

December 5, 2016

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 Ave., NW
Washington, DC 20210

Re: Proposed Revisions to the Form 5500 Annual Report

Dear Sir/Madam:

UnitedHealthcare is writing to provide comments regarding two Notices of Proposed Rulemaking addressing the Form 5500 Annual Report (the Annual Reporting and Disclosure Proposed Rule and the Proposed Revision of Annual Information Return/Reports Proposed Rule) published in the *Federal Register* on July 21, 2016. The proposed rules (collectively, the “Form 5500 changes”) issued by the Department of Labor (DOL) make significant revisions to the reporting requirements applicable to group health plans governed by the Employee Retirement Income Security Act (ERISA).¹

UnitedHealthcare (UHC) is dedicated to helping people live healthier lives and making our nation's health care system work better for everyone. UHC serves the health care needs of more than 100 million people worldwide, funding and arranging health care on behalf of individuals, employers, and government. As America's most diversified health and well-being company, we not only serve many of the country's most respected employers, but we are also the nation's largest Medicare health plan - serving nearly one in five seniors nationwide - and one of the largest Medicaid health plans, supporting underserved communities in 24 states and the District of Columbia. Recognized as America's most innovative company in our industry by Fortune

¹ The Proposed Revision of Annual Information Return/Reports (81 Fed. Reg. 47535) was also issued by the Department of Treasury and Pension Benefits Guaranty Corporation.

magazine for six years in a row, we bring innovative health care solutions to scale to help create a modern health care system that is more accessible, affordable, and personalized for all Americans.

UHC provides insurance coverage to and administrative services for several hundred thousand employer- and union-sponsored ERISA group health plans. As a result, we are a source of information used by plan sponsors to complete the Form 5500 annual report. Our comments below offer recommendations for streamlining the reporting process and minimizing the operational challenges raised by the Form 5500 changes.

As an initial matter, however, we wish to address the overall goals of the Form 5500 changes. According to the proposed rules, the new reporting requirements allow the DOL to more effectively fulfill its oversight responsibilities and improve the quality of information reported by group health plans used for policymaking and research.

UHC supports these goals and agrees that information about group health plan administration and operations is a critical component for regulatory review and decision-making by the DOL. These new requirements must be weighed against the potential costs. As noted recently by the Office of Management and Budget (OMB), “(u)necessarily burdensome paperwork requirements can undermine economic and other goals.”² In making changes to the Form 5500, the DOL must carefully consider the potential impact on reporting entities and whether the information collected truly meets the agency’s regulatory goals.

UHC is an industry leader in using data to improve patient health and provide cost-effective care delivery. We use information for a range of activities including chronic disease management, aligning provider reimbursement and care outcomes, improving consumers’ engagement with their health and wellbeing, and population health activities. These activities demonstrate the value of using information to make actionable decisions. We have also learned the importance of focusing our efforts in order to collect the right data at the right time.

Using Information for Actionable Decisions

According to the preamble to the Annual Reporting and Disclosure Proposed Rule, the Form 5500 changes address deficiencies in the existing information collection process. The DOL believes that “the current lack of information collected on the Form 5500 Annual Return/Report from group health plans impairs the effectiveness of EBSA’s ability to develop health care regulations and complicates the DOL’s ability to enforce such regulations and educate plan administrators regarding compliance.”³ While we understand the DOL may need additional plan information to fulfill its regulatory responsibilities, it is important to link data collection efforts with specific actionable decisions rather than just requesting group health plan information because it may be available.

As discussed in more detail below, some of the new data elements requested from group health plans do not appear to meet the goals laid out by the DOL. For example, group health plan

² Office of Management and Budget, *Testing and Simplifying Federal Forms* (August 9, 2012) accessed at: <https://www.whitehouse.gov/sites/default/files/omb/inforeg/memos/testing-and-simplifying-federal-forms.pdf>

³81 Fed. Reg. 47499.

sponsors are asked on Schedule J (Part IV) to indicate the number of claims approved and denied during the plan year. Setting aside questions about that lack of clarity regarding what is considered a “claim” and a “denial,” it is not entirely apparent how collecting this information on an industry-wide basis supports the DOL’s enforcement or policymaking activities.

If, for example, one group health plan denied 2 percent of claims during the plan year and another similar plan denied 4 percent of claims over the same period, does the difference in denial rates mean that the second plan failed in its responsibilities to participants? Or rather is the increase in denials determined by the nature of the claims, patient characteristics, types of health care providers or other factors? While we agree the number of denied claims may be an appropriate consideration for the DOL in looking at group health plans, we suggest the agency obtain the information from targeted plan audits and surveys rather than requesting the information from the entire industry.

UHC recommends the DOL carefully consider whether information requested on the Form 5500 annual report is necessary for regulatory oversight and policymaking and if the data will lead to actionable decision making. As part of this analysis, the DOL should determine if industry-wide collection of information is needed or if more targeted plan audits and surveys will provide the necessary data on a more effective basis.

Coordinating Data Collection Efforts

It is important to recognize that a variety of state and federal agencies routinely request information regarding group health plans. State insurance regulators conduct annual audits and market conduct exams of health insurance carriers providing coverage to group health plans. The National Association of Insurance Commissioners (NAIC) is developing the Market Conduct Annual Survey (MCAS) requesting detailed information from health insurers. Many states have or are establishing All Payer Claim Database (APCD) requirements for insurers mandating submission of information about claims, provider payments, enrollee demographics, and other data. The Centers for Consumer Information and Insurance Oversight (CCIIO) has developed new reporting requirements for Qualified Health Plan (QHP) issuers offering coverage through the Exchanges and have indicated these provisions will eventually be expanded to all health insurance issuers. Other agencies with oversight responsibilities request annual or other periodic submission of data from insurers and employers with respect to health benefits.

Unfortunately, many of these reporting requirements establish different data definitions, reporting formats, and submission timelines. Employers and plan service providers are responding to an increasing number of data requests designed to facilitate better regulatory oversight and policymaking that are actually working at cross purposes and unnecessarily increasing compliance costs.

We suggest the DOL work in collaboration with employers, service providers, state and federal regulatory agencies, and other stakeholders to develop a common set of information requests with uniform definitions and submission timelines. The DOL should minimize overlapping data requests – for example, consider deferring to state regulators with respect to information requests directed to health insurance issuers providing coverage to group health plans.

UHC recommends the DOL work with plan sponsors, service providers, regulatory agencies, and other stakeholders to coordinate information requests and develop a common set of data that is submitted for review. This initiative should seek to standardize data definitions, information formats, and compliance timelines and to minimize costs incurred by plans and service providers to collect and submit data.

Assessing Implementation Costs

The DOL estimates the new reporting requirements will increase annual compliance costs for all group health plans by approximately \$246 million.⁴ These estimates are part of the regulatory impact analysis required by Executive Orders 12866 and 13563 which direct federal agencies to “assess the costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits”⁵ In addition, the impact analysis assists plan sponsors and service providers with understanding the resources needed to implement the Form 5500 changes. Unfortunately, the estimates fail in several critical aspects to fully assess the potential compliance costs.

The cost estimates do not accurately take into consideration the impact of the Form 5500 changes on plan service providers. According to the “Technical Appendix” prepared by the DOL, the labor cost estimates include the costs expected to be incurred by group health plans and by service providers – but only if the service provider bills the plan for the work performed.⁶ Many of the new requested data elements (e.g., specific customer level information on claims, denials, and appeals) are not collected currently and will require plan service providers to create extensive revisions to administrative, operational, and information technology systems. UHC, like many service providers, does not charge group health plans for gathering the data used to complete the Form 5500 annual report. While this practice may change, the current estimates provided by the DOL do not adequately account for the total costs that will be incurred by service providers.

In addition, the estimates appear to significantly underestimate the time and costs that will be required to complete the Form 5500 report. For example, it is estimated that both small and large group health plans will need only 3.5 hours to complete the new Schedule J.⁷ The burden on large plans, however, is expected to be greater given that such plans typically use a variety of service providers (e.g., health insurance issuers, claim administrators, pharmacy benefit managers, behavioral health organizations) and provide multiple benefit options to enrollees. Gathering this data from the different service providers and consolidating the information –

⁴ According to the preamble to the Annual Reporting and Disclosure Proposed Rule large group health plan costs will increase about \$22 million and small plan costs will increase almost \$224 million. (*Estimated Burden Change by Type of Filer*, 81 Fed. Reg. 47502).

⁵ 81 Fed. Reg. 47505.

⁶ *Technical Appendix: Documentation of the Methodology Used to Calculate the Burden Associated with the Proposed Form 5500 21st Century Initiative*, U.S. Department of Labor, July 21, 2016 at p. 3 accessed at: <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/technical-appendices/documentation-of-the-methodology-used-to-calculate-the-burden-associated-with-the-proposed-form-5500-21st-century-initiative.pdf>.

⁷ *Labor Hour Estimates for Welfare Plans that Include Health Benefits*, 81 Fed. Reg. 47569.

along with information generated directly by the plans – will be a time consuming and costly undertaking and the labor cost estimates fail to consider the additional burdens for large group plan compliance.

We also question the estimated compliance costs for small group health plans (e.g., plans with fewer than 100 participants) which the DOL believes will average \$37 on an annual basis for insured plans and \$547 annually for self-funded plans.⁸ The Form 5500 changes request information most plans do not maintain in-house that must be obtained from multiple outside sources. Given the new requirements, we believe many smaller plans will need to rely on legal, accounting, and compliance experts for assistance in completing the form. These additional costs add to the challenges for many small businesses in providing cost-effective health benefits to their employees.

Finally, we are concerned that the DOL has not fully considered whether more cost-effective regulatory alternatives might be available. As noted, the OMB has directed agencies to carefully consider the impact of reporting requirements to ensure appropriate information is collected in the most efficient manner. We urge the DOL to reexamine the regulatory impact analysis to develop realistic estimates of the increased costs that will be incurred by group health plans and service providers in adopting the Form 5500 changes. It is critical for both the agency and impacted entities to clearly understand the resources that will be needed to implement the new reporting requirements and for the DOL to determine if more cost-effective alternatives should be considered.

UHC recommends that the DOL revise the cost estimates for implementing the Form 5500 changes to develop a better understanding of the true cost of compliance for group health plan sponsors and service providers.

Small Group Health Plan Reporting

The Form 5500 changes impose reporting requirements on many small group health plans (e.g., plans with fewer than 100 participants) that are currently exempt from filing. According to the DOL, an additional 2.1 million plans will submit Form 5500 annual reports if the proposed changes are adopted.⁹ We urge the DOL to re-visit the policy concerns that caused the DOL to exempt small fully insured and self-funded group health plans from the filing requirements in the first place.

We understand the desire for policy makers to gather more detailed information about the group health plan system. As an initial matter, we note that the DOL's Bureau of Labor Statistics (BLS), already collects data from the employer community with respect to group health plan design and sponsorship as part of the Current Population Survey (CPS).

The preamble to the Annual Reporting and Disclosure Proposed Rule states that the "DOL must rely on surveys instead of Form 5500 Annual Return /Report data, to generate even basic

⁸ *Ibid.*

⁹ *Estimated Burden Changes by Type of Filer*, 81 Fed. Reg. 47502.

estimate of the size of the ERISA group health plan universe.”¹⁰ BLS data, however, has been the gold standard for researchers, policymakers, and academics with an interest in the economy and the American workforce. Health care consultants such as Aon Hewitt and Mercer and research organizations such as the Kaiser Family Foundation also conduct surveys of the benefit plan community. Between the BLS survey as part of the CPS and the work currently being performed by benefit consulting and research organizations, we do not believe a credible case has been made for the elimination of the Form 5500 reporting threshold.

When the Form 5500 annual report was first adopted, as now, the DOL was concerned with the plan sponsorship rate among the small business community which lags far behind larger employers. In creating the safe harbor exemption for small plan reporting in 1975, the DOL recognized the concerns raised by employers with regard to the potential burdens that would be placed on sponsors:

Although most of the comments received indicated that the exemption set forth by the proposed rule would provide essential relief to certain small welfare plans from the expensive and burdensome task of filing various reports with the Secretary of Labor, they also argued that the exemption should be extended to include plans funded partly by employee or member contributions as well as contributions by the employer or employee organization.¹¹

Accordingly, small fully insured and self-funded group health plans were excepted from this filing requirement and we believe they should remain exempt. As an alternative, the DOL should consider relying on state oversight of fully insured plans or requiring periodic Form 5500 reporting once every two or three years, thereby reducing the burdens that will be imposed on small businesses.

UHC recommends the DOL continue the reporting safe harbor for small group health plans. If small health plan reporting requirements are adopted, the DOL should consider less burdensome alternatives – for example, reliance on state oversight of fully insured group health plans in lieu of Form 5500 reporting or requiring small plans to report on a more periodic basis.

Reporting Excepted Benefits

The Form 5500 changes are intended to apply to excepted benefits. Similar to our concerns regarding reporting by small group health plans, we believe requiring new and extensive reporting with respect to excepted benefits such as dental or vision coverage will unnecessarily increase plan costs and not provide any useful information to the DOL. In particular, we note that many of the newly required questions (e.g., claims, denials, and appeals) ask for data that is not currently collected by plans or service providers (especially on a plan specific basis) and other requested disclosures do not directly apply in the context of excepted benefits (e.g. compliance with the Mental Health Parity and Addiction Equity Act).

¹⁰ 81 Fed. Reg. 47499.

¹¹ 40 Fed. Reg. 34526.

UHC recommends that the DOL clarify that the Form 5500 changes do not apply to excepted benefits such as dental and vision coverage.

Phasing in Form 5500 Changes

The Form 5500 changes are intended to be effective for plan years beginning in 2019 (i.e., annual reports that will be filed beginning in 2020). While this timeline may appear to be sufficient, we ask the DOL to consider the impact of the revised information collection on group health plans, and in particular small plans that will be reporting for the first time. These entities will not only need to understand the new reporting obligations, but must also be ready to file reports electronically using the ERISA Filing Acceptance System (EFAST). Additionally, the DOL will need to dedicate the necessary operational and administrative systems and resources to process the new data including an additional 2 million reports from small group health plans.

When the DOL moved to the EFAST2 reporting system in 2016, the agency acknowledged that the process “required a balancing of available technology, funding, ease of use for the filing community, and usefulness of the system for end users.”¹² Under EFAST2, the DOL gradually brought the new reporting requirements on-line from 2006 to 2010, providing flexibility to employers to continue filing under the old paper filing system on a transition basis. Given the potential impact of the Form 5500 changes and reporting procedures, we suggest introducing the new requirements slowly over time to give sponsors, service providers, and the DOL the necessary time to develop and test their data collection and reporting systems.

UHC recommends that the reporting requirements be phased in over time to give plan sponsors, services providers, and the DOL sufficient time to implement the Form 5500 changes without significant disruptions.

Payment Delinquencies

The new Schedule A (Question 11) asks if there were any payment delinquencies for premiums during the year and whether the delinquency resulted in a coverage lapse. The Schedule A Instructions asks plans to report “premium payments that were not made within the time required by the insurance carrier”¹³ While most plans pay premiums within contracted timelines, there are situations where a payment may be made late – if even by a few days. As a general matter, insurers will work with employers to make sure premiums are paid and coverage continued and only in rare instances does a late payment negatively impact plan participants. We are concerned that reporting all late payments will be burdensome, not provide any useful information, and could negatively impact the financial standing of employers. We suggest the DOL revise this inquiry to focus on situations where a coverage lapse occurred and not have plan sponsors describe every instance where a late payment occurred.

UHC recommends that Schedule A be revised to reflect situations where a late premium payment adversely affected plan participants through a lapse in coverage.

¹² U.S. Government Accountability Office, *Private Pensions: Targeted Revisions Could Improve Usefulness of Form 5500*, GAO 14-441 (2014), p. 67, accessed at: <http://www.gao.gov/assets/670/663855.pdf>.

¹³ 81 Fed. Reg. 47614.

Service Provider Payments

The new Schedule C requests detailed information on plan service providers including information about direct and indirect compensation paid to the provider. The schedule asks plans to prepare a separate schedule for each service provider that received \$1,000 or more in direct or indirect compensation. A covered service provider includes providers of “accounting, auditing, actuarial, banking, consulting, custodial, insurance, investment advisory, legal, recordkeeping, securities or other investment brokerage, third party administration, or valuation services.”¹⁴ Although insured health plans are exempt from the disclosure provisions, they are intended to apply to self-funded welfare plans, including plans offering health coverage.

The instructions discuss bundled service arrangements and make clear that service providers to fully insured plans may take advantage of bundling for certain necessary support services (e.g., recordkeeping and insured service providers claims processing).¹⁵ Such providers are not required to “de-bundle” payments to subcontractors that provide essential services to the group health plan and report them to the plan sponsor as recipients of compensation for Schedule C purposes. We suggest that the proposed revisions also clarify that service providers offering comprehensive group health plan administrative services to self-funded plans may bundle services necessary for the administration of the group health plan for purposes of reporting compensation on Schedule C.

The failure to apply the same rule to self-funded plan service providers suggests that the DOL will require such service providers to provide information to plan sponsors indicating the indirect compensation (received through payments from the service provider) of subcontractors and affiliates of the service provider that are performing services on behalf of the group health plan and are being compensated accordingly. This disclosure is not only challenging for service providers to prepare but will also be confusing and certainly not useful for the plan sponsor. Further, requiring service providers to report in this fashion will cause a proliferation of Schedule C forms for the plan sponsor to complete since every provider typically subcontracts with multiple contractors to perform necessary services for the group health plan.

Many service providers contract with third parties for services across its entire book of self-funded business. Service providers do not allocate a specific part of its subcontractor compensation by the plan serviced but, rather, pay subcontractors on an aggregated basis. As a result, it will be challenging to allocate the specific share of “services” that the subcontractor has performed on behalf of a single group health plan. That amount, if able to be determined, is likely to be meaningless to the plan sponsor or the DOL since the disclosure will be of necessity a rote per capita amount based on the presumed volume of activity the service provider allocates to that group health plan.

The DOL has previously taken a broader view of the ability of service providers to bundle essential services and consolidate the filing of direct compensation under a single coordinating

¹⁴ Schedule C, 81 Fed. Reg. 47578.

¹⁵ See discussion at 81 Fed. Reg. 47617.

service provider.¹⁶ We urge the agencies to adopt this more flexible rule under the proposed changes. The revisions to Schedule C should state clearly that service providers to self-funded group health plans may bundle the underlying services provided by affiliates and subcontractors and report a single “direct compensation” payment in the amount of the total service fee paid by the plan sponsor.

UHC recommends revising Schedule C to clarify that service providers to self-funded group health plans may report a single direct compensation payment for the total service fee paid by the plan sponsor to the provider.

Reporting Claims and Appeals

As discussed above, most plan sponsors will be asked to report claims, denials, and appeals during the plan year (Schedule J, Part IV). Plans are asked to indicate the number of claims submitted, approved, and denied and the number of appeals that were upheld or overturned broken out by pre- and post-service claims. Additionally, plans must indicate the number and total dollar amount of any claims that were not paid within one month of being approved for payment.

While health insurers may report aggregated information on claims and appeals to some regulatory agencies, requiring specific data for every plan raises a number of challenges. Service providers will need to develop extensive reporting systems to track claims and appeals for each customer which will significantly increase the cost to administer health coverage – costs passed on to plans and participants.

We are concerned about the lack of clarity with respect to many of the terms used in Schedule J. For example, the claim definition is fundamental and impacts all related data computations including the volume of paid, denied, and appealed claims. The proposed Schedule J does not clearly indicate whether claims rejected due to incompleteness, member ineligibility or that otherwise fail to meet clearinghouse requirements should be counted as claims or claim denials. Equally unclear is whether “zero-paid” claims (i.e., those where the deductible has not been met or claims paid pursuant to the terms of the plan that nevertheless result in member liability) should be treated as paid or denied claims. Schedule J provides no guidance on how these outcomes should be treated and we suggest that these situations not be treated as claims or denials for purposes of Schedule J reporting absent further definitional guidance.

In addition, the requested claim “values” for both paid and denied claims are meaningless without specific guidance and context for both the value computation and specific claim type involved. Schedule J does not clarify how best to compute the reported claim values (billed charge, contract rates, shared-savings or, where relevant, Medicare or other allowable expense limitations). Even if achievable, normalized valuation for specific service types and treatment codes and adjustments for geographical variances do not take into consideration subjective patient needs and plan coverages to allow meaningful comparisons. The misleading conclusions

¹⁶ Department of Labor, *Frequently Asked Questions About the 2009 Form 5500 Schedule C*, Q13 and Q14, July 2008, accessed at: <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/schedulec.pdf>

about a plan's adjudication of various services that result could vastly outweigh the desired transparency.

Even if the definitions are clarified, there is significant effort and cost associated with producing the required data at the individual plan level - a fact illustrated by the DOL's own exponential cost projections for the affected plans. As discussed, we believe that the DOL's cost projections are grossly underestimated. The potential cost increase to individual plan sponsors, the limited guidance and resulting data reporting inconsistencies, the misinterpretations and erroneous conclusions and lack of coordination with other state and federal transparency initiatives all mitigate against the proposed reporting required by Schedule J.

UHC recommends that the DOL not collect plan specific data on claims and appeals. If DOL believes such information is needed, it should work with stakeholders – including employers, plan service providers, and other state and federal regulators – to further clarify and refine data definitions, reporting formats, and submission timelines.

Collection of Member Level Information

In addition, the DOL is seeking comments with respect to group health plan reporting requirements in light of the Supreme Court's recent decision in *Gobeille v. Liberty Mutual Insurance Co.*, 136 S.Ct. 936 (2016). The decision held that state APCD laws cannot mandate the submission of ERISA plan data. In general, APCD laws require submission of enrollee and patient level health care data. To date, there are fifteen active state APCDs, each with varying reporting requirements, including for example, variations in the data elements submitted, report formatting, data thresholds, and submission deadlines.

State APCD organizations have been working to develop a "common data layout" intended to bring conformity to the data requests and it has been suggested that Schedule J be expanded to include this information. We believe the DOL should not adopt any enrollee or patient specific information data requests for group health plans until such time as a common data layout is developed, and only after the DOL subjects such proposed requirements to the rulemaking process including public notice and comment. Any data submission requirements must address concerns about the cost of data collection and reporting, the usefulness of such information for regulatory oversight and policymaking, and ways to ensure protections for data security and health information privacy.

UHC recommends that the DOL not adopt any requirements for group health plans to provide enrollee or patient level data.

Self-Reporting Compliance Information

The new Schedule J (Part V) asks group health plan sponsors to certify that the plan is in compliance with applicable federal requirements including ERISA, Affordable Care Act (ACA), Health Insurance Portability and Accountability Act, and the Mental Health Parity and Addiction Equity Act. According to the preamble to the Proposed Revision of Annual Information Return/Reports, these "check-the-box" answers are designed to "promote compliance both by

requiring plan administrators to review particular aspects of plan operations in order to meet their annual reporting requirements and by enabling the Agencies to review basic plan compliance issues in an efficient manner.”¹⁷

We question whether the rule is necessary since employers are already subject to IRS requirements mandating reporting and payment of an excise tax in an amount of \$100 per day per applicable employee for failures to comply with federal health care laws. The DOL and Department of Health and Human Services have similar authority to assess fines for compliance violations. We are not convinced that additional legal requirements and penalties will increase plan compliance.

We suggest the DOL consider more effective ways to ensure group health plans are implementing applicable federal requirements. The DOL has instituted a number of initiatives to educate plan sponsors and service providers about their responsibilities including in-person seminars, plan compliance tools and other resources on the DOL website, and Frequently Asked Questions guidance on implementation of the ACA and other federal statutes. We think these efforts are a better approach for plan compliance rather than asking sponsors to check a box on a form.

UHC recommends the DOL revise Schedule J to remove the check-the-box questions with respect to compliance with federal legal requirements. Instead, the DOL should focus its efforts to make additional educational resources and tools available for sponsors and service providers.

We appreciate the opportunity to provide comments with respect to the Form 5500 changes proposed by the DOL and look forward to working with the DOL on this important issue.

Sincerely,



Payman Pezhman
General Counsel, Employer & Individual
UnitedHealthcare

¹⁷ 81 Fed. Reg. 47560. Fully insured small group health plans are exempt from this provision.