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Dec. 5, 2016

Mr. Joe Canary
Office Director
Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N–5655
U.S. Department of Labor
200 Constitution Ave. NW
Washington, D.C. 20210

Re: RIN 1210-AB63; Proposed Revisions to Form 5500, Annual Reporting and Disclosure

Dear Director Canary:

Magellan Health, Inc., (Magellan) welcomes the opportunity to comment on the U.S. Department of Labor (DOL) Employee Benefits Security Administration (EBSA) *Proposed Rule on Amendments to DOL Regulations Relating to Annual Reporting Requirements Under Part 1 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974, as Amended (ERISA) – Fed. Reg. Vol. 81, No. 140,* July 21, 2016 (proposed rule).

Headquartered in Scottsdale, Ariz., Magellan is engaged in the healthcare management business, and is focused on fast growing, complex areas of health, including special populations, complete pharmacy benefits, and other specialty areas of healthcare. Magellan's Healthcare business segment, among other services, includes the management of employee assistance programs (EAPs). In addition, Magellan's Pharmacy Management business segment is a full-service pharmacy benefit management (PBM) company specializing in solving complex pharmacy challenges for its customers by developing and executing smart solutions that leverage industry-leading experience and technology to exceed expectations for employer, third-party administrator, managed care and government customers, across commercial, Medicaid, Exchange, and Medicare lines of business.

Magellan commends EBSA and the DOL for their efforts to improve the information available to the administration and the public through plans' annual Form 5500 filings. However, we have a few concerns we believe EBSA should address when it issues the final Form 5500 reporting package and related guidance. Specifically, and as detailed further herein, Magellan believes

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Government Affairs

required disclosures of rebates paid by PBMs on Form 5500 would be inconsistent with the structure of the ACA; would have no real benefit for participants, beneficiaries or regulators; and, would implicate the concerns raised by the FTC across the past 15 years. Thus, we request that neither Schedule C nor Schedule J of the revised Form 5500 require disclosure of rebate-related amounts received by PBMs or paid by PBMs to plans. Magellan also requests the DOL exclude employers who adopt EAPs from Form 5500 filing requirements with respect to such programs, and especially from proposed Schedule J filing requirements.

Proposed revisions to Schedule C impacting current guidance and introduction of new Schedule J obligating disclosure of rebates paid by PBMs

When EBSA issued the most-recent revisions to Form 5500, the administration recognized the concerns raised consistently by the Federal Trade Commission (FTC) [1] amid state-level efforts to mandate disclosures by PBMs. The 2009 Schedule C of Form 5500 required disclosure of compensation paid to plan service providers, which was interpreted by EBSA through supplemental frequently asked questions (FAQs)[2] not to include disclosure of rebate-related amounts received by PBMs or paid by PBMs to plans, specifically:

> Q26. Pharmacy Benefit Managers (PBMs) provide services to plans and are compensated for these services in various ways. How should this compensation be reported?
>
> PBMs often act as third party administrators for ERISA plan prescription drug programs and perform many activities to manage their clients' prescription drug insurance coverage. They are generally engaged to be responsible for processing and paying prescription drug claims. They can also be engaged to develop and maintain the plan's formulary and assemble networks of retail pharmacies that a plan sponsor's members can use to fill prescriptions. PBMs receive fees for these services that are reportable compensation for Schedule C purposes. For example, dispensing fees charged by the PBM for each prescription filled by its mail-order pharmacy, specialty pharmacy, or a pharmacy that is a member of the

1. Letter from Maureen K. Ohlhausen, director, Office of Policy Planning; Michael A. Salinger, director, Bureau of Economics; and, Susan A. Creighton, director, Bureau of Competition, U.S. Federal Trade Commission, to Patrick T. McHenry, U.S. House of Representatives (July 15, 2005). *See also* similar letters to: Terry G. Kilgore, member, Commonwealth of Virginia House of Delegates (Oct. 2, 2006); and, Nellie Pou, assemblywoman, New Jersey General Assembly (April 17, 2007). *See also* Letter from James Cooper, acting director, Office of Policy Planning; Pauline M. Ippolito, acting director, Bureau of Economics; and, David P. Wales, acting director, Bureau of Competition, U.S. Federal Trade Commission, to James L. Seward, New York Senate (March 31, 2009).

2. Employee Benefits Security Administration, U.S. Department of Labor, "Supplemental Frequently Asked Questions about the 2009 Schedule C" (updated October 2010), https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/faq-sch-C-supplement.pdf.

PBM's retail network and paid with plan assets would be reportable as direct compensation. Likewise, administrative fees paid with plan assets, whether or not reflected as part of the dispensing fee, would be reportable direct compensation on the Schedule C. Payments by the plan or payments by the plan sponsor that are reimbursed by the plan for ancillary administrative services such as recordkeeping, data management and information reporting, formulary management, participant health desk service, benefit education, utilization review, claims adjudication, participant communications, reporting services, Website services, prior authorization, clinical programs, pharmacy audits, and other services would also be reportable direct compensation.

Q27. PBMs may receive rebates or discounts from the pharmaceutical manufacturers based on the amount of drugs a PBM purchases or other factors. Do such rebates and discounts need to be reported as indirect compensation on Schedule C?

Because formulary listings will affect a drug's sales, pharmaceutical manufacturers compete to ensure that their products are included on PBM formularies. For example, PBMs often negotiate discounts and rebates with drug manufacturers based on the drugs bought and sold by PBMs or dispensed under ERISA plans administered by a PBM. These discounts and rebates go under various names, for example, "formulary payments" to obtain formulary status and "market-share payments" to encourage PBMs to dispense particular drugs. The Department is currently considering the extent to which PBM discount and rebate revenue attributable to a PBM's business with ERISA plans may properly be classified as compensation related to services provided to the plans. Thus, in the absence of further guidance from the Department, *discount and rebate revenue received by PBMs from pharmaceutical companies generally do not need to be treated as reportable indirect compensation for Schedule C purposes*, even if the discount or rebate may be based in part of the quantity of drugs dispensed under ERISA plans administered by the PBM. If, however, the plan and the PBM agree that such rebates or discounts (or earnings on rebates and discounts held by the PBM) would be used to compensate the PBM for managing the plan's prescription drug coverage, dispensing prescriptions or other administrative and ancillary services, that revenue would be reportable indirect compensation notwithstanding that the funds were derived from rebates or discounts.

(*Emphasis* added.)

Magellan HEALTH

Obligating PBMs to disclose rebates does not advance the DOL's goals

We do not believe the proposed revisions to Schedule C should impact the supplemental guidance (quoted above) issued following the 2009 Form 5500 revisions. We believe the same concerns EBSA considered with respect to disclosure of PBM information continue to apply, as do those raised by the FTC's long-standing position with respect to proposed state-level disclosure regimes: "such disclosures may facilitate collusion, raise price, and harm the patients the bill is supposed to protect" (referencing a specific New Jersey bill).[3] To avoid the potential for confusion between PBMs and clients as to whether the proposed revisions to Schedule C impact this long-standing assessment, Magellan respectfully asks EBSA to confirm specifically those supplemental FAQs continue to apply to the revised Schedule C.

The proposed revisions also mandate a new Schedule J to Form 5500 for group health plans. The proposal indicates several reasons (*see* 81 Fed. Reg. 47496, 47497 to 47501 [July 21, 2016]) for mandating the new Schedule J. As applicable to PBMs, the proposed Schedule J would require disclosure of rebates paid by PBMs to the plan. We respectfully submit the following of the six stated reasons EBSA provided for the new Schedule J support requiring public disclosure of rebates paid by a PBM to the plan, the DOL's goals would not be advanced.

1. Support Oversight of Group Health Plans and Ongoing Implementation of the Affordable Care Act

Section 6005 of the ACA requires entities providing PBM services to a prescription drug plan or a qualified health plan offered through a health insurance exchange to provide certain information to the secretary of the U.S. Department of Health and Human Services. The information must be aggregated, with de-identified data, so the PBM and plan names are not disclosed to anyone other than the secretary. Under this requirement, the secretary may only disclose the information they received if it is in a form not disclosing the identity of the PBM or plan, or prices charged for drugs; and, the disclosure itself is either necessary to carry out the requirements of the ACA or the Medicare Part D program, for review by the Comptroller General, for review by the Congressional Budget Office, or to enable states to carry out the health exchange provisions of the ACA.

The limited nature and strong confidentiality protections for these disclosures was an intentional decision of the Congress, following input from the FTC, because of the negative impact such disclosures would have on the marketplace. Thus, Congress's intent in the ACA

3. Letter from Maureen K. Ohlhausen, director, Office of Policy Planning; Michael A. Salinger, director, Bureau of Economics; and, Susan A. Creighton, director, Bureau of Competition, U.S. Federal Trade Commission, to Nellie Pou, assemblywoman, New Jersey General Assembly (April 17, 2007).

strongly counsels against requiring public disclosure of PBM rebates through Form 5500 reporting.

2. Reporting to Satisfy Public Health Service Act Sections 2715A and 2717

When it enacted Sections 2715, 2715A or 2717 of the ACA, Congress did not include rebates in its specific list of types of information group health plans would be required to disclose. (Congress instead included PBM-specific reporting provisions in other provisions of the ACA, as noted above.) Magellan respectfully suggests this is further evidence Congress did not intend public disclosure of PBM rebates through Form 5500 reporting or otherwise beyond the bounds of the ACA's Section 6005.

3. Modernize Data Collection and Usability

Magellan believes public disclosure of rebates paid by a PBM to a plan to have limited to no value to participants, beneficiaries, or regulators. EBSA and other regulators can always request this information in the course of a plan audit if desired, just as the secretary of Health and Human Services has similar oversight authority, without requiring the type of public disclosures the FTC consistently has opposed.

Proposed revisions obligating EAP offerors to file Form 5500

According to footnote 5 of the proposed rule, the DOL proposes to require the filing of "some or all of the Form 5500 Annual Return/Report and all applicable schedules, including the Schedule J, regardless of whether such plans are exempt from certain market reform requirements under… ERISA § 733(c) (group health plans consisting solely of excepted benefits)." The proposed rule thus in part addresses EAPs, which provide "excepted benefits" "if they satisfy all of the requirements of [26 C.F.R. 54.9831-1(c)(3)(vi)]." By contract with its customers, the EAPs Magellan administers all provide "excepted benefits." Magellan believes all EAPs in the marketplace are similarly administered; that is, no EAP offers anything except "excepted benefits." For the reasons set forth herein, Magellan appreciates the opportunity to comment and respectfully asks EBSA to exempt the adopters of EAPs from Form 5500 filing requirements, and in particular from the proposed Schedule J filing requirements.

Magellan HEALTH

Employee assistance program characteristics

Magellan is a market leader in providing EAPs to employers, including corporations, labor unions, and federal, state and municipal governmental agencies. For more than 30 years, Magellan has worked with its customer organizations, their members, and our network clinicians to help individuals address personal issues early, minimizing the impact of those issues on workplace productivity. Magellan employees and network providers offer to individuals covered by Magellan administered-EAPs confidential brief counseling: a problem-focused form of individual or family counseling (telephonic and outpatient) that seeks resolution of short-term problems in living (e.g., parenting concerns, emotional stress, marital and family distress, and substance use) and setting and maintaining realistic goals achievable in a one- to five-month period. Telephonically, Magellan employees also offer 24/7 crisis counseling to individuals covered by Magellan administered-EAPs, focusing on defusing the caller's emotional reaction to a situation and then referring the caller to appropriate available services both within and outside the EAP offering. Magellan also offers a variety of online tools and resources for employees.

In addition to such brief counseling, EAPs also include human resources-focused critical incident stress management services: consultations with employers as employers in connection with sudden, unanticipated, traumatic incidents that produce a high degree of stress in specific affected workplaces; management consultations with supervisors who seek assistance and expert advice in dealing with difficult employees; substance use treatment compliance monitoring consistent with federal requirements imposed on certain employers operating in certain industries; seminars and trainings geared towards employee education and supervisory skills; legal and financial consultation services (including providing individuals with access to attorneys and financial planners for free initial consultations and continued services/consultations at discounted rates); and, work-life services (including providing individuals with immediate referrals to vetted services and supports for older adults, child care, pet care, car repair, etc.; service providers; and, concierge services, such as discounted entertainment tickets).

EAPs are not "health plans"

EAPs fundamentally are not a healthcare benefit. Promoting a productive and contributing workforce is not an extension of traditional group health plans, and employers are willing to subsidize certain services for their employees to increase worker productivity. Employers have recognized a return on investment for providing discounted optional benefits for individual and family living supports that extend well beyond "brief counseling."

Needless to write, EAPs as Magellan has just described them "do not provide significant benefits in the nature of medical care." In 2014, Magellan welcomed the DOL's recognition of this fact in its promulgation of final regulations effective for plan years beginning on or after Jan. 1, 2015 to bring EAPs within the already existing statutory definitions of "excepted benefits," found at §2791(c)(2)(C) of the Public Health Service Act (the "PHSA"), §733(c)(2)(C) of the ERISA, and §9832(c)(2)(C) of the Internal Revenue Code (the Code). As set forth in the Preamble to those final regulations, the express purpose of classifying EAPs as offering "excepted benefits" was to "ensure that employers are able to continue offering EAPs as supplemental benefits to other coverage, and to ensure that in circumstances in which an EAP with limited benefits is the only coverage, or the only affordable coverage provided to an employee, that the coverage does not unreasonably disqualify an employee from potential eligibility to receive a premium tax credit under section 36B of the Code if the employee enrolls in coverage under a qualified health plan through the Exchange" (79 Fed. Reg. 59130, 59133, Oct. 1, 2014).

Magellan notes the phrase "does not provide significant benefits in the nature of medical care" also appeared in the Internal Revenue Service's 2004 Notice 2004-50, 2004-2 C.B. 196 (Aug. 16, 2004) offering "certain basic information" on "health savings accounts:"

> Q10. Does coverage under an EAP, disease management program, or wellness program make an individual ineligible to contribute to a health savings account?
>
> An individual will not fail to be an eligible individual under section 223(c)(1)(A) solely because the individual is covered under an EAP, disease management program or wellness program *if the program does not provide significant benefits in the nature of medical care or treatment, and therefore, is not considered a "health plan" for purposes of section 223(c)(1)*. To determine whether a program provides significant benefits in the nature of medical care or treatment, screening and other preventive care services as described in Notice 2004-23 will be disregarded. See also Q&A 48 on incentives for employees who participate in these programs.
>
> *Example (1)*. An employer offers a program that provides employees with benefits under an EAP, regardless of enrollment in a health plan. The EAP is specifically designed to assist the employer in improving productivity by helping employees identify and resolve personal and work concerns that affect job performance and the work environment. The benefits consist primarily of free or low-cost confidential short-term counseling to identify an employee's problem that may affect job performance and, when appropriate, referrals to an outside

> organization, facility or program to assist the employee in resolving the problem. The issues addressed during the short-term counseling include, but are not limited to, substance abuse, alcoholism, mental health or emotional disorders, financial or legal difficulties, and dependent care needs. *This EAP is not a "health plan" under section 223(c)(1) because it does not provide significant benefits in the nature of medical care or treatment.*
>
> (*Emphasis* added.)

Again, the express purpose of concluding EAPs with the design described above in A-10 of Notice 2004-50 is to ensure employers may enroll employees in EAPs without disqualifying those employees from participation in the employer's health savings accounts, which are coupled only with high deductible health plans and not with other kinds of health coverage. Fundamentally, the Internal Revenue Service and the DOL both have concluded EAPs as designed and administered by Magellan as described herein (and as designed and administered by Magellan's competitors, as well) are not "health plans" "providing significant benefits in the nature of medical care and treatment."

<u>Obligating EAP offerors to file Forms 5500 does not advance the DOL's goals</u>

Because EAPs do not "provide significant benefits in the nature of medical care and treatment," the six stated reasons for the proposed rule (*see* 81 Fed. Reg. 47496, 47497 to 47501 [July 21, 2016]) would not be advanced by requiring employers who implement EAPs to file Forms 5500 with respect to those EAPs, and particularly the filing of proposed Schedule J.

1. Modernizing Financial and Investment Reporting by Pension Plans

EAPs are neither pension plans nor retirement plans, and manage no assets or investments of adopting employers or members.

2. Support Oversight of Group Health Plans and Ongoing Implementation of the Affordable Care Act

As discussed above, EAPs specifically were characterized in DOL regulations in contrast to characteristics of group health plans:

> (vi) Employee assistance programs. Benefits provided under employee assistance programs are excepted if they satisfy all of the requirements of this paragraph (c)(3)(vi).

(A) The program does not provide significant benefits in the nature of medical care. For this purpose, the amount, scope and duration of covered services are taken into account.

(B) The benefits under the employee assistance program are not coordinated with benefits under another group health plan, as follows:

(1) Participants in the other group health plan must not be required to use and exhaust benefits under the employee assistance program (making the employee assistance program a gatekeeper) before an individual is eligible for benefits under the other group health plan; and

(2) Participants' eligibility for benefits under the employee assistance program must not be dependent on participation in another group health plan.

(C) No employee premiums or contributions are required as a condition of participation in the employee assistance program.

(D) There is no cost sharing under the employee assistance program.

45 C.F.R. §2590.732(c)(3)(vi).

EAPs with these characteristics fall within the Health Insurance Portability and Accountability Act's (HIPAA's) "excepted benefits" rubric, which eliminates the offeror/administrator/sponsor of such plans from HIPAA's group health plan provisions. As quoted above, the very reason the DOL adopted the above regulations was to ensure the ACA's group health plan personal and employer responsibility and market reform provisions would not be compromised by an employer's automatic enrollment of all employees in the employer's EAP.

Two specific examples contained in the proposed rule of how the Form 5500 is intended to advance the oversight goal demonstrate that Form 5500 filings for EAPs would not advance that goal. The proposed rule describes adverse financial consequences that could be averted by Form 5500 filings (81 Fed. Reg. 47499 [July 21, 2016]). But employers adopting Magellan-administered EAPs do not pay claims. Magellan does, so there is no danger of the employer being unable to pay claims incurred by enrollees for brief counseling sessions. Magellan reasonably believes all of its competitors similarly pay provider claims. Further, the above quoted DOL regulation requires EAPs charge enrollees neither premiums nor any cost sharing for brief counseling sessions. Thus enrollees will not "fac[e] bankruptcy over unpaid medical expenses." *Id.* Second, the DOL in the proposed rule predicts that Form 5500 filings could be used to assess group health plan and health insurance coverage compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA). *Id.* But EAPs are not subject to the MHPAEA because they provide no medical/surgical benefits against which the brief counseling sessions could be compared.

3. Reporting to Satisfy Public Health Service Act Sections 2715A and 2717

Because EAPs offer "excepted benefits," none of Sections 2715, 2715A or 2717 of the ACA apply to EAPs. These sections apply to "group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage." 26 IRC §9832 defines health insurance coverage; "excepted benefits" are expressly excluded from such definition. Because EAPs offer only "excepted benefits," none of Sections 2715, 2715A or 2717 of the ACA apply to EAPs.

4. Modernize Data Collection and Usability

The Proposed rule states:

> This project would standardize and structure the Form 5500 Annual Return/Report to make key retirement and health and welfare benefit data, including information on assets held for investment, more available and usable in the electronic filing and data environment."
>
> *Id.* at 47500.

For the reasons already set forth herein, EAPs simply possess no "key retirement and health and welfare benefit data."

5. Updating and Improving Reporting of Service Provider Fee and Expense Information

As with the first objective of the proposed rule, this fifth objective is geared toward "pension plan fiduciaries:"

> A key purpose of the required fee disclosures in the ERISA section 408b-2 regulation is to help make sure that *pension plan fiduciaries* can more effectively negotiate service provider fees based on a better understanding of compensation that the service provider expects to receive, including from third party sources that might represent a conflict of interest.
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> *Id*. (*emphasis* added).

Further, because EAPs do not "provide significant benefits in the nature of medical care and treatment," there are no "third party sources" of "compensation" (e.g., prescription drug rebates) to compensate administrators of EAPs like Magellan besides the fees it receives from

employers who adopted Magellan-administered EAPs. Magellan largely prices its EAP administration on a per-employee, per-month basis, with certain other services priced on a fee-for-service basis. Magellan believes its competitors similarly so price EAP administration services. Magellan's employer customers know up-front exactly what compensation Magellan will receive for its services.

6. Improving Employee Benefit Plan General Compliance with ERISA and the Code

Finally, this last objective is not furthered by requiring employers who adopt EAPs to file Form 5500, and particularly the proposed Schedule J thereto, precisely because offerors of "excepted benefits" are exempted from a great deal of ERISA, as amended by HIPAA and the ACA. For example, none of the DOL regulations collected at Part 2590 of Title 29 of the Code of Federal Regulations are applicable to EAPs. 29 CFR §2590.732(c)(3).

With respect to the proposed Schedule J in particular, as described in the *Proposed Revision of Annual Information Return/Reports; Proposed Rule*, 81 Fed. Reg. 47534 (July 21, 2016), that Schedule would seek to collect "group health plan characteristics;" "service provider and stop loss insurance information;" financial information (e.g., "total cash contributions received from employees… attendant to the provision of health benefits"); "health benefit claims processing and payment" (within the framework of pre- and post-service benefit payments); and, "compliance information" (including "trust compliance" and "summary of benefits and coverage," HIPAA, MHPAEA, Women's Health and Cancer Rights, etc. compliance). *Id.* at 47635-37.

For all of the reasons heretofore set forth, filing the Schedule J as described makes little sense to be required of EAPs. Tellingly, Magellan finds it extremely significant that the *Proposed Revision of Annual Information Return/Reports; Proposed Rule* contains the following proposed instruction about Schedule J: "Line 9b(1) Group Health Benefits. If the plan provides health, dental, or vision coverage, answer "Yes" and check all that apply. If you answered "Yes" here, you must attach Schedule J--Group Health Plan Information. Plans that offer excepted benefits *that consist of limited scope dental or vision benefits must still file a Schedule J*." *Id. at* 47612.
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In summary, we respectfully ask that neither Schedule C nor the proposed Schedule J of the revised Form 5500 require disclosure of rebate-related amounts received by PBMs or paid by PBMs to plans. Magellan also asks EBSA to exclude employers who adopt EAPs from Form 5500 filing requirements with respect to such programs, and especially from proposed Schedule J filing requirements.

Once again, we thank the DOL for this opportunity to provide input on the proposed revision of annual reporting requirements.

Should you have any questions or need any clarification, please do not hesitate to contact Claire Wulf Winiarek, senior director of public policy, at (860) 507-1918 or cwulfwiniarek@magellanhealth.com; or, Brandin Hay, senior director and legal counsel, at (314) 387-5870 or bhay@magellanhealth.com.

Thank you for your attention to this important matter.

Sincerely,

Meredith A. Delk, Ph.D., MSW
Senior Vice President, Government Affairs