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# Northeast Benefits Management, LLC

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**TO:** Sen. Ann Cummings; Chair  
Members of Senate Committee on Finance

**FROM:** Sherry O'Leary, CEBS, CLU, ChFC  
Principal, Northeast Benefits Management, LLC

**SUBJECT:** Testimony on S.41- An act relating to regulating entities that administer health reimbursement arrangements

**DATE:** February 7, 2019

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Good afternoon, my name is Sherry O'Leary and I am a principal of Northeast Benefits Management, LLC located in S. Burlington, VT. Thank you for the opportunity to provide written testimony. We are one of the many small businesses in VT and provide a variety of benefit plan services including, but not limited to, administration of Health Reimbursement Arrangements (HRA), Flexible Spending Accounts (both health and dependent care), and Qualified Small Employer Health Reimbursement Arrangements (QSEHRA). It is important to note that administration of the types of plans referenced above isn't our total revenue source similar to other administrators' in and out-of-state. Many of these companies also have locations outside of VT. While NBM has been in existence since 2002, I personally have been in the industry in various capacities since 1985.

## **Concerns Regarding S.41**

Overall, adding further regulation including surplus or reserve requirements would likely put many administrators out of business.

Administrators are already required to comply with many regulations, outside of the terms of their contract with their client, which include language included in ERISA documentation, DOL claims regulations, HIPAA, COBRA, debit card regulations (if debit cards are utilized), CMS regulations for Sec 111 reporting (HRA) and NACHA banking regulations.

It appears that S.41 may have been generated due to untimely claims payments, inadequate staffing, and poor customer service.

Perhaps, it might be helpful to explain what a typical process is in setting up a new group as well as how a claim can be processed to better understand a third party administrator's role as well as the employer's role. Please note that this process is over-simplified for this purpose. This explanation relates to HRAs. A similar process would take place for other types of plans.

1. First there is a design discussion which determines what types of expenses are allowed within the confines of the regulations, what the reimbursement formula will be for the eligible expenses and what sources the claims will come from. For

example, claims could be received directly from a download from an insurance carrier, claims could be via a debit card or submitted from a participant via mail, fax, email, mobile app, etc. Depending upon the nature of the design, claims may come from more than one source.

2. Once this has been determined, a contract is prepared and executed assuming the group wants to move forward and has done any additional due diligence, such as reference checks.
3. The administrator will then need certain information in order to set the group up on their claims platform and banking, including a census and other pertinent data to build the required documents. Once this information is received, the group is set up, debit cards are ordered (if applicable) and materials are generated for distribution. It is also important that the employer provide updated changes on employees as they occur. A change in an employee's status may impact the amount of benefit that they are eligible for.
4. Once a claim is received, it is first looked at to determine whether it is eligible. If claims are being paid from a carrier download, the processing can't begin until the download is received. Eligibility would be determined by the Plan Document or Summary Plan Description (SPD) and then it would be acted upon whether approved or declined based upon the DOL claims regulations that we have to follow that are included in the SPD that needs to be distributed by the employer. The claims regulations provide a specific time line in which a claim must be acted upon. The Plan Document and SPD is generally part of the services of the administrator and would be outlined as a service in the contract.
5. In regards to debit cards, it is important to note that a debit card can't be ordered until the employee's information is provided. There are certain times of the year when the vendors that mail debit cards experience a higher volume than normal (around open enrollment) and card mailing may take longer than at other times of the year. We frequently experience that when employees don't receive a card that we can see has been mailed that it is quite often because the plain white envelope that it comes in was thrown out. It is also important to know that debit cards will not work at all service providers including some pharmacies if they have not complied with the debit card regulations. There is a website where a pharmacy can be looked up to see if they have complied. We are aware that there are some VT pharmacies that have not complied mainly from a cost perspective and because of this debit cards would not work at these locations.

As one of the concerns had to do with timeliness of claims payment, which is regulated by DOL claims regulations, it would seem that perhaps you may want to hear from the DOL before any decisions are made.

In regards to some of the other concerns that are not related to claims payments, I'm not sure how one could regulate something such as poor customer service as it is widespread throughout many industries.

In addition, many employers administer some of these plans in-house to save money and

don't even realize that they are subject to any of the current regulations. As the bill indicates that it would regulate entities administering or proposing to administer one or more health reimbursement arrangements on behalf of a public or private employer, it would appear that these employers would be included. Determining who these companies are would be very difficult to identify and monitor.

Our claims website vendor with debit card capabilities requires that we have E&O, and a Fidelity Bond. I would expect that other claims website vendors would require the same or the administrator (with the exception of in-house administration) would have it in place as a best practice.

### **Conclusion**

Adding further regulation including surplus or reserve requirements would likely put many administrators out of business as many of the administrators are small businesses without much in reserves and income specifically generated by this administration varies significantly. I would speculate that gross revenue related to these services for many of the small employers is under \$300,000.

It would seem like requesting that the DOL weigh in before making any decisions would make sense.

Finally, at this time I would suggest a stakeholder group work with DFR to determine the options with a report back to the committee rather than requiring rule-making.

Thank you for your time.