



Insurance Administrator of America, Inc.

Tuesday, November 22, 2016

Joe Canary, Director
Office of Regulations and Interpretations
Employee Benefit Security Administrator
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, D.C. 20210
EMAIL: e-ORI@dol.gov

RE: Proposed Comments Request for the Annual Return
Report of Employee Benefit Plans
RIN 1210-AB 63 OMB Number 1545-1610 (81 Fed. Reg. 18687)

Dear Mr. Canary,

On July 21, 2016, the Department of Labor (Department) published a Notice of Proposed Rulemaking proposing changes to the Form 5500 annual report for employee benefit plans. The proposal included a new Schedule J. Insurance Administrator of America (IAA) is responding to your request for comment.

IAA provides Medical Claim administration for employers and municipalities that have established “self-funded” medical plans for their employee members. Our clients vary in size and geographic location. We hope our comments are helpful and we look for the DOL perspective in a final rule that clarifies the issues we have outlined below related to the Schedule J.

Recognizing that the DOL has the authority to establish additional reporting and disclosure requirements for ERISA welfare benefit plans, we respectfully request that the Department take into consideration the expansive requirements in the proposed regulation that includes collection of claims data, financial disclosure, etc. ERISA Section 104 and Section 505 provide statutory authority for the Department to collect health care claims and related data from group plans. While the Department has the authority to pursue health care claims and related data, the reasonableness of the request should be balanced with small business’s ability to provide the information.

The proposed regulations are significant and would take a substantial amount of time to complete. Small employers would need to take extreme measures to secure the great amount of information that is requested from their many third party vendors--a daunting expensive task for a small employer.

If the Department maintains the Schedule J as proposed, it is merely establishing a vehicle for broad based non-compliance by a large part of the business community—majority of whom are small businesses who do not have the resources to complete the requested task. For this reason, IAA strongly recommends a three year implementation period to allow the vendor community and small businesses to complete the systems adjustments necessary to be able to file the reports requested with the

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appropriate data called for in Schedule J. The additional time is necessary to achieve the DOL's goal of updating the Form 5500 and for receiving accurate data.

Lack of Data

IAA is concerned that only a few employers will be able to comply with the request for information. Fully-insured employer plans with fewer than 100 employees will not have access to the detailed data through the insurance carriers, including denial and appeal rates. A small employer would not be able to complete the stop-loss data because if they are within a bundled carrier (e.g. one of the major carriers) the break down between the stop-loss premium and the administrative fee is not always disclosed and the attachment point is not always revealed in the contract. Additionally, some information sought on the Schedule J is considered to be proprietary in nature and some employers would not want their competitors to see the information.

As professionals, TPAs recognize that many small plans have services that calculate COBRA and other services related to their benefit plan. As a result, small employers often do not know all the information related to COBRA short of the date of termination and will have to rely on billing services, or record keeper to supply them with the information.

Impact is Significant

The impact of the great volume of information that small employers would need to provide is significant. This negative impact for small business, fearful that they may face penalties for lack of compliance is very real. We have concerns that some small employers may not want to face the additional administrative requirements and make decisions that could negatively impact their employees' ability to receive health benefits at all.

We feel strongly that in order to fulfill the mandate adequately, the data requests in Schedule J must be designed to elicit consistent responses across all plans. The following comments will help make the data request more consistent and provide the need clarity.

Part I - Group Health Plan Characteristics

5. Check all that apply to the plan:

- As presented this data request is somewhat vague. The correct answer where the benefit option is a high deductible plan that is claiming grandfathered status, combined with an HRA, that is not, would be difficult to discern in light of the way the question is worded. This is because this benefit package option contains two distinct plans, which is a scenario that does not seem to be contemplated by the provided choices. We respectfully request that the first sentence be clarified in the following manner: "One or more components of a benefit package option that individually, or in combination, are claiming grandfathered status under the ACA."

6. How many persons were offered COBRA benefits during the plan year? Of those persons counted above, how many persons elected COBRA benefits? How many persons were receiving coverage under the plan through COBRA during the plan year?

- We are not certain what is meant by this question. One reading indicates that the sentences “Of those persons counted above, how many persons elected COBRA benefits?” and “How many persons were receiving coverage under the plan through COBRA during the plan year?” mean the same thing. If a person elects COBRA that person is receiving benefits. In the alternative it could be asking of those who elected COBRA how many filed claims that were approved. Clarification of this question would be appreciated.

7a. Did the plan or plan sponsor receive any rebates, reimbursement, or refunds other than those reported on Schedule A Form service providers during the plan year?

- This is not the type of information that would be generally be available to the plan sponsor, especially if this question also includes MLR rebates for fully insured groups. Currently, TPAs return all PBM rebates to their groups and return them to the group’s plan account (more about these rebates and trusts below). As for PBM rebates, the PBM rebates are reported on Schedule H or I (depending on the group) under “Expenses” (E1) under benefit payment and payments to provider. This is the same place service providers report provider refunds which also go back to the group’s plan account. We respectfully request further clarification in order to ensure this question and others that follow are answered more fully, particularly given 7b below.

7b If you answered yes to Line 7A, enter separately the amount and date received of each rebate, reimbursement, or refund. For each rebate, reimbursement, or refund listed, complete elements 7b(2) and 7b(3).

7b(2) Type of service provider that provided each rebate, reimbursement, or refund: options include health insurance issuer, third-party administrator, pharmacy benefit manager, other (specify).

7b(3) How each rebate, reimbursement, or refund was used (Check all that apply): amount returned to participants, premium holiday, payment of benefits, other.

8a. If any benefits were provided pursuant to an insurance policy that was not reported on Schedule A, were there any premium payment delinquencies for premiums due but unpaid during the year? If yes, indicate whether any premium delinquency resulted in a lapse in coverage.

- Self-funded health plans with stop-loss currently report stop-loss, life, dental or vision insured policies that may be included in one plan (one plan number) on Schedule A (or C depending). We respectfully request additional clarification on this question so that a clear answer can be provided. We are concerned that often the rebates are not received until a different plan year and the reporting would be hard to complete when due.

Part II - Service Provider and Stop Loss Insurance Information

9. Third Party Administrator/Claims Processor, including a health insurance issuer subject to an "administrative services only (ASO)" or other arrangement: Name, EIN, NAIC NPN. If third party administrator/claims processing or similar services are being provided to the plan through a prototype/off-the-shelf ASO arrangement, enter the identification number of such insurance product.

- Not all service providers have NAIC NPN's. We suggest adding the words after NPN in the first sentence "if available."

10. Mental Health Benefits Manager. Name, address, EIN, NAIC NPN.

- Not all service providers have NAIC NPN's. We suggest adding the words after NPN "if available."

11. Substance Use Disorder Benefits Manager. Name, address and telephone number, EIN, NAIC NPN.

- Not all service providers have NAIC NPN's. We suggest adding the words after NPN "if available."

12. Pharmacy Benefit Manager/Drug Provider. Name, address, EIN, NAIC NPN.

- Not all service providers have NAIC NPN's. We suggest adding the words after NPN "if available."

13. Independent Review Organization. Name, address, EIN, NAIC NPN.

- Not all service providers have NAIC NPN's. We suggest adding the words after NPN "if available."

14. Wellness Program Manager. Name address, EIN, NAIC NPN.

15. Was there a stop loss policy associated with the plan's obligation to pay health benefits? If so, complete the following (Include information on all stop loss policies issued in connection with plan benefits, including policies with the employer/plan sponsor as the insured). Name of insurance carrier, EIN, NAIC NPN, Total premium, attachment point of coverage (individual attachment point of coverage (if applicable), aggregate attachment point of coverage (if applicable). Claim limit (individual claim limit (if applicable), aggregate claim limit (if applicable). Policy or contract year from ____ to ____.

- The wording in the first sentence may lead to inconsistent responses. The data request recognizes that some stop loss policies are issued to the plan, and some are issued to the sponsor. This recognition leads us to make the point that in the case of the sponsor being the policyholder, the stop loss policy is not technically associated with, or in connection with the plan's obligation to pay benefits. It is more akin to a Property & Casualty policy that reimburses the policyholder for liabilities that exceed specific levels. We respectfully suggest that the question should simply ask whether the plan or the plan sponsor purchased stop loss insurance.

Part III - Financial Information. Plans that complete Schedule H (financial information) skip to Part IV.

16. Contributions received during the plan year or receivable as of the end of the plan year. Employer contributions received. Employer contributions receivable. Participant contributions received. Participant contributions receivable. Other contributions received or receivable. Total contributions.

- While this data request appears straightforward it may also lead to inconsistent responses. For example different plans may interpret “contributions receivable” differently? Some may consider contributions receivable to be equal to claims payable at the close of the plan year, less any unencumbered cash on the books at the close of the year. Others may consider contributions receivable to be equal to the total claim reserve, which includes claims payable and IBNR less unencumbered cash at the close of the plan year. Clarification on this request would be appreciated.
- We are concerned that small groups that do not complete a Schedule H would be required to have outside consultants, such as payroll providers and other vendors coordinate to give this information to complete the form. This will take additional time and expense for a small employer.

17. Was there a failure to transmit to the plan any participant contributions or repayments as of the earliest date on which such contributions can reasonably be segregated from the employer's general assets?

- This might be a reasonable question for a single-employer plan, but we don't know how a multi-employer plan that requires participant contributions through payroll deductions would obtain or determine this information. We know when the contributions were mailed and when they were received by the plan, but we don't know when they were deducted from the participant's pay.

Part IV - Health Benefit Claims Processing and Payment

18a. Enter the number of post-service benefit claims submitted during the plan year.

- We can identify a number of issues with this question that will lead to inconsistent results.
 - Is each duplicate claim counted as a claim? This can be problematic because the number of duplicate claims received during the normal course of claims administration is not insubstantial. One plan may count only the original processed claim and not the duplicates. Another plan may count the original claim, and all of the duplicates as separated claims.
 1. Is a claim submitted by mistake for a person not covered by the plan counted as a claim?
 2. Is a claim submitted after the corresponding pre-service claim was denied counted as a post-service claim?

3. If a claim is denied because sufficient information was not provided in order to pay the claim, and subsequently the information is received that allows the Plan to pay the claim are these two claims or one?
 - We request that claim be defined as the date the services were provided to the participant by the medical provider.

How many of those claims were approved during the plan year?

- We have similar concerns about this question. For example, how are duplicate claims handled? If a claim is approved and 3 duplicates are denied this would seem to require the answer to be one approval and 3 denials. This is clearly not a fair representation of the ratio of approvals to denials. Is a post service denial of the same claim that resulted in a pre-service denial a separate denial?
- Consistent with our request for clarifying definition for the previous data point we respectfully request that a "claim" be defined as the date the services were provided to the participant by the medical provider.
- We also have a separate concern that is a problem in terms of defining what information you are seeking. How are payments handled where a deductible, coinsurance, or copayments are applied? In these cases there is an approval and a technical denial (adverse benefit determination) in the same transaction. Does the Department mean to say that each payment is counted as an approval and a denial simultaneously? We respectfully request that for the purposes of this data point that the Department clarify that if a payment is made and it is reduced only by plan deductibles, coinsurance, or copayments, that only such payment be considered as the relevant data, and be reported as an approval.

How many of those claims were denied during the plan year?

- Our concerns for this data point are virtually the same as those of the previous data point. For example, how are duplicate claims handled? If a claim is approved and 3 duplicates are denied this would seem to require the answer to be one approval and 3 denials. This is clearly not a fair representation of the ratio of approvals to denials. Is a post service denial of the same claim that resulted in a pre-service denial a separate denial?
- Consistent with our request for clarifying definition for the previous data point we respectfully request that claim be defined as the date the services were provided to the participant by the medical provider.
- We also reiterate our concerns about the treatment of claims that are approved with the application of deductibles, coinsurance, or copayments. As stated above in these cases there are an approval and a technical denial (adverse benefit determination) in the same transaction. Does that mean each such payment is counted as an approval and a denial? We respectfully request that for the purposes of this data point that if a payment is made and it is reduced only

by plan deductibles, coinsurance, or copayments, that only such payment be considered as the relevant data, and be reported as an approval.

How many of those claims were pending at the end of the plan year?

- Different Plans will certainly have different definitions of “pending” status. Some may consider any unprocessed claim is its inventory as pending; while some may consider only those claims that have been processed in some manner but not finalized as pending; still others may only consider claims for which information has been requested to be pending. These are just some examples that come to mind. We respectfully request that the term “pending” be clarified in the final regulation.

18b. Enter the number of post-service benefit claim denials appealed during the plan year

- We respectfully recommend that the data request include the caveat that the request be for appeals that were submitted according to the Plan’s appeal procedures by an individual who has standing.
- How many of those appeals were upheld during the plan year as denials?
- How many of those appeals were overturned and approved during the plan year after appeal?
- We recommend that the data request include the caveat that the request be for appeals that were submitted according to the Plan’s appeal procedures by an individual who has standing.

18c. Enter the number of pre-service benefit claims appealed during the plan year. How many of those appeals were upheld during the plan year as denials? How many of those appeals were approved during the plan year after appeal?

- We recommend that the data request include the caveat that the request be for appeals that were submitted according to the Plan’s appeal procedures by an individual who has standing.

19. Were there any claims for benefits or appeals of adverse benefit determinations that were not adjudicated within the required time-frames. If yes, enter number of claims, number of appeals.

- The ability of a TPA to provide this data can be problematic depending on the number of time frames to be measured or evaluated? Were “clean claims” submitted? What about coordination of benefit, workers comp, subrogation investigations?
- We recommend that the data request include the caveat that the term adjudicated be defined as the final disposition of the claim for benefits, or appeal of adverse benefit determination.

20. Did the plan fail to pay any claims during the plan year within one month of being approved for payment? If yes, enter the number of claims not paid within one month, total amount not paid within one month, number of claims not paid within three months or longer.

- Does “paid” mean released from the plan’s account or does it mean processed from the date received into our system? A service provider can’t approve a claim until it is processed, but the

time frame seems to refer to the DOL timely filing limit. Our concern is that an employer would not know whether a claim approved for payment is different than a payment. We respectfully request that clarification for this issue be provided.

21. Total dollar amount of benefits paid pursuant to claims during the plan year.

Part V - Compliance Information. Plans that file the Form M-1, skip questions 24 - 30.

22a. Were all plan assets held in trust, held by an insurance company qualified to do business in a State, or as insurance contracts or policies issued by such an insurance company? If no, check all that apply and enter an explanation. Options include: Plan assets not held in trust based on reliance on Technical Release 92-01, Other.

23. Are the plan's summary plan description (SPD), including any summary descriptions of modifications, and summary of benefits and coverage (SBC) in compliance with the applicable content requirements?

- The importance of correct disclosure is self-evident, and all professional service providers strive to provide accurate advice to assure that the content requirements of the SPD are followed, however mistakes do happen and such mistakes are not necessarily readily apparent.
- We have similar concerns regarding an affirmative answer for SBC content compliance. These concerns are compounded the following statement in the instructions preceding Version April 2017 of the SBC – “To the extent a plan’s terms that are required to be in the SBC template cannot reasonably be described in a manner consistent with the SBC template and instructions, the plan or insurer must accurately describe the relevant plan terms while using its “best efforts” to do so in a manner that is still consistent with the instructions and template format as reasonably possible.” As you may be aware, “best efforts” is open to interpretation; this is also true for the term “reasonably possible”.
- For the above reasons, if an answer in the affirmative turns out to be incorrect, even if in good faith, the plan sponsor could be held liable for the incorrect response. We respectfully request that the Form allow for a statement in this section track the signature section of the Form 5500 by inclusion of the statement – “to the best of my knowledge and belief” and make this answer not subject to enforcement action.

24. Is the coverage provided by the plan in compliance with the provisions of the Health Insurance Portability and Accountability Act of 1996, as incorporated in ERISA, and the Department's regulations thereunder?

- The importance of correct disclosure is self-evident, and all professional service providers strive to provide accurate advice to assure that the content requirements of the SPD are followed, however mistakes do happen and such mistakes are not necessarily readily apparent. We

respectfully suggest that the form allow for a statement in this section to track the signature section of the Form 5500 by inclusion of the statement – “to the best of my knowledge and belief” and make this answer not subject to enforcement action.

25. Is the coverage provided by the plan in compliance with the provisions of Title I of the Genetic Information Nondiscrimination Act of 2008 as incorporated in ERISA, and the Department's regulations issued thereunder?

- The importance of correct disclosure is self-evident, and all professional service providers strive to provide accurate advice to assure that the content requirements of the SPD are followed, however mistakes do happen and such mistakes are not necessarily readily apparent. We respectfully suggest that the form allow for a statement in this section to track the signature section of the Form 5500 by inclusion of the statement – “to the best of my knowledge and belief” and make this answer not subject to enforcement action.

26. Is the coverage provided by the plan in compliance with the Mental Health Parity Act of 1996 and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and the Department's regulations issued thereunder?

- The importance of correct disclosure is self-evident, and all professional service providers strive to provide accurate advice to assure that the content requirements of the SPD are followed, however mistakes do happen and such mistakes are not necessarily readily apparent. We respectfully suggest that the form allow for a statement in this section to track the signature section of the Form 5500 by inclusion of the statement – “to the best of my knowledge and belief” and make this answer not subject to enforcement action.

27. Is the coverage provided by the plan in compliance with the Newborns' and Mothers' Health Protection Act of 1996 and the Department's regulations issued thereunder?

- The importance of correct disclosure is self-evident, and all professional service providers strive to provide accurate advice to assure that the content requirements of the SPD are followed, however mistakes do happen and such mistakes are not necessarily readily apparent. We respectfully suggest that the form allow for a statement in this section to track the signature section of the Form 5500 by inclusion of the statement – “to the best of my knowledge and belief” and make this answer not subject to enforcement action.

28. Is the coverage provided by the plan in compliance with the Women's Health and Cancer Rights Act of 1998?

- The importance of correct disclosure is self-evident, and all professional service providers strive to provide accurate advice to assure that the content requirements of the SPD are followed, however mistakes do happen and such mistakes are not necessarily readily apparent. We respectfully suggest that the form allow for a statement in this section to track the signature section of the Form 5500 by inclusion of the statement – “to the best of my knowledge and belief” and make this answer not subject to enforcement action.

29. Is the coverage provided by the plan in compliance with Michelle's Law?

- The importance of correct disclosure is self-evident, and all professional service providers strive to provide accurate advice to assure that the content requirements of the SPD are followed, however mistakes do happen and such mistakes are not necessarily readily apparent. We respectfully suggest that the form allow for a statement in this section to track the signature section of the Form 5500 by inclusion of the statement – “to the best of my knowledge and belief” and make this answer not subject to enforcement action.

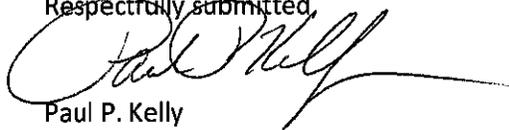
30. Is the coverage provided by the plan in compliance with the Affordable Care Act and the Department’s regulations issued thereunder?

- Compliance information for clients is provided by their service providers; generally an employer does not know the answer to this question, because they are given an annual update of required federal requirements.
- The importance of correct disclosure is self-evident, and all professional service providers strive to provide accurate advice to assure that the content requirements of the SPD are followed, however mistakes do happen and such mistakes are not necessarily readily apparent. We respectfully suggest that the form allow for a statement in this section to track the signature section of the Form 5500 by inclusion of the statement – “to the best of my knowledge and belief” and make this answer not subject to enforcement action.

31a. Was the plan subject to the Form M-1 filing requirements during the plan year? If yes, complete Lines 31b and 31c.

- Regardless of the aforementioned issues raised regarding the definition of several provisions, we would be happy to meet with the Department to discuss any issues raised in our comments. Because we believe that in many situations, in order to comply with these new provisions, this would require a system upgrade of some sort for many TPAs, we strongly request a three-year delay in implementation.

Respectfully submitted,



Paul P. Kelly
President