National Business Group on Health®

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

December 5, 2016

Submitted electronically via: www.regulations.gov

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

Re: RIN 1210-AB63 - Proposed Revision of Annual Information Return/Reports and Proposed Rule Regarding Annual Reporting and Disclosure

Dear Sir or Madam:

The National Business Group on Health is pleased to respond to the Department of Labor's, the Internal Revenue Service's, and the Pension Benefit Guaranty Corporation's (the Agencies') proposed rule and notice of proposed forms revisions regarding the Form 5500 Annual Return/Report of Employee Benefit Plan. Our comments pertain to the proposals applicable to group health plans, particularly Schedule J (Group Health Plan Information).

The National Business Group on Health represents 416 primarily large employers, including 69 of the Fortune 100, who voluntarily provide group health plan coverage and other employee benefit plans to over 55 million American employees, retirees, and their families. Our members employ and provide health benefits for employees under a wide variety of work arrangements, including full-time, part-time, seasonal, and temporary. In addition, our members often operate multiple lines of business and tailor employee work and benefit arrangements to the specific needs of each line of business.

As our members continue to comply with the reporting and disclosure requirements under ERISA, the Affordable Care Act, and other statutes, primary concerns will be (1) minimizing the administrative and cost burdens associated with those requirements while (2) maintaining a commitment to transparency, quality, and efficiency in the health care system overall. Allowing plan sponsors flexibility to adapt their Form 5500 compliance procedures to existing work, benefit, and administrative arrangements will reduce compliance burdens and allow plan sponsors to devote more resources toward maintaining and improving health benefits for their employees. Therefore, the National Business Group on Health welcomes the Agencies' efforts, in revising Form 5500, to

minimize administrative burden and duplicative reporting and modernize data collection and usability.

In particular, the National Business Group on Health supports the Agencies' proposals to:

- Have group health plans combine reporting obligations under PHS Act sections 2715A and 2717, as incorporated into section 715(a)(1) of ERISA, with Form 5500 and

- Make key retirement and health and welfare benefit data more available and usable in the electronic filing and data environment.

In addition, we encourage the Agencies to take into account the plan designs and administrative practices typical of large, self-insured employer-sponsored plans by:

(1) Allowing plan sponsors flexibility to report in a manner that accommodates plans' current administrative and recordkeeping procedures;

(2) Clarifying definitions of required data elements;

(3) Minimizing duplicative information reporting by employers who already share plan data with federal agencies;

(4) Maintaining the current Form 5500 filing procedures, which have group health plans filing electronically with a single entity (DOL);

(5) Allowing sufficient time for plan sponsors to coordinate with and obtain relevant data from multiple third-party administrators; and

(6) Allowing relief from applicable penalties when employers make reasonable, good faith efforts to comply.

We provide further discussion of these recommendations below.

I. Current Plan Administration and Recordkeeping

As noted above, the National Business Group on Health supports the Agencies' efforts to minimize the administrative burden of reporting on Forms 5500. To that end, we ask the Agencies to consider that complying with Form 5500 requirements, as currently proposed, will involve substantial reprogramming of recordkeeping systems and staffing resources for our members. Our members' concerns include the following:

- Our members often operate multiple lines of business and tailor plan designs to the specific needs of each line of business. Their health plans often make numerous benefit packages with different premium, coinsurance, deductible, and copayment levels available to employees. Cost-sharing levels, premiums, and

coverage options may vary with employees' compensation. Many of our members currently do not maintain the information required in the proposed Schedule J for all of their plans in a uniform, readily accessible format. Thus, for many of our members, providing information on claims paid, denied claims, and dollar amounts will involve substantial changes to administrative procedures and reprogramming of recordkeeping systems.

- Providing the information on the proposed Schedule J will involve extensive coordination with plans' third-party service providers and may necessitate renegotiation of service agreements with those service providers. Our members are concerned that the burden estimates in the Agencies' proposed rule substantially understate the cost of compliance and administrative burden involved with the proposed Form 5500 and Schedule J.

- As noted above, our members employ full-time, part-time, seasonal, and temporary employees, and employees' eligibility for health coverage may change mid-year, such as when they shift between part-time and full-time status. Reporting on claims for employees who have coverage for less than a full plan year, have coverage for multiple periods within a plan year, work for multiple related employers in a single plan year, or change benefit packages within a plan year will require substantial changes to administrative procedures and reprogramming of recordkeeping systems.

- Our members estimate that the necessary changes to administrative procedures and reprogramming of recordkeeping systems described above will require at least 12 months, assuming that final regulations clearly define the data elements necessary for Form 5500 reporting.

For the reasons described above, the National Business Group on Health recommends that:

(A) In developing final regulations, the Agencies allow employers to report in a manner that accommodates plans' current administrative and recordkeeping procedures.

(B) To the extent possible, the Agencies rely on information that employers already report to other federal agencies and information from third-party administrators.

(C) Final regulations allot sufficient time for plan sponsors to coordinate with and obtain relevant data from multiple third-party administrators.

II. Required Data Elements

In addition, our members are concerned that the Agencies' proposals do not provide clear guidance on many of the data elements they propose to require. Specifically:

- Regarding rebates, reimbursements, and refunds: Reconciliation of claims and expenses for purposes of these amounts often occurs months—sometimes over one year—after the close of a plan year. Group health plans would not be able to incorporate such information into Form 5500 reporting for any given plan year by the current filing deadline.

- For some group health plans, rebates, reimbursements, or refunds are contingent on performance guarantees, which also involve a long reconciliation process. Again, group health plans would not be able to incorporate such information into Form 5500 reporting for any given plan year by the current filing deadline.

- For many group health plans, the amounts of service provider rebates, reimbursements, and refunds—for example, with respect to pharmacy benefit managers—are incorporated into overall plan costs and are not reported to plans separately. This information would not be available to group health plans for reporting purposes unless the Agencies specifically required service providers to provide the information.

- There are many scenarios involving claims that may not fall clearly within a "paid" or "denied" category. For example, plans often require providers to resubmit claims if the initial submission was incorrect. Our members do not view this scenario as a "denial."

- In addition, many group health plans refer to carrier or third-party administrator practices and definitions to define a "denial." Therefore, group health plans do not currently maintain a uniform definition of "denial."

- Reporting on "contributions" will vary widely with plan designs. Employer and participant "contributions" take many forms in addition to premium payments, such as HSA contributions, wellness incentives, and contributions based on the terms of collective bargaining agreements. At this point, it is unclear how such contributions should be treated for purposes of Form 5500 reporting.

- The proposed Schedule J does not specify whether plans should report regarding coverage for domestic partners (as opposed to spouses).

Therefore, we recommend that final regulations and instructions clarify definitions of required data elements and the reporting obligations of both plans and their service providers.

III. *Gobeille v. Liberty Mutual Insurance Co.*

Regarding the Supreme Court's decision in *Gobeille v. Liberty Mutual Insurance Co.*, we emphasize that our members support using group health plan data—including claims data—for the benefit of plan participants.[1] Our members are committed to promoting transparency, quality, and efficiency in the health care system overall and believe that analysis and use of claims data can play a significant role in achieving those goals. However, we encourage the Agencies to consider the following with respect collection of claims data:

- Group health plans have obligations under ERISA, HIPAA, and other statutes to maintain the confidentiality and security of group health plan data for the benefit of plan participants.

- Any collection of claims data from self-insured group health plans should be in a uniform format and at a single location. Any other collection system would undermine ERISA's purpose of providing a uniform, federal regulatory scheme.

- Large, self-insured group health plans generally rely on a number of third-party service providers to process, store, and transmit claims data. Therefore, any data collection efforts will require extensive coordination with these third parties.

- Our members support analysis of claims data to promote transparency and efficiency in the health care system. However, we encourage the Agencies, as they consider claims data collection, to solicit input from self-insured group health plans to ensure an efficient and confidential reporting process that generates data in a format that group health plans can use to benefit plan participants.

Likewise, our members would benefit from a clearer understanding of the Agencies' underlying goals for the Form 5500 proposals and the views of other parties involved with compliance such as third-party service providers and retirement plans. Therefore, we recommend that the Agencies hold a public hearing on the Form 5500 proposals.

IV. Relief from Applicable Penalties

As detailed above, complying with the Form 5500 requirements as proposed will involve substantial reprogramming of our members' recordkeeping and other systems and coordination with third-party service providers. Therefore, it is likely that Forms 5500 will include inadvertent errors, particularly in the first years of implementation. Such errors also are likely to occur in situations such as mergers and acquisitions among

[1] Brief for the Nat'l Business Group on Health as Amicus Curiae, p. 26, *Gobeille v. Liberty Mutual Ins. Co.*, 136 S.Ct. 936 (2016), *available at* http://www.scotusblog.com/wp-content/uploads/2015/10/14-181-bsac-American-Benefits-Council-et-al.pdf.

different employers when employers may need to transition from one plan and recordkeeping system to another.

In addition, employees sometimes must notify plan sponsors of eligibility changes that may affect information on the Form 5500, such as when a spouse or other dependent becomes eligible or ineligible for coverage. Plan sponsors often do not receive such notification immediately—sometimes not until months after the event—which may necessitate retroactive coverage changes and claims processing. These scenarios may result in inadvertent errors in Forms 5500.

Therefore, we recommend that the Agencies provide relief from applicable penalties when filers can show they made good faith efforts to comply with Form 5500 reporting requirements.

Again, thank you for considering our comments and recommendations on proposed changes to Form 5500. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012 if you would like to discuss our comments in more detail.

Sincerely,

Brian J. Marcotte
President and CEO