material, 90 days after the date on which such change takes effect, and (z) with respect to all other changes, the first day of the next following plan or policy year; and (ii) the Regulation will apply to claims filed after the loss of grandfathered plan status becomes effective.

C. Explanation

As of the Applicability Date, it is reasonable to anticipate that some claims filed in the immediately preceding plan year will be in the process of initial review or internal appeal. Similarly, if a group health plan ceases to provide grandfathered health plan

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10 ACA § 1251; see also Temp. Reg. § 54.9815-1251T (relating to the determination of a plan’s status as a grandfathered health plan).

11 Temp. Reg. § 54.9815-2719T(g). The applicability date of the Regulation for individual health insurance issuers is for policy years beginning on or after September 23, 2010.

12 Id. (referencing Temp. Reg. § 54.9815-1251T). The interim final regulation implementing the grandfathered health plan rules provides that section 2719 of the PHS Act (implementing the new requirements for internal claims and appeals and external review processes) does not apply to grandfathered health plan coverage. Temp. Reg. § 54.9815-1251T(c).
coverage, it is likely that some claims filed before the change in plan status will be in the process of initial review or internal appeal.

All parties, whether plan sponsors, insurers, third party administrators (“TPAs”), or claimants, have an interest in the application of uniform review and internal appeal standards with respect to the processing and payment of a claim. Application of the Regulation to a claim filed prior to the Applicability Date and in the initial review or appeal process is likely to create uncertainty, delay, and other practical difficulties due to the application of two separate sets of claims procedure requirements. For example, if an initial review is substantially completed before the Applicability Date, it is unclear under the Regulation whether the review must then be delayed to permit compliance with the additional requirements imposed under the Regulation, such as to provide a “rationale” and solicit and permit “testimony,” review for compliance with the heightened conflicts of interest provisions, or to modify the terms of the notice related to the nearly-completed review. We believe that these practical difficulties are best resolved by the adoption of a “bright line” effective date for the application of the Regulation. A bright line approach would create certainty for all parties and is easily communicated to claimants and administered by the plan sponsor, insurer, or TPA.

We note that similar concerns were addressed in a like fashion when the DOL claims procedure regulation (the “DOL Claims Regulation”) was last amended, effective January 1, 2002. That regulation expressly provides that it applies to “claims filed” on or after the first day of the plan year beginning on or after July 1, 2002.

With respect to group health plans that cease to provide grandfathered plan coverage, additional compliance actions will be required under the ACA. For example, such a plan must be amended to incorporate the applicable review and appeals processes and must identify and contract with independent review organizations providing external appeals, expand explanation of benefits (“EOBs”) disclosures, and modify similar documents. Moreover, participants and claimants must be notified of the new processes. As previously noted, the interim final regulation relating to the determination of a plan’s status as a grandfathered plan does not specify when grandfathered status is lost. Accordingly, we recommended that the interim final rule regarding the determination of grandfathered plan status be revised to provide that the loss of grandfathered plan status will be effective: (i) in the case of a change that is deemed material under section 2715(d)(4) of the PHS Act, 90 days after the date on which such change takes

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13 See additional requirements set forth in Temporary Regulation section 54.9815-2719T(b)(2)(ii).

14 29 C.F.R. § 2560.503-1.


effect; and (ii) with respect to all other changes, the first day of the next following plan or policy year (the “Status Change Effective Date”). Because the Regulation requires a number of additional disclosures and changes in administrative practices and procedures, we further recommend that the final Regulation be revised to expressly provide that the loss of grandfathered status be effective as of the Status Change Effective Date. Also, consistent with our recommendation above for non-grandfathered plans, we recommend that with respect to a grandfathered plan that loses grandfathered plan status, only claims submitted on or after the Status Change Effective Date be subject to the requirements of the Regulation.

II. MODIFY THE DEEMED EXHAUSTION STANDARD

A. Summary

The Regulation includes a “deemed exhaustion” provision, pursuant to which a claimant will be deemed to have exhausted the internal review and appeals process of a group health plan if the plan fiduciary or issuer fails to “strictly adhere” to “all” of the minimum internal claims and appeals standards imposed under such rules. Deemed exhaustion is applicable regardless of whether the plan fiduciary or issuer substantially complies with the internal claims and appeals processes or whether the error or deviation is minor or de minimis.

In the event of a deemed exhaustion, a claimant may elect to initiate an external review or pursue any remedy available under section 502 of ERISA or State law, as applicable. If a claimant elects to initiate an external review, the effect of the deemed exhaustion is that an adverse benefit determination, or final internal adverse benefit determination, has been rendered, which determination is then subject to de novo review. Thus, in reaching a decision on external review, the independent review organization (“IRO”) “is not bound” by any decision reached during the internal grievance process. If a claimant elects to pursue remedies under section 502 of ERISA, the effect of a deemed exhaustion is that the claim or internal appeal will be deemed denied on review, without the exercise of discretion by an appropriate fiduciary, permitting a court to review the denial de novo.

B. Recommendation

17 Id.
We recommend that the Departments revise the final Regulation to modify the “deemed exhaustion” standard for the internal claims and appeals processes to provide that procedural failures that do not prejudice the rights of the claimant will not trigger the deemed exhaustion standard, consistent with the standard developed under case law.

C. **Explanation**

As noted above, the Regulation provides that in the event a plan fiduciary or issuer fails to “strictly adhere” to “all” of the applicable standards set forth in the Regulation, a claimant will be deemed to have exhausted the plan’s review and internal appeals processes and, if the claimant elects to pursue remedies under section 502 of ERISA or initiate an external review, the claim will be subject to a *de novo* standard of review. This strict adherence requirement represents a significant departure from long-standing authority and we believe in most cases will afford no substantial benefit to any claimant, will likely increase the costs associated with the claims process, and will delay resolution of claims.

When a plan document affords a fiduciary discretion to determine benefits, the fiduciary’s determination is subject to judicial review under an abuse of discretion standard. Even when a plan fiduciary fails to comply with all of the procedural requirements applicable to reviews or internal appeals, it is well-settled that an abuse of discretion standard continues to apply, unless the failure is so egregious or flagrant that it causes the claimant substantive harm.

Moreover, the additional requirements imposed under the Regulation materially increase the complexity and burdens of the initial review and appeals processes. For example, decisions concerning urgent claims must now be provided “not later than” 24 hours after receipt; EOBs must include additional items of information; and claimants must be provided with a “rationale” before an adverse benefit determination is rendered and afforded the opportunity to provide “testimony” and examine claims files. Under the accelerated decision requirements of the Regulation, it is very likely that minor procedural errors will occur despite the best efforts of plan fiduciaries and insurers acting in good faith to comply with the requirements of the Regulation. However, unlike existing case law, under the Regulation inadvertent, minor, or *de minimis* procedural errors or deviations that have no impact on either the conduct of the claims or appeals processes or the substantive outcome of any claim will trigger a loss of the abuse of discretion standard.

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24 See, e.g., *Militello v. Central States, Southeast & Southwest Areas Pension Fund*, 360 F.3d 681 (7th Cir. 2004); *Jebian*, 349 F.3d 1098, 1107 (9th Cir. 2003); *Perrino v. S. Bell Tel. & Tel. Co.*, 209 F.3d 1309, 1318 (11th Cir. 2000); *Terry v. Bayer Corp.*, 145 F.3d 28, 39 (1st Cir. 1998); *Buttram v. Central States et al.*, 76 F.3d 896 (8th Cir. 1996).
Many of the foregoing arguments were raised and rejected when the current DOL Claims Regulation was promulgated. However, the DOL subsequently published “Frequently Asked Questions,” or FAQs, acknowledging that “not every deviation” from claims or appeals processes justifies proceeding directly to court.

Noting that a claimant’s remedies are limited under ERISA section 502, the Preamble to the Regulation explains that strict adherence to claims review procedures is now necessary to ensure that a claimant is afforded access to the administrative review process mandated by ERISA. We believe, however, that this approach does not take into account the addition of a significant new safeguard (i.e., the requirement to provide continued coverage pending the outcome of an internal appeal) that counterbalances the limitation of remedies available under section 502 of ERISA. Also, in the event of an adverse benefit determination, a claimant may now elect to proceed with an external review by an IRO.

For the reasons mentioned above, we believe that continuation of the current standard developed and followed by the case law is reasonable and appropriate and thus we recommend the removal of words and phrases such as “all” and “strict adherence” from the Regulation with respect to procedural compliance.

III. CLARIFY THE REQUIREMENT TO PROVIDE CONTINUED COVERAGE PENDING THE OUTCOME OF AN INTERNAL APPEAL

A. Summary

The Regulation requires that group health plans provide “continued coverage” pending the outcome of an internal appeal. For this purpose, the Regulation provides that a group health plan must comply with the requirements in the DOL Claims Regulation, which provides that benefits for an “ongoing course of treatment” cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

B. Recommendations

- We recommend that the Departments revise the Regulation to clarify that the requirement to provide continued coverage pending the outcome of an internal appeal is limited to the approved ongoing course of treatment that is the subject of the pending claim, and ceases once the internal review process has ended.

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26 See DOL 2008 Compliance Assistance FAQs, Q&A-F2.
We also recommend that the Departments revise the Regulation to clarify that the plan may rescind coverage and recoup benefits paid when the claim involves fraud or the claimant made an intentional misrepresentation of material fact.

Further, we recommend that the Department revise the Regulation to coordinate how, or clarify whether, a rescission of coverage for an ongoing course of treatment is considered an “adverse benefit determination” that would restart the internal review process.

C. Explanation

We believe it would be helpful for the Regulation to further address what is meant by the requirement that a group health plan provide “continued coverage” pending the outcome of an internal appeal.\(^{30}\) By citing the DOL Claims Regulation with approval, the Regulation suggests that the requirement will be satisfied by providing coverage only for the ongoing course of treatment that is the subject of the pending claim. Similarly, the Preamble to the Regulation supports this construction by suggesting that the continued coverage requirement is analogous to the current DOL Claims Regulation, which limits continuation to an approved ongoing course of treatment that is the subject of the claim.\(^ {31}\) Use of more specific language regarding the scope of continued coverage would be helpful, because the uncertainty created by the requirement may impose unintended costs and burdens on plans and plan sponsors and create litigation risk.

If the requirement to provide “continued coverage” is intended to include coverage for all benefits, thereby including subsequent or additional courses of treatment, then at least with respect to internal appeals involving eligibility (e.g., an employee enrolls an individual who does not satisfy the specified family relationship with the employee or the individual has reached a certain age),\(^ {32}\) we believe the continued coverage requirement in the Regulation should be narrowed. In such circumstances, we suggest that the Regulation provide that “continued coverage” refers only to a claimant’s approved “ongoing course of treatment” at the time the internal appeal commences.

It would also be helpful for the Departments to revise the Regulation to clarify that the group health plan may eliminate continued coverage for an ongoing course of treatment once the internal review process has ended for any reason, such as, for example, if the claimant failed to provide information required to process the claim, the


\(^{31}\) See 75 Fed. Reg. 43,330, 43,352 (2010); Temp. Reg. § 54.9815-2719T, II(b)(1) (stating that in the context of the continued coverage requirement, a plan cannot reduce or terminate an “ongoing course of treatment”).

\(^{32}\) See ABA Section of Taxation, “Comments on Regulations Regarding Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections under the Patient Protection and Affordable Care Act”, (September 15, 2010), available at http://www.americanbar.org/content/dam/aba/migrated/tax/pubpolicy/2010/091510comments.authcheckdam.pdf.
claimant has failed to timely appeal the claim, or the claim has been denied on internal appeal.

We further recommend that the Departments revise the Regulation to expressly provide that the group health plan may rescind coverage (including “continued coverage” for an ongoing course of treatment) and recoup benefits paid with respect to claims involving fraud or when the claimant made an intentional misrepresentation of material fact.33

Assuming rescission is permitted due to a misrepresentation by the claimant, clarification is requested to address (i) whether such a rescission is an adverse benefit determination that starts the internal and external review processes all over again and (ii) whether continued coverage is required during such review. If, at the subsequent internal and external review the claimant is determined to have misrepresented the facts, and the coverage is rescinded, then we do not believe that it is the intent of the ACA that such rescission constitutes another adverse benefit determination that starts the process over once again. Such a result would cause delays in the processing of the claim and an increase in the administrative cost and complexity of the plan. We suggest that the final Regulation be clarified to provide that the foregoing facts do not trigger a “restart” in the processes.

IV. CLARIFY THE SCOPE OF DETERMINATIONS ELIGIBLE FOR THE EXTERNAL REVIEW PROCESS

A. Summary

The Federal external review process applies to any adverse benefit determination, except a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the group health plan.34 The Regulation provides that a Federal external review process will be established that will be similar to the process set forth in the NAIC Model Act.

B. Recommendation

- We recommend that the Departments revise the Regulation to clarify that the scope of adverse benefit determinations that are eligible for the Federal external review process is limited to medical determinations and that no legal determinations (i.e., not limited solely to eligibility decisions) are subject to the Federal external review process.

33 Id.
C. **Explanation**

We are concerned that the Regulation is not entirely clear as to the types of adverse benefit determinations that are eligible for the Federal external review process. The Regulation states that the Federal external review process applies to “any adverse benefit determination,” except a denial, reduction, termination, or a failure to provide payment for a benefit due to a failure to meet the plan’s eligibility requirements.\(^{35}\) The Regulation further provides that the Federal external review process to be established will be “similar” to the process in the NAIC Model Act.\(^{36}\) However, the NAIC Model Act appears to only apply to benefit denials that are based on medical decisions (“Medical Determinations”).\(^{37}\) The scope of determinations covered by the NAIC Model Act is substantially narrower than the definition of “adverse benefit determination” in the DOL Claims Regulation.\(^{38}\)

The Release provides additional guidance and interim procedures for Federal external reviews. We note that the discussion in the Release regarding contracts between the plan and an IRO requires the IRO to “utilize legal experts” when appropriate to make “coverage determinations” under the plan.\(^{39}\)

However, the Regulation and the Release do not address what types of “legal” determinations (other than eligibility decisions, which are expressly excluded), if any, are eligible for the Federal external review process for which the IRO would need to utilize legal experts. It would be helpful for the Regulation to list or provide examples of legal determinations that would not be subject to the Federal external review process. Examples of other “legal” determinations that we believe should be listed in the final Regulation as not eligible for the Federal external review process include:

(i) a determination that a benefit is not a covered benefit;

(ii) a partial denial when a group health plan pays less than the total amount of the claim due to the terms of the plan (or health insurance coverage),

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\(^{35}\) *Id.*


\(^{37}\) NAIC Model Act § 3(A) (providing that the definition of “adverse determination” means a determination “that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated”).

\(^{38}\) DOL § 2560.503-1(m)(4) (defining “adverse benefit determination” to include determination of a participant’s or beneficiary’s eligibility to participate in a plan, determination based on the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate); see also Temp. Reg. § 54.9815-2719T(a)(2)(i) (expanding the definition to include “any rescission of coverage”).

\(^{39}\) DOL Technical Release 2010-01, § A(3).
including the application of co-payments, deductibles, or other cost-sharing requirements;

(iii) the imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits;

(iv) denial of a benefit due to a group health plan’s subrogation or coordination of benefit provisions; and

(v) a rescission of coverage (within the meaning of section 2712 of the PHS Act).

We believe that claimants, plan sponsors, insurers, and TPAs would benefit from additional guidance in the final Regulation regarding the types of determinations that are eligible for the Federal external review process. We further believe such additional guidance would further a primary purpose of the Regulation to provide uniformity in claims processing and to simplify the system for consumers and plan administrators.

V. CLARIFY THE IRO CONTRACTING REQUIREMENT FOR SELF-INSURED GROUP HEALTH PLANS

A. Summary

The Release includes helpful interim safe-harbor guidance for non-grandfathered, self-insured group health plans subject to the Federal external review process. One requirement in the Release for standard external reviews for self-insured group health plans requires each group health plan to “contract with at least three” accredited IROs for assignment to the IROs on a rotating or random basis to conduct the Federal external review.

B. Recommendation

- We recommend that the Departments revise the Regulation to clarify that the safe-harbor requirement for a self-insured group health plan to “contract with at least three” IROs may be satisfied by a TPA for the group health plan, in lieu of the group health plan.

C. Explanation

The Affordable Care Act imposes a number of new requirements on sponsors of group health plans that choose to offer employer-sponsored health care coverage. In particular, plan sponsors of ERISA-covered self-insured group health plans will be

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40 DOL Technical Release 2010-01.
41 Id. at § A(3).
among the most affected by the Regulation due to the requirement to implement a new, yet to be implemented, Federal external review process.

Plan sponsors of self-insured group health plans routinely contract with TPAs to assist the sponsors with day-to-day administration and claims processing for the plans. Because a TPA provides similar services to a number of group health plans, the TPA will likely have more expertise in the administration of claims, be in a better position to select and contract with a greater number of IROs and may be more efficient in doing so on account of economies of scale available with respect to the TPA in contrast to an individual plan sponsor. We believe this would be particularly helpful in the case of plans offered by smaller employers. Accordingly, we suggest that the Regulation expressly provide that the plan sponsor may delegate authority to its TPA to contract directly with the IROs to satisfy this contracting requirement, subject to the IRO non-conflict of interest and other requirements under the Regulation and the Release.

We acknowledge and appreciate the tremendous efforts of the Departments in providing timely and helpful informal guidance regarding implementation of the Affordable Care Act. In particular, we note the DOL “FAQs About the Affordable Care Act Implementation Part I,” Q&A-9, which provides that a TPA for a self-insured plan may contract directly with IROs to satisfy the IRO contracting requirement.\textsuperscript{42} We recommend that the Departments provide formal guidance regarding this contracting issue by revising the Regulation to expressly provide that the plan sponsor may delegate authority to its TPA to contract directly with IROs.

\textsuperscript{42} See DOL “FAQs About the Affordable Care Act Implementation Part I” (Sept. 20, 2010), Q&A-9, available at: \url{http://www.dol.gov/ebsa/faq/faq-aca3.html}. 

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