



The
ERISA
Industry
Committee

December 5, 2016

Employee Benefits Security Administration
Attention: RIN 1210-AB63; Annual Reporting and Disclosure
Room N-5655
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

RE: Form 5500 – Annual Reporting and Disclosure

To whom it may concern:

The ERISA Industry Committee (“ERIC”) is pleased to comment on the proposed amendments issued by the Department of Labor (DOL), the Internal Revenue Service (IRS), and the Pension Benefit Guaranty Corporation (PBGC) (collectively, “the Departments”) on July 21st, 2016, concerning updates to the annual reporting and disclosure for plan sponsors via Form 5500, specifically relating to the new Schedule J health plan reporting.

ERIC’S INTEREST IN FORM 5500 SCHEDULE J

The ERISA Industry Committee (ERIC) is the only national trade association that advocates exclusively on behalf of large employers on health, retirement and compensation public policies on the federal, state and local levels. ERIC supports the ability of its large employer members to tailor retirement, health, and compensation benefits to meet the unique needs of their workforce, providing benefits to millions of workers, retirees, and their families.

ERIC’s member companies offered comprehensive group health benefits to their employees long before the passage and implementation of the Affordable Care Act (ACA), and over the past six years have spent considerable time, effort, and resources to ensure compliance with the law, as well as to maintain compliance with the myriad other federal requirements placed upon group health plans subject to the Employee Retirement Income Security Act (ERISA). As such, ERIC members are keenly aware of the burdens associated with demonstrating compliance with laws governing group health plans, including the annual filing of Form 5500.

COMMENTS

I. THE PROPOSED AMENDMENTS SHOULD BE WITHDRAWN AT THIS TIME

ERIC appreciates the Departments’ hard work in ensuring that plan sponsors comply with disclosure requirements under ERISA, the Internal Revenue Code, ACA, and other relevant laws. The proposed Schedule J would impose significant new and, we believe, unnecessary burdens on plans sponsors with little, if any, benefit. Therefore, it seems inappropriate to rush through such significant changes to reporting requirements while a new Administration is preparing to take over, including a changing of the guard of an estimated 4,000 federal appointees, with their respective differing views on enforcement, compliance, and reporting necessities.

Much of the proposed Schedule J reporting is reliant upon provisions of the ACA – a law that the incoming Administration and the incoming leadership of the 115th Congress have vowed to repeal, delay, dismantle, and otherwise not enforce. We urge the Departments to delay making wholesale changes to the Form 5500 in anticipation of complying with a law that may be about to

experience drastic change. Moving forward with the Form 5500 changes will likely cause a considerable waste of time and resources on behalf of plan sponsors, as well as the Departments.

Regardless of the fate of the ACA, the current Administration has correctly delayed implementation of numerous ACA provisions. These include a number of the “transparency” provisions that the Departments are attempting to implement with this proposed rule. ERIC members believe that the Departments should continue to delay implementation of these provisions until there is certainty regarding the fate of the ACA.

It is true that the Departments have responsibilities under the Mental Health Parity and Addiction Equity Act (MHPAEA) to report biennially on parity compliance and enforcement. However, up until this point, the Departments have been able to perform this reporting without massively expanding reporting requirements upon plan sponsors. At the time of the publication of this proposed rule, there do not appear to be extenuating circumstances that necessitate broader reporting in order to comply with this longstanding legislation.

Further, the ACA gives the Secretary broad authority to indefinitely waive certain reporting requirements. For instance, under subsection (a)(2)(E) of section 2717 of the Public Health Service Act (PHSA), the Secretary “may provide exceptions to such requirements for group health plans and health insurance issuers”. Without significant justification presented as to the utility, necessity, and urgency of this data collection, the Secretary should exercise this authority and continue to forego such reporting until it is clear (and certain for the future) exactly what data is needed under the law, why this data should be collected, and what exactly the Departments intend to do with said data. The proposed rule mentions that this data is intended to be used for consumers to evaluate group health plans and make decisions on whether or not to elect coverage – but that flies in the face of other ACA efforts to simplify plan disclosures and comparisons for consumers.

DOL is also requesting comment on reporting requirements for group health plans in light of the *Gobeille v. Liberty Mutual* decision. In that case, the Supreme Court of the United States (SCOTUS) invalidated a state data collection requirement that would have imposed claims reporting upon self-insured ERISA plans operating within the state of Vermont. In no way did this decision compel or empower the federal government to increase reporting requirements; in fact, SCOTUS affirmed that government entities must have specific statutory authority to demand detailed information reporting from plan sponsors regarding their health claims data. If there is to be a federally-run all-payers health claims database, that database will require specific legislative authorization, which will necessarily include details relating to what must be reported, to whom, by whom, when, and in what format. All of these determinations require congressional action and, as such, are at this time outside of the authority of the Departments to make.

II. IF THE DEPARTMENTS MOVE FORWARD WITH SCHEDULE J, SIGNIFICANT CHANGES ARE NECESSARY

At this time, ERIC believes the Departments should withdraw the proposed amendments, including all efforts to implement Schedule J group health plan reporting. However, should the Departments choose instead to move forward with this burdensome new reporting requirement, a number of changes should be considered, and a number of concerns by the regulated community should be addressed.

Plan sponsors have significant questions and trepidation about the purpose of the proposed reporting requirement. Beyond a general concern that the Departments are engaged in a “fishing expedition,” looking for ways to penalize plans that are operating in good faith but may have produced paperwork errors, there are concerns over the portrayal of data that would be reported.

For instance, the Departments are requiring disclosure of data that could confuse plan participants due to the complicated nature of health claims. Examples include:

- the number of post-service benefit claims that were submitted, approved, denied and appealed during a given plan year;
- the number of post-service benefit claims that were upheld as denials on appeal and payable after appeal;
- whether there were any claims for benefits not adjudicated within the required timeframes;
- the number of pre-service claims that were appealed, upheld on appeal as denials, and approved on appeal during the plan year;
- whether a plan was unable to pay claims at any time during the plan year, and, if so, the number of unpaid claims; and
- total dollar amount of claims paid during the year.

This data does not in fact give current or prospective plan participants useful information about the experience they are likely to have with a given group health plan. In fact, it is likely to portray plans in a false light, giving beneficiaries a false impression about the reliability of their benefits, the ability of plan participants to have inappropriate claims denials corrected, and the stability of a given self-insured plan. ERIC questions the purpose the Departments have in seeking to publish this kind of information about large group health plans' claims, and whether the information is likely to have an unnecessary negative effect on employer-employee relations.

Detailed information relating to denied claims and appeals could pose a risk to beneficiary privacy, and even if that information is protected, it could still be very difficult to collect. This is in part due to the protections that plan sponsors have put in place, using outside arbiters such as independent review organizations (IROs) to adjudicate claims. In some cases, a group health plan might have data at hand regarding claims that were appealed through the group medical plan, but claims under the pharmacy, mental health, dental and vision benefits could be in the hands of different vendors, in different formats, and could be very complicated to obtain, promulgate, and convey to the Departments in a uniform and meaningful manner.

It would also be difficult to account for pending claims that have not yet been directly billed to a plan sponsor. Plans estimate liability for such claims at the end of a given reporting period, but do not have direct access to a comprehensive list of what those claims are or the actual costs. Requiring plan sponsors to report on this would constitute a significant new cost without providing a commensurate benefit to the Departments or plan participants.

Some of this information is confidential as well. Requiring plan sponsors to publicly report data relating to rebates, refunds, and reimbursements will significantly undermine the ability of plans to negotiate favorable rates with providers and vendors. The Departments should instead consider, what is the purpose of collecting this data? If the purpose is actually to determine how plan sponsors direct money collected through rebates etc., a better approach might be to collect a list of vendors that offered rebates, and a short description of how the plan or plan sponsor generally directed funds received pursuant to rebates or refunds.

Additional details about denied claims, rebates, reimbursements, and refunds should not be added to Schedule J, because the value of the data does not justify the huge compliance burden. Large plan sponsors have numerous staff members that spend thousands of hours in a given year negotiating and monitoring this kind of data, and requiring plan sponsors to take a snap-shot and publicly report that data is likely both to misinform the public and plan beneficiaries, and to raise compliance costs significantly enough that it could have a deleterious effect on premiums. Plan sponsors that engage with multiple carriers would have an exponentially more difficult time

collecting the requested data. In an environment in which there is increased emphasis on providing plan beneficiaries with choice and competition among plans, such a massive reporting burden could serve to frustrate those goals.

Many plan sponsors will have difficulty gathering some of the required data, for instance, how many participants made contributions to the plan, how many participated but did not contribute, and how many opted out. This will lead to confusion similar to that caused by reporting requirements under the shared responsibility (6055/6056) mandate in the ACA, wherein categorizing workers, calculating participation and hours worked, and finding missing participants became an extremely costly and challenging endeavor. It might be more beneficial to both plans and the Departments for plans instead to disclose a short description of the plan and its design features, along with the formulas used to determine which employees may participate, and what they will contribute.

Another problem that is sure to arise relates to the use of different vendors for different aspects of a group health plan. For instance, many plans contract with different companies to administer COBRA, mental health, and other aspects of the group health plan. ERIC members have learned through experience with shared responsibility reporting that these vendors often refuse to cooperate, do not share data in the same formats, and charge handsomely for additional information and report generation – all of which adversely affects costs for plan participants, and produces no value for those plan beneficiaries.

ERIC also believes that some of the data required in the proposed rule on Schedule J is in fact reported elsewhere in other reporting requirements – in some cases even elsewhere in the Schedule J. For instance, a requirement to indicate the approximate number of persons covered under a plan at the end of the year, as well as funding arrangements, is already mirrored by other reporting requirements on the Form 5500. Duplicative reporting could increase the likelihood of errors resulting from reporting the same or similar information in multiple sections, and could increase the likelihood of differing interpretations in what information is required to be reported in each section. Duplication also results in wasted time and effort, both for plan sponsors and for the Departments that ultimately will be responsible for processing, reconciling, and analyzing the reported data.

This kind of duplication, when compared with the Departments' narrative of being focused on ferreting out plan noncompliance, gives the impression of a "gotcha" motive in which plans – who are trying to comply with the law, report accurately, and provide benefits to tens of millions of Americans – are treated antagonistically under the law. Take for instance requirements to certify compliance with the ACA. No reasonable person could be 100 percent comfortable certifying that a plan was in complete compliance with all of the varied confusing, labyrinthine, conflicting, unclear requirements upon a group health plan under the ACA, other than certifying compliance in good faith. Numerous other reporting requirements, as well as data demanded by the current and future Form 5500, are meant to assess compliance. So what purpose does asking an individual to certify compliance serve, other than to assign blame for mistakes, confusion, or errors?

Plan sponsors are concerned that with this greatly expanded reporting regime, any place in which plans respond with uncertainty about compliance could directly trigger audits, penalties, and lawsuits. This could have a serious chilling effect on the reporting of data that the Departments could legitimately use for the public good. Instead, the Departments should affirm a safe harbor that allows erroneous filings to trigger plan self-correction, such that a plan sponsor can ensure compliance at a reasonable future date.

III. EFFECTIVE DATE SHOULD BE DELAYED, AND GOOD-FAITH COMPLIANCE ACCEPTED

Recent Congressional efforts to increase the penalties associated with late filing of Form 5500 only exacerbate the challenges posed by such a massive increase in reporting requirements. As such, the Departments should be flexible in the filing deadline, giving plans as much time as possible to comply. Further, the Departments should apply a good-faith compliance standard given the conflicting, incomplete and complicated reporting requirements that currently apply, especially if penalties are to be imposed and passed on to plan beneficiaries. One approach could be to apply a “substantial compliance” standard in the case of plans that experience challenges in assembling the required data.

ERIC appreciates the opportunity to provide comments on this proposal. If you have questions concerning our comments, or if we can be of further assistance, please contact us at (202) 789-1400.

Sincerely,



James P. Gelfand
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