



# **GROUP & PENSION ADMINISTRATORS, INC.**

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Sent via email to: [e-ORI@dol.gov](mailto:e-ORI@dol.gov)

Office of Regulations and Interpretations  
Employee Benefits Security Administrators  
U. S. Department of Labor  
200 Constitution Avenue, NW  
Washington, DC 20210

RE: Comments on Proposed Schedule J to Form 5500

Dear Department of Labor,

Thank you for the opportunity to comment on the Notice of Proposed Rulemaking regarding changes to the Form 5500 annual report for Employee Benefit Plans. We appreciate your giving consideration of real world impacts that these regulations will have.

We are a third party administrator of group health plans (mostly ERISA but some non-Federal governmental entities) predominately located in the Southwest but with locations and/or lives in all 50 states. These group health plans represent over 300 employers with around 250,000 plan participants.

The DOL has a difficult task in gathering information together on the variety of plans offered across this great country in order to understand them and report to Congress. While acknowledging the difficulties, we respectfully submit that the Form 5500 and the new schedule J are not the proper mechanisms for accomplishing this goal.

There are many items on the proposed schedule J that will be difficult for a self-funded plan to provide – especially a smaller employer as they are more than likely to have many of these functions outsourced to different entities and coordinating alone will be difficult.

Part of the difficulty in providing comes from what is being asked for and how it is being asked. For instance you ask for how many persons were offered COBRA. Does this mean individual belly buttons or the employee which would include their qualified beneficiaries? Is this the unit or each QB? Without clear definitions this will be confusing. And speaking of confusing; what is the difference between how many person elected COBRA benefits and how many persons are receiving coverage under the Plan through COBRA?

Part IV will be especially challenging to consistently complete. A better definition of a claim will need to be provided to be able to answer some of the questions without providing misleading information. For example, it asks for the number of post-service claims submitted during the plan year. Does this include duplicate claims for the same date of services? Is that one claim or is it a claim each time it is submitted? If the claim had missing information and the additional information was later supplied; is that one claim or two? What about a claim that was submitted but it wasn't for a covered member or even an employee of that employer?

Equally difficult to interpret questions are “How many of those claims were approved during the plan year?” and its flip side “How many of those claims were denied during the plan year?” Based on the DOL’s own claim regulations, just about every claim is in part “approved” or paid, and in part “denied” or has an adverse benefit determination. The regulations say that if the plan doesn’t pay 100% of billed charges (and who in their right mind would pay billed charges from a provider when they are full of overcharges and errors), then there is an adverse benefit determination. For example, a provider bills \$100 for an office visit. The PPO network allowable for that service is \$80. The members co-pay is \$20. The Plan pays the provider \$60 which is all the plan should pay as the network discount and the member responsibility aren’t payable by the plan so under the regulations, \$40 is an adverse benefit determination and \$60 is paid. Is this claim “approved” or “denied”?

The current definition of an adverse benefit determination includes things like network discounts, deductible, co-payment, co-insurance, and other member responsibilities which if taken as a “denial” will greatly exaggerate “denials” and misrepresent true denials. If there are types of “denials” that the DOL is concerned about, maybe they should request those instead of a blanket “denials” without an express definition of what is meant.

The questions on appeals are also difficult to address. What is an appeal? Is it just one that is requested based on the actual appeals procedures under the plan by a plan participant or is it any provider that calls to complain they aren’t paid enough?

Reporting on appeals could also prove to be difficult. Not all claims systems have a code for “appeal” so that you could just run a report that spits out a number. If you ask about a particular claim, you could follow the life of that claim from beginning to end which could include any appeal but claim/benefit codes are usually based on the types of services and not the types of claims (pre, post, appealed, etc.) therefore pushing a button and running a report to get a number will prove a challenge. If this will be needed, companies and plans will need time to get their systems programmed to accomplish this.

For the Compliance Information section, we would respectfully submit that this just be some kind of “best of my knowledge and belief” certification instead of a black or white yes or no because some of these regulations don’t have black or white instructions and many contained “best faith efforts” that could be open to interpretation.

We thank you for the opportunity to provide comments that we hope will improve compliance efforts that our self-funded plans are making. We hope that you will give them serious consideration and are hopefully for a positive response.

Thank you,

Joanie Verinder  
Compliance Director