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December 5, 2016

RIN 1210-AB63; Annual Reporting and Disclosure

Phyllis C. Borzi
Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Room N-5655
Washington, D.C. 20210

Submitted Electronically via Regulations.gov

Re: RIN 1210-AB63; Annual Reporting and Disclosure
Notice of Proposed Rulemaking, 81 Fed. Reg. 47496 (Jul. 21, 2016)
Notice of Proposed Rulemaking, 81 Fed. Reg. 47534 (Jul. 21, 2016)

Dear Assistant Secretary Borzi,

We are writing on behalf of America's Health Insurance Plans (AHIP) to offer comments in response to Department of Labor (DOL) Notices of Proposed Rulemaking titled "Annual Reporting and Disclosure" (81 Fed. Reg. 47496) (NPRM) and "Proposed Revision of Annual Information Return/Reports" (81 Fed. Reg. 47534) (NPFR) (collectively NPRMs), both published in the *Federal Register* on July 21, 2016. The NPRMs relate to annual reporting requirements under Part 1 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974 (ERISA) and corresponding changes to the Form 5500 Annual Return/Report forms and accompanying schedules (Form 5500), including a newly proposed Schedule J intended for reporting certain group health care related information (Schedule J).

AHIP is the national trade association representing the health insurance community. AHIP's members provide health and supplemental benefits through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

AHIP supports the agencies' stated objective of improving and streamlining financial reporting requirements so that federal agencies, Congress and the public (including plan participants and beneficiaries) are able to better understand the activities and investments of employee benefit plans. Our comments address only those proposals that impact our members' group health plan products and their employer customers.

AHIP has significant concerns regarding the proposed changes in the purpose, type, and scope of data collected from group health plans and that the agency underestimates the significant new burdens its proposals will impose on both health plans and their small business customers. For all of the reasons set forth below, AHIP urges DOL to withdraw the proposed changes relating to group health plan reporting. We recommend, instead, that DOL assess existing data sources, consider voluntary surveys and pursue additional engagement and outreach with interested stakeholders.

Summary of AHIP Comments and Recommendations

Below we summarize AHIP's major comments and recommendations regarding the NPRM's proposed regulations and forms:

- **Extension of Requirements to Small Plans is Burdensome, Punitive and Doesn't Have Commensurate Benefit:** AHIP opposes expanding Form 5500 reporting to include small groups under 100 participants, which would include an estimated 2.15 million small employer welfare plans that provide health benefits. This new filing requirement extends well beyond a "registration" requirement and is not required by law. Based on conversations with experts in our membership, we believe that the compliance burden and costs are underestimated and do not include downstream costs. This includes substantial costs to insurers in the form of developing and operationalizing new data reporting requirements, corresponding information technology costs and a significant increase in customer services necessary to assist small business customers in compiling reportable information. Moreover, this requirement would significantly impact small businesses, not only in the form of new reporting requirements, but also corresponding increases in tax preparation fees and penalties for failure to file or providing inaccurate or incomplete information.
- **Collection of Granular Group Health Plan Data Does Not Assist Participants and Beneficiaries:** The DOL's proposal creates a new data collection repository at a granular health plan level that does little to support Form 5500 reporting as a tool for plan participants' and beneficiaries' to understand their respective benefit plans. Specifically, the NPRMs would require the reporting of information that: (1) lacks a standard set of data elements creating apples-to-oranges data collection; (2) duplicates or conflicts with data collected by other authorities; (3) can only be obtained from multiple service providers and vendors; (4) expands the scope of data collection to include plan types that should otherwise be excluded such as dental and long-term-care; and (5) is unlikely to assist the agency.

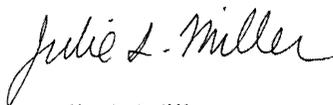
December 5, 2016

Page 3

- **Utilization of Schedule J as a Tool to Collect APCD Data is Inappropriate and the “Common Data Layout” Is Incomplete and Lacks Input from Impacted Stakeholders:** AHIP counsels against any premature adoption at the federal level of the Common Data Layout (CDL) as a standardized set of data definitions or format. The CDL is still in development by a private voluntary group, which is neither statutorily authorized to develop such a scheme nor who’s efforts have included or received appropriate stakeholder input. AHIP understands that some commenters have recommended that DOL add a new data collection of self-funded plan data using the CDL scheme to create a work-around to the Supreme Court’s decision in *Liberty Mutual v. Gobeille*. We caution against using the Form 5500 as a vehicle for this data collection and any adoption of an in-development data set.¹
- **The Expanded Reporting Exceeds the DOL’s Authority:** AHIP believes the DOL’s proposal to collect certain group health plan data exceeds the agency’s statutory authority. This includes reporting of data not otherwise contemplated under appropriate federal laws. This also may conflict with federal law exempting the business of insurance from most federal regulation if there is an intent to regulate or review prototype or off-the-shelf insured policies. AHIP also has concerns regarding the agency’s failure to describe the need for such data, privacy concerns associated with certain data types to be reported, and potential expansion of agency audit activities.

We have included detailed recommendations in the attachment for DOL to consider as revisions in the event the proposal is not withdrawn. Our detailed comments follow in an Attachment.

Sincerely,



Julie S. Miller
General Counsel

¹ For example, the NPRM’s preamble reference to *Gobeille v. Liberty Mutual Insurance Company*, 136 S. Ct. 936 (2016) has already invited comment from the National Academy for State Health Policy (NASHP) and several states to expand Schedule J reporting to require the filing of all-payer claims database (APCD) data. This filing approach would utilize a corresponding CDL scheme that NASHP and other entities have sought to develop and which would subsequently be shared with states. However, the CDL is untested, was developed for a different purpose, has not received review by a sufficiently broad range of stakeholders and would, in this context, require reporting at the employer-based group health plan level that would raise significant privacy concerns. (NASHP comments available online at: <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB63/00030.pdf>)

RIN 1210-AB63; Annual Reporting and Disclosure

ATTACHMENT

AHIP's Detailed Comments

I. DOL Authority to Require Reporting of Group Health Plan Data as Contemplated Under Proposed Schedule J.

AHIP has significant concerns regarding the agency's claim of authority to require the reporting of new and expanded group health plan data under proposed Schedule J. We recommend that DOL withdraw proposed Schedule J pending further review, and conduct additional engagement and outreach with interested stakeholders as well as an assessment of other data sources.

A. DOL Authority to Require Group Health Plan Data Reporting

AHIP believes the DOL's promulgation of new and expanded group health plan data reporting requirements under Form 5500 Schedule J exceeds the scope of authority granted to the agency under ERISA. We question the DOL's interpretation that the incorporation of Affordable Care Act (ACA) required reporting requirements for group health plans and health insurer issuers in the group and individual markets as found in §§ 2715A and 2717 of the Public Health Services Act (PHSA), (added by the ACA) and incorporated into ERISA at § 715 conveys to DOL an express grant of ERISA-based statutory authority permitting them to require the reporting of certain data sought in Schedule J. 81 Fed. Reg. at 47499.

Section 2715A of the PHSA provides that group health plans not offered through an Exchange are only required to submit information that may be in addition to that otherwise required under the ACA to the Secretary of Health and Human Services (HHS) and state insurance commissioners. Section 2717 of the PHSA provides that the Secretary of HHS (in consultation with experts in health care quality and stakeholder) must develop reporting requirements for use by a group health plan. Together, these grants of authority make it clear that ACA-contemplated data reporting rests with HHS. Indeed, even if DOL and HHS authority to require such reporting is deemed "concurrent" by virtue of ERISA § 715,² any exercise of such concurrent authority must necessarily be coordinated between the two agencies and any corresponding reporting requirements cannot exceed the ACA's statutory bounds on required reporting.

² See, e.g. FAQs About Affordable Care Act Implementation (Part XV), Dept. of Labor, p. 2, fn. 3 (Apr. 29, 2013) (available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xv.pdf>) and FAQs About Affordable Care Act Implementation (Part XXVIII), Dept. of Labor, p. 1, fn. 1 (August 11, 2015) (available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xxviii.pdf>).

Yet, certain data collection proposals in the NPRM indicate such coordination is lacking. For example, the DOL proposes additional data elements under Schedule J Questions 19 and 20 that would require group health plans to report on the timeliness of claims adjudication and payment. This is outside the scope of the transparency in coverage requirements under § 2715A of the PHSA and does not align with existing HHS reporting requirements for health plans offering coverage through the Exchanges. In other instances where overlapping agency data calls exist (such as data currently collected by the IRS but which cannot be shared due to inter-governmental limitations), AHIP submits the appropriate method for DOL to obtain such information is to properly address corresponding statutory authorizations, not require duplicative data reporting that creates new burdens for small employers and their insurers.

Regarding DOL reliance on PHSA authority under §§ 2715A and 2717 and corresponding ERISA § 715, AHIP encourages DOL to pay due consideration to the Supreme Court decision in *Gobeille v. Liberty Mutual Insurance Co.*, 136 S. Ct. 936 (2016), which is instructive insofar as what the Court's decision *did not* examine. In *Gobeille*, the Court noted that the ACA contains its own anti-pre-emption provision which states that it shall not “be construed to preempt any State law that does not prevent the application of the provisions” of the ACA. *Gobeille* at 946-47 (citing 42 U.S.C. § 18041(d)). In examining both that provision and the interplay of the incorporation of ACA §§ 2715A and 2717 into ERISA § 715, the Court stated that the ACA's own “anti-pre-emption provision *might prevent* any new ACA-created reporting obligations from pre-empting state [APCD data] reporting regimes like Vermont's, *notwithstanding* the incorporation of these requirements in the heart of ERISA.” *Gobeille* at 947 (emphasis added). However, because the Court was examining a pre-emption question, and not whether the DOL had actual authority to require such reporting, it determined that it had no need to resolve the issue. *Id.* In short, the Court did not determine (indeed, did not even address) whether DOL has authority to require such reporting – either under ERISA alone, or under ERISA by virtue of its incorporation of ACA-based reporting requirements.

Finally, the DOL's expanded reporting requirements do not appropriately consider the bounds on federal authority regarding the regulation of the business of insurance, a practice reserved to the states and inscribed under federal law by the McCarran-Ferguson Act. For example, by requiring reporting of identifying numbers for “off-the-shelf” or prototype insurance that is regulated by the states, DOL would seem to be intended to allow for an analysis of a state-approved insurance policy and would appear to create a conflict with the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, which exempts the business of insurance from most federal regulation.

B. Group Health Plan Data as Required Under Proposed Schedule J is Outside the Scope of Traditional ERISA Reporting

The expansion of Form 5500 data to include large amounts of claims and plan characteristic data that are not primarily financial in nature represents a dramatic departure from existing Form 5500 reporting requirements and the bounds of ERISA.

ERISA's core function is the design and administration of employee benefit plans, including establishing prescriptions on the vesting of benefits, claims processing and the designation of beneficiaries. Absent an exemption, ERISA plans are required to file annual reports containing financial and actuarial data to enable the DOL to evaluate a plan's management and solvency. Current ERISA reporting requirements reflect those core functions and focus on data aimed at exposing the mismanagement of funds, failure to pay employee benefits and transparency around plan financial assets or allocations to ensure plan fiduciaries can meet their obligations. The plain language of the statute makes clear that reporting and disclosure requirements are limited to: (1) providing a summary plan description to plan participants; and (2) furnishing an annual report (Form 5500) to the DOL, which itself has traditionally focused on the financial soundness of the plan.

However, many of the reporting requirements found in proposed Schedule J differ in nature and function from data currently reported. For example, new and/or expanded reporting requirements detailing plan beneficiaries covered under COBRA, claims processing data akin to APCD data reporting requirements (discussed in more detail in Section II, *infra.*),³ receipt and use of rebates, refunds or reimbursements from a service provider, identification of plan service providers, stop loss related data including attachment points and data regarding prototype plans all have little to no bearing whatsoever on the financial soundness of a plan, do not cast light on plan fiduciary behavior or otherwise assist in determining whether beneficiaries are receiving entitled benefits.

C. DOL Must Articulate a Clear Need or Purpose for Requiring the Reporting of Group Health Plan Data and Clarify How It Intends to Use Such Data

AHIP appreciates the DOL's desire to update Form 5500 reporting, and in many instances supports those initiatives, including updating reporting processes so that already reported data-types are more easily accessible and uniformly reported. However, in the case of expanded group health plan data reporting, AHIP believes the DOL has not demonstrated a clear need for such information, has failed to elaborate a purpose for collecting such data and has not provided adequate clarity regarding how the agency intends to use such data once reported.⁴

³ The collection of which Justice Ginsburg described in her dissenting opinion in *Gobeille* as "a chore divorced from ERISA's objectives." *Gobeille* at 958.

⁴ Notably, none of the fifteen reports the agency cites as the underlying foundation in support of its proposed changes reference a need for expanded (or, as the agency states "a more robust Form 5500") reporting of group health plan data. 81 Fed. Reg. 47496-98, n.1 Rather, and consistent with ERISA's fundamental purpose, each of those reports focuses primarily on plan financial data reporting and efforts the DOL (and other agencies) should undertake to improve the same, either by improving existing Form 5500 data reporting or undertaking internal efforts to improve agency processes, transparency and stakeholder outreach and education.

At least one report cited by DOL⁵ – in addition to omitting any reference to group health plan data – recommends that rather than expand Form 5500 reporting to include more data, the agency should instead focus on better utilizing existing data already reported to the agency by improving data accessibility. DOL 2014 Rpt., pp. 1, 8-9. The same report also highlights the need for the agency to improve its own internal processes surrounding changes to Form 5500 content and instructions, noting the agency’s efforts suffered from a significant lack of transparency. *Id.* at pp. 1, 7. Similarly, another cited report⁶ highlights issues dating back to 2009 when the DOL revised Form 5500 to require reporting of indirect compensation data elements, including agency officials telling the GAO “that they do not have specific plans for using the data received as a result of the new Form 5500 requirements and will wait to see what information is reported before deciding what to do with the data.” GAO 2009 Rpt., pp. 1, 16. Ultimately, the GAO concluded in the same report that “despite the changes to the Form 5500, the new information provided may not be very useful to Labor, plan sponsors, and others” and accurately foresaw that the agency would need to issue further clarification and guidance to plan sponsors to better identify and explain the data the agency sought. *Id.* at pp. 1, 11-14, 20.

AHIP raises these points to underscore our own concerns regarding the agency’s lack of clarity in explaining the need for additional group health plan data, including most importantly how the agency intends to subsequently use such information. For example, the NPRM makes repeated reference to “enforcement”, but only in the broadest of senses. How group health plan data will assist the agency in reviewing the financial soundness of employee benefit plans subject to its review (the core purpose underlying Form 5500 reporting) is left unexplained.

Absent clarification, stakeholders are left to assume the expanded data reporting requirements are intended to augment DOL’s ability to target its enforcement of existing audit requirements. If true, AHIP believes this would amount to an impermissible end-run around the enforcement authority and specific enforcement mechanisms (e.g. individualized letters to plans requesting additional reporting) enumerated under ERISA itself. Again, one of the agency’s own cited reports illustrates the concern.⁷ In a 2010 report, the ERISA Advisory Council expressly noted that ERISA’s “statutory language and [...] legislative history reinforce the conclusion that a primary purpose of the audit requirement is to protect plan participants. But such protection presupposes an auditor and audit of adequate quality. Yet, the DOL’s authority over employee

⁵ 81 Fed. Reg. 81, 47497, n. 1 (citing Dep’t of Labor Office of Inspector Gen., 05–14–003–12–12, EBSA Could Improve Its Usage of Form 5500 Data (2014) (available at www.oig.dol.gov/public/reports/oa/2014/05-14-003-12-121.pdf) (“DOL 2014 Rpt.”))

⁶ 81 Fed. Reg. 81, 47496-97, n. 1 (citing U.S. Gov’t Accountability Office, GAO–10–54, Private Pensions: Additional Changes Could Improve Employee Benefit Plan Financial Reporting (2009) (available at www.gao.gov/assets/300/298052.pdf) (“GAO 2009 Rpt.”))

⁷ 81 Fed. Reg. 81, 47497, n. 1 (citing 2010 ERISA Advisory Council Report: Employee Benefit Plan Auditing and Financial Reporting Models, Dep’t of Labor (available at www.dol.gov/ebsa/publications/2010ACreport2.html) (“ACR 2010 Rpt.”)) (focusing solely on employee retirement benefit plans and corresponding *financial* audits).

benefit plans audits is very circumscribed. Moreover, the DOL has almost no authority, if any, over employee benefit plan auditors.” ACR Rpt., s. III(C). And perhaps of relevance to the current NPRM, subsequent legislative efforts intended to remedy this lack of authority have been unsuccessful. However, rather than recommend the agency expand data reporting requirements, the Advisory Council report instead recommended the DOL undertake efforts to improve the quality of existing independent auditing requirements, primarily outreach focused on auditor education as a means of improving audit quality and reducing filing errors. ACR Rpt., s. IV(A)(4), (B)(6).

***Recommendation:* AHIP recommends DOL withdraw its proposed Schedule J pending further study and review, including additional stakeholder engagement and outreach to clarify the agency’s need for new and expanded reporting of group health plan data, to better elaborate how the agency intends to use such data, and to resolve any questions regarding the agency’s authority to require such reporting.**

II. Collection of APCD Data and Expansion of Annual Reporting Requirements in Response to Gobeille v. Liberty Mutual

DOL requested public comments on “those conforming amendments and the proposed annual reporting requirements for plans that provide group health benefits, including the new Schedule J, in light of the Supreme Court’s recent decision in *Gobeille v. Liberty Mutual Insurance Co.*, 136 S. Ct. 936 (2016).”⁸ In *Gobeille*, the Supreme Court ruled that Vermont’s all-payer claims health database reporting law was preempted by ERISA as it applies to self-funded employer plans. Since the decision, states with APCDs have pursued opt in and/or opt out approaches whereby self-funded employer plans could determine whether to continue to report APCD data to the state through third party administrators (TPAs).

The National Academy for State Health Policy (NASHP) and the All-Payer Claims Database Council (a collaboration between the National Association of Health Data Organizations (NAHDO) and the Institute for Health Policy at the University of New Hampshire), have submitted detailed comments encouraging DOL to require group health plans to submit Common Data Layout (CDL) datasets as part of their Schedule J submissions.⁹ These organizations urge the collection of these additional data elements from ERISA plans under Schedule J through pilot programs in States with APCD capacities.¹⁰

⁸ 81 Fed. Reg. 47534, 47559 (July 21, 2016).

⁹ See fn. 1, *supra*.

¹⁰ Eighteen states have or are in the process of establishing APCDs. Requiring data collection that would differ for ERISA group health plans based on whether a state has established an APCD would be in tension with ERISA’s goals of promoting national uniformity for plans that operate across several states. Moreover, even with a CDL approach, each state might require additional elements/formats.

A. The U.S. Supreme Court Did Not Consider Whether DOL had Existing Authority to Require APCD Data Collection

As discussed previously in Section I, *supra.*, AHIP questions the statutory basis for Schedule J data collection under ERISA. That lack of statutory authority is present here too. This deficiency is not remedied by a close reading of *Gobeille*. In *Gobeille*, the Court focused only on the issue of whether Vermont's law requiring APCD data reporting by ERISA plans was preempted by ERISA's broad federal pre-emption clause. Although the Court acknowledged that DOL has authority to establish additional reporting and disclosure requirements for ERISA plans, it expressly stated that it was not opining on whether the DOL was *authorized* to require group health plans to report data of the type collected by a state's APCD. *Gobeille*, 136 S.Ct. 936, 945 (2016) ("the [Secretary of Labor] *may be* authorized to require ERISA plans to report [APCD] data similar to what Vermont seeks, *though that question is not presented here.*") (emphasis added)). Furthermore, based on its own estimates the DOL's proposal would increase the number of small plans required to report from slightly over 6,000 to over 2.1 million. 81 Fed. Reg. at 47502. As a practical matter, small health plans are commonly offered by small businesses. Therefore, the DOL's proposal would effectively require well over one third of small business employers to report some manner of Form 5500 data, including claims data.¹¹ Such a dramatic expansion of DOL reporting requirements is likely to raise new legal questions that could only be resolved after additional judicial review.

B. CDL Remains a Work in Progress.

There is a distinct lack of uniformity among the states regarding the manner in which they currently collect APCD data. Each state currently operating an APCD collects not only different data types, but also use disparate collection methods that rely on definitions that oftentimes vary across jurisdictions. This non-uniform approach to developing APCDs creates apples-to-oranges comparison problems that limit a multi-state analysis and raises costs for health plans reporting data in multiple states.

While our members are generally supportive of a move to a common data framework to simplify, standardize and improve data reporting burdens for the current (and any future) state-level APCDs, it is important to note that the CDL itself has not yet undergone the necessary review by the involved stakeholders, including health plans, providers, consumers, privacy advocates and employers. NASHP, in Appendix B, to its comment letter admits as much. ("Specifications for data submission are under review by various stakeholder groups.") Therefore, any requirement that CDL datasets be included or otherwise incorporated into federal-level Schedule J reporting would be premature. Moreover, the CDL is being developed in the context of data collection from payers and not on an employer-by-employer basis. A federal-level pilot program that would require CDL data collection from insured and self-funded group health plans (rather than

¹¹ The U.S. Small Business Association estimates there are approximately 5.5 million small businesses that employ 100 or fewer employees in the United States. *See* U.S. Small Business Administration, Office of Advocacy, Research and Statistics, Firm Size Data (2011) (available online at: <https://www.sba.gov/advocacy/firm-size-data>).

by insurers or TPAs) would be outside of the scope for which the CDL is being developed.

Lastly, the CDL is being developed by a group of volunteer state agency staff who are neither authorized to adopt such format, develop it, nor mandate its use in any state. It is clearly a voluntary effort amongst state agencies that could change on a moment's notice, with no comment period, review or implementation schedule. Any DOL mandate requiring the use of such a format would add yet another data burden on employers and group health plans to produce claims data that does not conform to the eighteen (18) state-based APCDs that already exist. Such a requirement would not operate to lessen or streamline reporting, but would instead result in an increase in associated compliance costs.

C. CDL Submission by Group Health Plans to DOL Raises Significant Privacy/HIPAA Concerns.

The CDL elements set out in Appendix B to the NASHP letter include Medical File Data Elements which are clearly protected health information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA) and state privacy laws. While state APCD laws generally require this information to be reported on an aggregated, confidential, and encrypted basis through third party administrators, Form 5500 data reporting is required on a group health plan-by-group health plan basis. This significant variation in the way such data is reported under Form 5500 could lead to privacy concerns as employer groups lack familiarity with affording the same level of protection to this kind of highly confidential data.

***Recommendation:* AHIP strongly urges DOL to withdraw proposed Schedule J in its entirety. If it is not withdrawn, AHIP opposes any additional expansion of proposed Schedule J reporting, which would be contrary to ERISA's purposes and presents an impermissible workaround to the Supreme Court's ruling in *Gobeille*. Should a system of national and standardized data collection to populate APCDs be developed, it should be done so under appropriate new statutory authority, afford consistency across market segments, and be undertaken only in connection with a well-vetted regulatory and standard-setting process that appropriately takes into account stakeholder concerns, including privacy. Further, DOL should reject any suggestions that would incorporate into Form 5500 Schedule J data collection a requirement that data be reported under the CDL format.**

III. Small Plan Reporting Expansion

Under the NPRM, DOL proposes expanding basic Form 5500 reporting requirements to include fully insured and fully or partially self-insured small-employer group plans. 81 Fed. Reg. 47497, 512. AHIP has concerns that DOL has significantly underestimated the associated compliance costs and burdens the new reporting requirements will impose on impacted stakeholders, which include both insurers and the small business employers they support. In addition, DOL has not compellingly described why such new reporting, even in limited form, is

necessary – particularly in light of current oversight and reporting requirements that exist for insured products at the state level. Accordingly, we recommend that DOL withhold expanding Form 5500 reporting to include fully insured or fully or partially self-insured small-employer group plans and that the agency conduct a revised analysis that more accurately accounts for the additional costs that may be borne by impacted stakeholders.

A. DOL Underestimates the Corresponding Compliance Costs and Burdens

DOL estimates that the Form 5500 Annual Return/Report would collect data from approximately 2.15 million welfare plans that provide group health benefits that are currently exempt from reporting under the current 5500 annual reporting rules. 81 Fed. Reg. at 47501. DOL’s estimated burden analysis provides that small health plans currently excluded from filing requirements would, under the proposal, see a change from 6,200 current annual filings to 2,158,000 annual filings. *Id.* at 47502. DOL also believes that the burden is very limited for these new filers, almost all of which are fully insured plans with fewer than 100 participants, “because they are only required to provide registration-type and other nominal benefit coverage information.” *Id.* at 47501. DOL further estimates the burdens associated with the more limited reporting (i.e. completing only lines 1-5 on Form 5500 and lines 1-8 on Schedule J) by fully insured small group health plans to be approximately 623,000 hours, impacting 1,869,000 new filers and resulting in an annual aggregate cost of \$69.6 million, or just \$37 per filer. *Id.* at 47516, 47524, fn. 64. In the case of small group health plans required to complete more comprehensive Form 5500 reporting, the estimated annual per-filer cost increases to \$511. *Id.* at 47503.

The DOL estimates and numbers simply don’t reflect the full scope of operational costs, downstream impacts, and other corresponding compliance burdens small businesses, insurers, and other entities will encounter, and which AHIP projects are likely much higher than the agency estimates.

For example, DOL’s burden estimate overlooks a number of downstream compliance costs that will be imposed on both small business employers required to report for the first time as well as the insurers upon which those first time filers will necessarily rely upon to provide them with relevant reporting information. Small business employers do not have ready access to the specified reporting elements found in the revised Form 5500 and new Schedule J. As a result, those filers must rely on their health plans, third party administrators (TPAs) and agent/brokers to provide the necessary information so that the small business filer can accurately comply with corresponding reporting requirements. This will lead to increased administrative burdens and costs for both insurers and small business employers. Other unintended consequences appear to have been overlooked, including small employers experiencing a rise in the cost for tax preparations and filings due to their increased reporting burden, increased penalties associated with non-compliance, as well as an increased reliance upon health plans by agent/brokers who sell small group insurance coverage as they work to assist their client filers in completing necessary Form 5500 reporting requirements.

Another example of the burden associated with the new Schedule J is the information required to be reported on Line 7 relating to rebates from service providers. Small plans (as well as large plans) would be required to seek out information from multiple service providers in order to provide this information. It is also unclear as to the basis/reasons for collecting this information, including MLR rebates. Sections 2715A and 2717 of the PHSA did not include rebates in the list of specific types of information that group health plans are required to disclose. Moreover, the information does not clearly have benefits for participants, beneficiaries or regulators, and could implicate concerns relating to competition if reported on the granular basis that seems to be required in Line 7.

Finally, the agency's cost burden analysis also appears to neglect to account for the significant operational costs insurers will encounter in providing information to their insured clients. Many health insurers manage small group and large group accounts in separate systems with separate staff and underlying processes. For employer-sponsored coverage that is classified as "small employer" coverage under state law, health plans do not have mechanisms in place to gather and disseminate the information specified in the proposed rule. Implementation of the rule as proposed would require health insurers to retrain staff and implement new processes and systems for managing small employer accounts. For example, health insurance companies will need to develop an entirely new data retrieval system or significantly expand the programming and functions of existing data retrieval and reporting systems in order to extract the proposed data elements for small group plans. Writing, creating, and executing an entirely new data retrieval system or substantially modified systems for extracting the proposed data elements for small group insurance plans will significantly increase administrative burden and costs associated with compliance on health insurance companies, potentially affecting consumers through higher premiums.

B. Agency Need and Corresponding State Oversight of Small Plan Products

The NPRM states that the information DOL intends to collect from small businesses is needed "in order to get this crucial information about that significant component of the nation's health care delivery system and reinforcing for the fiduciaries responsible for many of those plans the need to satisfy important consumer protections required by Title I of ERISA and the Affordable Care Act-related health care benefits." 81 Fed. Reg. 47501.

Under current law, small employers are not obligated to provide health insurance.¹² When those small employers do provide health insurance through a fully insured health insurance plan, they purchase products approved by state regulators for sale in the small group market. These products are thoroughly reviewed by state regulators and must comply with all applicable state and federal laws before they are approved for sale. Requiring small employers to provide

¹² Note that the DOL definition of "small employer" for purposes of this rule differs from the definitions under current and state law. In most states, for the purpose of purchasing health insurance, "small employers" are employers with 50 or fewer eligible employees. While not all employers treated as "small" for the purpose of the proposed rule would meet the state definition for "small employers," many would.

additional detail on their health plans at significant cost is unlikely to provide additional compliance value beyond the enforcement functions already undertaken by state regulators to ensure these employer plans comply with applicable laws and regulations. The NPRMs fail to articulate a clear and compelling need that demonstrates otherwise.

The agency also cites education as an important compliance goal for extending these reporting requirements. Education can be accomplished through voluntary webinars, educational materials, and other channels targeted to small employers. The proposed approach of extending Form 5500 to small employers instead exposes these small businesses to penalties that have recently been increased to \$2063/day for each day the form is filed late. Even the Delinquent Filer Voluntary Correction Program, established by DOL to encourage filing with reduced penalties, provides penalties that accrue over time. As a result, DOL should assume significant non-compliance with this new requirement, an element that should be factored into a revised burden and cost analysis for impacted stakeholders.

Recommendation: AHIP recommends DOL retain the current exemption to the annual Form 5500 reporting requirements for fully insured and fully or partially self-insured small-employer plans.

IV. DOL Should Withhold from Finalizing and Adopting Schedule J Transparency-Related Data Elements.

Under new Schedule J, DOL proposes to require that group health plans report detailed information under Part IV – Health Benefit Claims Processing and Payment. 81 Fed. Reg. 47510-512, 47557-559. Group health plans would be required to submit the following information:

1. ***Question 18a.*** The number of post-service benefit claims that were submitted during the plan year, including the number that were approved during the plan year, denied during the plan year, or still pending at the end of the plan year
2. ***Question 18b.*** The number of post-service benefit claim denials appealed during the plan year and the number of appeals that were upheld or overturned and approved during the plan year.
3. ***Question 18c.*** The number of pre-service benefit claims appealed during the plan year, including those that were upheld or approved after appeal.
4. ***Question 19.*** Whether any claims or appeals were not adjudicated within the required timeframes and, if so, the number of claims and/or appeals.
5. ***Question 20.*** Whether any claims were not paid within one month of being approved for payment and, if so, the number of claims and total amount not paid.
6. ***Question 21.*** The total dollar amount of benefits paid pursuant to claims during the plan year.

December 5, 2016

Page 14

81 Fed. Reg. 47587-588. The DOL is also considering whether to require submission of additional information on denied claims, including the dollar amount of claims that were denied during the plan year, the denial code, and/or whether the claims were for mental health and substance use disorder benefits or for medical/surgical benefits. 81 Fed. Reg. 47559.

AHIP recommends that the DOL ensure that required reporting by group health plans on claims payment information is consistent with other required transparency in coverage reporting under § 2715A of the PHSA, as added by § 1311(e)(3) of the ACA. While the proposed rule establishes reporting requirements for group health plans, issuers of these health plans may also have TPA business or health plans on the individual exchange, which have existing reporting requirements under the § 1311(e)(3) of the ACA, as implemented by regulations at 45 CFR 155.1040(a) and 156.220. Thus, it is critical that both the scope and definitions of data elements required under proposed Schedule J, specifically those related to claims payment and processing, are consistent with existing requirements.

Clear, standard definitions are needed for accurate reporting of claims information under Questions 18a-c and 21. Consistent with our prior related comments to the Department of Health and Human Services,¹³ we strongly recommend the DOL wait to finalize the definitions of claims, denials, and appeals until the NAIC finalizes and adopts these definitions as part of the Market Conduct Annual Statement. While the DOL already has a definition for adverse benefit determination, using this unique definition would place an unnecessary burden on health plans to collect and report information on claims, denials, and appeals for each reporting requirement.

It is critical that health plans report on a consistent set of data elements. The DOL proposes additional data elements under Questions 19 and 20 that would require group health plans to report on the timeliness of claims adjudication and payment. This is outside the scope of the transparency in coverage requirements under § 2715A of the PHSA and does not align with existing reporting requirements for health plans offering coverage through the exchanges. Thus, we recommend the DOL not finalize these data elements.

DOL also notes that it is considering additional collections of data on claims adjudication practices and policies. This would require plans to report more information on denied claims, such as the dollar amount of claims that were denied during the plan year, the denial code, and/or whether the claims were for mental health and substance use disorder benefits or for medical/surgical benefits. These data elements would similarly be outside of the scope of § 2715A and would be challenging to report accurately. For example, while the NAIC is considering standardization around denial codes, this could result in thousands of “standard” codes, as is the case in Medicare Advantage, which would not provide meaningful information for consumers. If a subset of standard high-level denial codes were established, health plans would need to crosswalk their denial codes to them. This would be a significant multi-year effort and could only be established prospectively (*i.e.*, not for historical denial code information).

¹³ See AHIP comments regarding Transparency in Coverage Reporting by Qualified Health Plans (CMS-10572) submitted to Office of Management and Budget, Office of Information and Regulatory Affairs (May 27, 2016).

Similarly reporting dollar amounts of denied claims for mental health and substance use disorder benefits separately from medical surgical benefits does not provide consumers with actionable information and does not demonstrate compliance/non-compliance with the Mental Health Parity and Equity Addiction Act. Because this is outside the scope of the PHSA § 2715A transparency requirements, and the challenges in reporting this information in a way that would be meaningful to consumers, we recommend the DOL not finalize these data elements.

Recommendation: DOL should withhold from finalizing the definitions of claims, denials, and appeals until related NAIC efforts are finalized and adopted. In addition, DOL should decline to finalize and adopt data elements requiring group health plans to report: 1) on the timeliness of claims adjudication and payment; and 2) more information on the dollar amount of denied claims, denial codes, and whether denied claims were for medical/surgical or mental health and substance use disorder benefits.

V. Compliance Concerns

Proposed Schedule J includes in Part V a list of Yes/No/NA questions relating to whether the plan's coverage is compliant with a broad array of Federal laws and regulations, including summary plan description requirements, HIPAA, GINA, Mental Health Parity and Equity Addiction, WHCRA, Michelle's Law, ACA and all the DOL regulations implementing it. 81 Fed. Reg. at 47588. These laws and the regulations implementing them are complex and may not be easily answered by a plan administrator.

Most critically, it is unclear what purpose this checklist/attestation serves. Group health plans that provide coverage through insurance products rely upon their insurers to provide compliant coverage. Fully or partially self-insured plans are required to comply with these laws through the separate operative provisions of ERISA that apply these laws to these plans and penalties exist for non-compliance through Section 4980D. Unless DOL intends to apply duplicative penalties in addition to other penalties, this checklist does not seem to serve a valid purpose.

Recommendation: DOL should not adopt a compliance checklist for plan administrators.

VI. Excepted Benefits and Product-Specific Plans Should be Excluded from any Expanded Form 5500 Reporting Requirements

As proposed under the NPRM, all "group health plans" that meet the definition in 733(a) of the Act, including plans that claim "grandfathered" status under 29 CFR 2950.715-1251, would be required to file a Form 5500 and applicable schedules, including the proposed Schedule J, regardless of whether such plans are exempt from certain market reform requirements under ERISA § 732(a) (exemption for certain small group health plans that have

less than two participants who are current employees) or ERISA § 733(c) (group health plans consisting solely of excepted benefits). *See e.g.* 81 Fed. Reg. 47498, n. 5.

Accordingly, any employee welfare benefit plans as defined in ERISA § 3(1) that do not meet the definition of “group health plan” under ERISA § 733 (i.e., they do not provide medical care) are not subject to the proposed enhanced reporting requirements applicable to group health plans. Put another way, if a plan covers under 100 participants at the beginning of the plan year and is fully insured, unfunded, or a combination of the two, and does not provide coverage for medical care (such as is the case with certain excepted benefits), then such plan does not need to file a Form 5500. However, if a plan covers fewer than 100 participants at the beginning of the plan year and is fully insured, unfunded or a combination of the two, and offers coverage for medical care (but is an excepted benefit), then such plan would need to file a Form 5500 and a Schedule J.

AHIP believes that the agency’s interpretation, if adopted, would erode existing and long-standing interpretations of “excepted benefits.” Excepted benefits products are currently subject to long-standing and extensive state regulatory regimes, yet the NPRM includes no discussion of (if indeed it is the DOL’s intent to require Form 5500 reporting for excepted benefits plans) or attempt to reconcile the proposed regulations with the McCarran-Ferguson Act. Further, excepted benefits products are typically not regulated in the same manner as health insurance coverage under HIPAA or the ACA.

It would also appear under the NPRM that the DOL has intended for employer-sponsored, group stand-alone dental plans, group limited scope dental or vision benefits, and ERISA-covered long-term care (LTC) insurance arrangements¹⁴ (to the extent that an LTC arrangement constitutes a welfare benefit plan) to be subject to the Form 5500 reporting requirements. 81 Fed. Reg. 47556. Proposed Form 5500 revisions provide, “[w]elfare benefits other than group health include disability, life insurance, apprenticeship and training, scholarship funds, severance pay, etc.” 81 Fed. Reg. 47556. By removing the small plan filing exemption, the agency’s intent appears to be to implicate these products in the Form 5500 filing requirements. However, these requirements are conceptually inconsistent and are likely to result in differing interpretations. For example, LTC insurance products are more akin to long term disability and life insurance products (which are exempted from reporting) than to traditional group health plans (which are required to report).

Accordingly, a Form 5500 reporting exception for excepted benefits, which are fundamentally different from traditional health insurance coverage, would be consistent not only with Congress’ historic treatment of these products but would also comport with existing ACA interpretations on

¹⁴ The proposed Form 5500, Line 9b(3), will be reorganized as a series of check boxes asking filers to indicate all plan-provided welfare benefits other than health, dental, vision, or disability, and would include a new checkbox for long term care insurance. 81 Fed. Reg. 47571. Schedule A, Insurance Information, would also add new “breakouts” for LTC. 81 Fed. Reg. 47576.

a variety of other requirements that clearly exclude “excepted benefits” from a large portion of compliance requirements. To require otherwise would not only run contrary to existing statutory rules, but would also result in significant administrative burdens which AHIP believes were not adequately estimated when the agency proposed the changes to the regulations and forms.

Similarly, in the small-employer markets/products, the DOL’s proposed revisions are significant for small, unfunded and fully-insured group health plans.¹⁵ If adopted as proposed, issuers will face increased administrative work for all product types, the associated costs of which are likely to impact employer plans and/or be passed on to consumers in the form of higher premiums. These new reporting requirements can also be particularly confusing in the Administrative-Services Only (ASO) business, where a plan sponsor may not understand who/what entity must file what form. An unintended consequence could lead to fewer products being offered by the sponsors in these groupings.

Recommendation: DOL should revise the NPRM to clearly exclude excepted benefits and product-specific plans from expanded Form 5500 reporting requirements.

VII. Effective Date: DOL Should Establish a Compliance Safe Harbor for any Finalized Changes to Form 5500 Reporting Requirements.

The NPRM provides that if adopted the proposed revisions would apply generally for plan years beginning on or after January 1, 2019 and that the EFAST2 system (the administration of which is itself in the process of a contract recompete) would be expected to begin processing PY 2019 Form 5500 and related Schedules beginning January 1, 2020. 81 Fed. Reg. 47534.

AHIP supports the DOL’s integration of Form 5500 revisions with the EFAST2 system recompete process. However, based on the number of changes proposed in the NPRM we encourage the DOL to allow additional time beyond the contemplated effective date to allow entities to come into compliance. If finalized as proposed, filers will be required to update systems and otherwise operationalize a host of new and expanded reporting requirements, particularly those new and expanded reporting requirements found in Schedule J. For example, it is common for existing Form 5500 filers to require anywhere from 18 to 24 months to fully update systems to account for new and/or expanded data reporting requirements, including developing, testing and then executing related systems coding. That timeframe may increase for any entities reporting for the first time and to ensure the proper implementation of new or updated systems.

In addition, it is anticipated that the DOL and other agencies will need to undertake comprehensive education and other outreach initiatives aimed at assisting plan sponsors and related plan administrators to understand both new filing requirements and corresponding

¹⁵ See § 2520.104-20 for current exemptions from annual reporting requirements.

compliance ramifications. Therefore, allowing adequate time for educational and compliance efforts will be a critical component in ensuring a successful rollout of both the EFAST2 system and implementation of any finalized revisions to Form 5500 filing and reporting requirements.

***Recommendation:* DOL should allow a minimum of 24 months following any final rule effective date to provide adequate time for reporting entities to come into compliance. Likewise, AHIP recommends the agency adopt a minimum two-year moratorium on any related enforcement efforts following a final rule effective date so that impacted stakeholders have sufficient time to develop, test and implement good faith compliance efforts.**