UNITEHERE!

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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 Avenue N.W.
Washington, DC 20210

Re: Annual Reporting and Disclosure
RIN 1210-AB63

Dear Sir or Madam:

The following comments are submitted on behalf of UNITE HERE HEALTH (the Fund) in response to the proposed rules for Annual Reporting and Disclosure published in the July 21, 2016 Federal Register. The Fund is responsible for the health care benefits and wellness of approximately 250,000 people across the United States. Our Fund is a Taft-Hartley nonprofit health fund solely dedicated to providing affordable, high quality health benefits to our participants and their families. We are very proud of the comprehensive health benefits we have provided to our members for the last 40 years and appreciate the opportunity to provide comments on the proposed rules.

As a multiemployer health fund, the Fund completes one Form 5500 for 23 health plans that participate in the Fund. Gathering the required reporting data for these plans is a very time-intensive task that requires months to conduct. Therefore, the Fund has great interest in the proposed rules and their impact on this process, particularly the new Schedule J which would require substantial additional information to be reported and would add to the workload and expense the Fund experiences in meeting reporting and disclosure requirements.

We understand the Secretary of Labor's requirement under the Affordable Care Act (ACA) to prepare an annual report that includes certain general information on self-insured group health plans using data collected from the Form 5500 Annual Return/Report. However, we do not feel that certain data being requested would provide any additional insight to the Department of Labor (the Department) on a plan's overall compliance, financial soundness or claim payment practices. With the objective of providing the Department with relevant data so that it can fulfill its enforcement and reporting obligations, while reducing time and expense of data collection for plan sponsors, we respectfully provide the following comments.

General Comments

Supporting Oversight of Group Health Plans and Ongoing Implementation of the Affordable Care Act (ACA)

The Department states in the Executive Summary that the current lack of information collected on the Form 5500 Annual Return/Report impairs the effectiveness of the Employee Benefits Security Administration's (EBSA's) ability to enforce regulations and educate plan administrators regarding compliance. We urge the Department to consider the relevance and applicability of each requested data item to enforcement and compliance objectives.

For example, the Executive Summary indicates that the amount of outstanding claims for a self-insured plan would be a critical flag for further investigation into whether the group health plan is able to pay outstanding claims and could prevent a participant from facing bankruptcy over unpaid medical expenses. Our experience is that there are a number of reasons claims may be outstanding for a short period of time at any point, including the need for additional information from a participant or provider and that outstanding claims are not necessarily an indication of a plan's financial stability. In most instances, the number of outstanding claims has nothing to do with the financial solvency of the plan sponsor (which typically is not processing claims directly) but rather administrative issues relating to the plan's third-party administrator (if applicable). To use this data as an indicator for investigation would lead to a potential unnecessary use of time and resources for not only the plan sponsor, but for the Department as well. A better indicator of a plan's financial condition would be the Schedule H for self-funded plans that hold assets in trust.

In addition, we believe that any use of Annual Return/Report data as a research tool, particularly for private researchers, should be secondary to its statutory intent of improving enforcement and ensuring compliance. To the extent the data is being requested with a goal of promoting private research, we object to the potential additional cost and effort required of plan sponsors in providing this data.

Reporting to Satisfy Public Health Services Act (PHS Act) Sections 2715A and 2717

The Department proposes conforming amendments in 29 CFR 2590.715-2715A and 29 CFR 2590.715-2717 to clarify that compliance with the proposed annual reporting requirements by group health plan subject to ERISA would satisfy the ACA reporting requirements under PHS Act sections 2715A and 2717 that were incorporated in ERISA through ERISA section 715(a)(1). The Executive Summary of the proposed rules indicates that EBSA is coordinating with HHS on using the Form 5500 Annual Return/Report as an alternative mechanism to satisfy these reporting requirements.

While we commend the Department on its efforts to streamline reporting and reduce unnecessary duplication, we note that the proposed changes to Form 5500 as currently drafted address very few of the transparency provisions of PHS Act Sections 2715A and 2717. In fact, the Department notes in the Executive Summary that it may propose collecting additional data in the future and has indicated that it is also considering collecting more information on denied claims, including the dollar amount of claims denied, denial codes and the type of claim (mental health/substance abuse or medical/surgical). The Department further requests comments on the new Schedule J in light of the Supreme Court's recent decision in *Gobeille v. Liberty Mutual Insurance Co.,* 136 S. Ct. 936 (2016). We are greatly concerned that the newly-expanded reporting requirements of Schedule J are only a starting point for much more extensive data requests in future years.

Based on these concerns, we strongly object to the proposed conforming amendments as they would, in effect, convey broad authority to the Departments for any future information requests they deem necessary to promote compliance, increase transparency and educate the public without input from stakeholders, including the sponsors of self-funded health plans. We also object to the expansion of data reporting to the level requested in *Gobeille* and urge the Department to consider the extraordinary financial burden reporting at this level would present to self-funded health plans, both those with less than and more than 100 participants. Further to this point, ERISA Section 107 requires that plans retain records required to document the accuracy of Form 5500 information for six years after the filing date. Considering the breadth of the expanded reporting requirements under consideration, this would amount to an exponential expansion of the record retention standards.

We prefer that the Departments delay the conforming amendments until after they have had an opportunity to identify, finalize and obtain stakeholder feedback on the data required to fully meet the requirements of PHS Act Sections 2715A and 2717.

Comments on proposed Schedule J

Part I – Group Health Plan Characteristics
We request your consideration of the following:

1. We do not understand how the request for information on the number of participants who were offered and elected COBRA (items 6a-6c) applies or is relevant to plan compliance. The Fund, like other multiemployer plans, offers participants the ability to self-pay for coverage at the end of their eligibility at a much lower cost than the COBRA rate. This fact would skew the numbers of individuals electing COBRA relative to those who were offered such coverage and would not necessarily be an accurate representation of the uptake of continuation coverage.
2. While we understand how certain plan reimbursements and refunds (items 7a-7b), such as medical loss ratio refunds and premium holidays, relate to the operation of fully-insured plans, we do not understand the relevance of rebates from pharmacy benefit managers to plan operations or compliance. Many plans of benefits, including some of those administered by the Fund, have confidentiality agreements with their pharmacy benefit managers regarding rebates received by the plan. We object to the inclusion of this information on Schedule J and request that the Departments remove it from the form.

Part IV – Health Benefit Claims Processing and Payment
We request your consideration of the following:

1. Proposed Schedule J requires information on the number of approved, denied and pending claims. Under current Department claims regulations, a claim can be deemed "denied" (an adverse benefit determination) in a number of circumstances, including when deductibles and copays are applied. If the intent of this request is to report only those claims that were denied completely, this would require significant new programming to track claims in this manner. Therefore, we request clarification on this information request and consideration of the potential cost associated with collecting this data.
2. As noted earlier, we caution the Department in using the number of claims pending at the end of the plan year as an indicator of a plan's financial stability. There are a number of reasons that a claim may be in pending status at the end of the year and this is not a direct correlation to a plan's financial ability to make payment. We also urge caution in using the number of claims

approved on appeal as an indication of unnecessary claim denials. When submitting appeals, participants and providers often submit additional information that was not available during the initial adjudication of a claim, leading in a reversal of the initial claim determination.

3. We do not understand the relevance of the 1-month and 3-month timeframes associated with claim payments in item 20. We would also like to make the Department aware that this data is not tracked or reported in current claim systems and would require substantial reprogramming to produce.

Part V – Compliance Information

Generally, we object to the broad nature of the compliance questions included in this Part. While health plans strive to ensure compliance with the law, there may be inadvertent violations that cannot be determined without a rigorous ongoing audit of all plan operations. An attestation to full compliance could amount to a false statement to the Department with potential liability for the plan's Board of Trustees. We also noted that while the Department has authority to require multiple employer welfare arrangements (MEWAs) to self-report compliance, there does not seem to be authority to require non-MEWAs to certify compliance. If these questions do remain as part of Schedule J, we would prefer that the questions be revised to inquire about a plan's good faith effort to comply with the laws noted rather than a blanket statement of compliance.

Again, we appreciate the opportunity to comment on the proposed rules, and look forward to continued opportunities to share our concerns on these and other proposed rules.

If you have any questions or would like to discuss these comments, please contact me at dtaylor@unitehere.org.

Sincerely,

D. Taylor
President, UNITE HERE