

## APPENDIX B

**EBSA'S RESPONSE**

U.S. Department of Labor

Assistant Secretary for  
Employee Benefits Security Administration  
Washington, D.C. 20210DATE: **SEP 22 2016**

MEMORANDUM FOR: ELLIOT P. LEWIS  
Assistant Inspector General for Audit

FROM: PHYLLIS C. BORZI *Phyllis C. Borzi*  
Assistant Secretary of Labor for Employee Benefits  
Security

SUBJECT: EBSA Response to OIG Performance Audit  
Report No. 05-16-003-12-121

This is in response to the recommendations in your September 1, 2016 draft audit report regarding whether the Employee Benefits Security Administration (EBSA) provided adequate oversight of safeguards against the improper denial of claims in ERISA-covered self-insured health plans. We first discuss EBSA's work to protect plan participants, then respond to your specific recommendations.

**Background**

EBSA is responsible for administering and enforcing the fiduciary, reporting and disclosure, and other provisions of Title I of the Employee Retirement Security Act of 1974 (ERISA). Under ERISA, the Secretary of Labor is responsible for protecting the rights and financial security of more than 685,000 private pension plans and 2.3 million health plans and a similar number of other welfare benefit plans. Together, these plans hold approximately \$8.7 trillion in assets and cover more than 143 million workers, retirees and their families.

EBSA's enforcement program seeks to detect and correct violations that result in monetary recoveries for employee benefit plans, participants and beneficiaries, and to obtain other corrective remedies including, but not limited to, significant broad-based reforms for large plans or common service providers. EBSA accomplishes these objectives through the conduct of civil and criminal investigations. The integration of EBSA's enforcement and effective participant assistance programs allows the Agency to augment and better leverage its limited enforcement program resources by obtaining informal resolution of complaints prior to initiating more resource-intensive investigations. Many civil violations are also effectively and efficiently resolved through voluntary compliance and losses are restored to plans and participants. However, when voluntary compliance efforts fail or are not appropriate, EBSA and the Solicitor of Labor (SOL) may initiate civil litigation. Together, EBSA and SOL determine which cases are appropriate for litigation. EBSA also utilizes its criminal enforcement program to pursue the most egregious violators of laws protecting private employee benefit plans. The Agency works closely with other law enforcement agencies as well as federal and state prosecutors to pursue criminal actors who victimize these plans.

Since 2002, EBSA has implemented two highly successful self-correction programs designed to encourage voluntary compliance in order to better leverage its resources. The Agency's Voluntary Fiduciary Correction Program (VFCP) encourages plan officials to voluntarily comply with ERISA's

fiduciary and prohibited transactions provisions by self-correcting certain specified violations of the law. Similarly, the Delinquent Filer Voluntary Compliance Program (DFVCP) encourages voluntary compliance with the annual reporting requirements under ERISA. Together, these two programs provide an efficient mechanism for self-identifying and correcting violations, and free up investigative resources for other, more complex issues.

Complementing the investigative arm of the enforcement program, EBSA's participant assistance staff responds to inquiries from members of the public who seek information or have complaints about their benefits. The Agency's benefits advisors are able to assist the public in understanding their rights under their plans and are often able to informally resolve disputes, thereby obtaining benefits for these workers and their families. This informal dispute resolution process enables EBSA to answer individuals' inquiries without utilizing the more resource intensive investigative process, allowing EBSA to direct its investigative resources to more egregious and wide-spread violations of ERISA. Over the period covered by the Report (FY 2012 - FY 2015) EBSA's 114 benefits advisors responded to over 879,000 inquiries from participants, beneficiaries, plan fiduciaries and service providers in all types of ERISA-covered employee benefit plans. During this period, the benefits advisors obtained over \$1.28 billion in wrongfully denied employee benefits for 519,000 participants and beneficiaries. The participant assistance program is also the source of some of our best investigative leads, producing several hundred cases per year—cases that, in the absence of this program, might not have been discovered.

A substantial portion of the benefits advisors' work involves assisting individuals with wrongfully denied health plan claims. Between FY 2012 and FY 2015 EBSA received 68,000 inquiries relating to health benefits claims. As EBSA previously outlined for OIG, it is important to note that these 68,000 inquiries were not all related to partially or fully denied benefits claims, as stated in the OIG report, but also included general inquiries about the payment of health claims. For example, health plan participants and beneficiaries contact benefits advisors with questions such as 'How do I submit a claim for my benefits from my health plan?', or 'I submitted my health claim yesterday, when can I expect to receive payment of my benefits?' These 68,000 records resulted in more than 1,700 health benefit recoveries where benefits advisors secured more than \$67 million in benefits for 84,000 health plan participants.

EBSA works to inform the public with regard to benefits issues so that plan participants have access to information about their rights and responsibilities under their plans. Workers and their families can then monitor their own benefits and hopefully obtain any necessary plan correction before serious financial damage is done. EBSA also educates plan officials by conducting outreach and education programs. Benefits will be more secure if plan officials are more knowledgeable and therefore in a better position to be in compliance with ERISA and its regulations. Important components of EBSA's educational work include three broad education campaigns: (1) the Retirement Savings Education Campaign (RSEC); (2) the Health Benefits Education Campaign (HBEC); and, (3) the Fiduciary Education Campaign. These programs target plan sponsors and other plan officials, service providers, and plan participants to inform them of their rights and responsibilities under ERISA. In addition, as part of its outreach and education efforts, EBSA works cooperatively with private and public sector organizations, including state commissioners of insurance. In addition to these three campaigns, EBSA conducts outreach to dislocated workers through rapid response events delivered in conjunction with states and other DOL agencies. Outreach is also conducted via public awareness events such as Congressional staff briefings, webinars, job fairs and other venues.

EBSA's total authorized investigative staff includes 464 employees who work out of EBSA's field offices (in total, the Agency has authority to hire 963 employees who must discharge all of the Agency's responsibilities, including its regulatory work, education and outreach, research, administrative, and investigative work). Generally, an investigator examines a plan to determine whether it is operated in accordance with its terms and the rules set forth in Title I of ERISA and related regulations. The ERISA Enforcement Manual guides the conduct of EBSA investigations. Of particular concern in most investigations is whether the fiduciaries are carrying out their fiduciary duties appropriately, especially with regard to monitoring service providers; prudent investment of plan assets; the payment of plan expenses; proper diversification of investments; avoidance of self-dealing and prohibited transactions; the timely collection of contributions; adherence to required claims procedures and prudent claims administration.

EBSA focuses its enforcement resources on National Enforcement Projects, Major Cases and Employee Contributions priorities as outlined in the annual EBSA Operating Plan and each of the ten regional office program operating plans. As in years past, EBSA will continue its Health Benefits Security Project (HBSP) which is a comprehensive national health enforcement project, combining EBSA's established health plan enforcement initiatives with the new protections afforded by the Patient Protection and Affordable Care Act of 2010 (ACA). The HBSP involves a broad range of health care investigations, including examinations for compliance with ERISA Part 7, civil and criminal investigations of multiple employer welfare arrangements (MEWAs), investigations of plan service providers to ensure their claims processes are providing benefits as promised and that fee arrangements are transparent, and criminal investigations of fraudulent medical providers to self-funded plans. Overall, EBSA strives for a balanced enforcement program in which complex issues and Major Cases are an organizational priority because of their wider impact on compliance and enforcement efforts while smaller cases (typically involving participant complaints) continue to be a significant part of the Agency's enforcement activities. For the time period FY 2012 –FY 2014, EBSA conducted 1,899 health investigations. This number encompasses all types of health plans, whether they are self or fully-funded.

In addition to its enforcement work, EBSA has issued guidance to implement the internal claims and appeals provisions under the ACA. All regulations and subregulatory guidance governing internal claims and appeals and external review under the ACA are subject to joint interpretive jurisdiction with the Departments of Health and Human Services (HHS) and the Treasury. With respect to external review, EBSA and HHS, through regulatory and subregulatory guidance, established a framework by which plans and issuers would provide external review, based on the type of coverage provided. With respect to self-insured plans subject to ERISA and/or the Code, EBSA and HHS set forth a procedure that permits plans that are not subject to a state external review process to provide external review by contracting with accredited independent review organizations (IROs) to perform such reviews. To date, EBSA and HHS have issued several rounds of regulatory and subregulatory guidance to implement these external review requirements including final rules on internal claims and appeals and external review on November 18, 2015.

Since 2010, EBSA and HHS issued the following:

- Technical Release 2011 – 01 on March 18, 2011, extending the guidance set forth in Technical Release 2010 – 02;

- Technical Release 2011 – 02 on June 22, 2011, setting forth interim procedures for State and Federal external review;
- An amendment to the interim final regulations on June 24, 2011, at 76 FR 37207 setting forth additional guidance with respect to the internal claims and appeals and external review provisions of PHS Act section 2719 in response to comments received regarding the interim final regulations.
- Technical Release 2013 – 01 on March 13, 2013, extending the interim procedures for State external review set forth in Technical Release 2011 – 02.
- The Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections Under the Affordable Care Act on November 18, 2015, 80 FR 72192, finalizing the guidance on the internal claims and appeals and external review provisions of PHS Act section 2719 in response to comments received regarding the interim final regulations. Among other things, the final regulations codify previously issued tri-department subregulatory guidance on external review processes.

### **Recommendations**

#### **1. Reduce or eliminate exemption thresholds for small plans.**

On July 12, 2016, together with the Department of Treasury and the Pension Benefit Guaranty Corporation (PBGC), the Department published proposed regulatory revisions that would modernize and improve the Form 5500 Annual Return/Report filed by private sector employee benefit plans. The Department also consulted with the Departments of Health and Human Services on proposed changes for plans that provide group health benefits. Specifically, the proposal would amend the annual reporting exemption for small unfunded and insured welfare plans and require all plans that provide group health benefits to file a Form 5500 and a new Schedule J that would collect more detailed information about various aspects of plan administration, such as enrollment, claims processing, and benefit offerings. The proposal includes some simplified reporting options for small unfunded and insured group health plans. The proposal would also modernize the financial and other annual reporting requirements on the Form 5500 and make the investment and other information on the Form 5500 more data-mineable. The project is also focused on enhancing the agencies' ability to collect employee benefit plan data that best meets the needs of changing compliance projects, programs, and activities. EBSA, under the authority granted by ERISA and the ACA, has proposed, as part of the project, requiring health plans to report more detailed information about various aspects of plan administration, such as enrollment, claims processing, and benefit offerings. Comments on the proposed rule and the proposed form revisions are due October 4, 2016. In response to requests, the due date for comments was extended until December 5, 2016.

#### **2. Require that aggregate claims information be reported for all reporting health and welfare benefit plans.**

See our response to Recommendation 1. If adopted, the Department expects the new Schedule J and related changes in group health reporting will result in significant improvements in information on the characteristics of plans that provide group health benefits; aggregate claims data, including breakdown

information on pre-service claims and post-service claims; identification of key plan service providers; and general compliance information.

With respect to claims information in particular, the Schedule J would include a range of claims payment data, including information on how many post-service benefit claims (benefit claims) were submitted during the plan year, how many benefit claims were approved during the plan year, how many benefit claims were denied during the plan year, how many benefit claim denials were appealed during the plan year, how many appealed claims were upheld as denials, how many were payable after appeal, and whether there were any claims for benefits that were not adjudicated within the required timeframes. The proposed Schedule J would also seek data on how many pre-service claims were appealed during the plan year, and how many of those appeals were upheld during the plan year as denials and how many were approved during the plan year after appeal. In addition, plans would be asked to report whether the plan was unable to pay claims at any time during the plan year and, if so, the number of unpaid claims. Plans would also be asked to report the total dollar amount of claims paid during the plan year, and if the plan provides benefits through an insurance policy, to identify any delinquent payments to the insurance carrier within the time required by the carrier, and whether any delinquencies resulted in a lapse in coverage.

The preamble to the proposal explained that, in addition to the information requested in the new Schedule J, the Department was considering whether to require plans to report more information on denied claims, such as the dollar amount of claims that were denied during the plan year, the denial code, and/or whether the claims were for mental health and substance use disorder benefits or for medical/surgical benefits. The Department acknowledged that reporting information on denied claims may present definitional and data classification challenges, *e.g.*, possible need for a more uniform classification of denial codes for Form 5500 reporting than may currently be in place across plans and issuers. In addition, we noted that there may be a need to establish a uniform measure for “dollar amount,” for example, should it be based on a provider’s point-of-service fees, the schedule of fees the plan has negotiated with service providers, Medicare reimbursement rates, or state published prevailing fees, or some other “reasonable” method for determining the dollar amount of denied claims. The Department specifically asked for public comments on whether this would be reasonable information to collect and, if so, the methodology a plan would employ to determine and report the “dollar amount of claims denied” during a plan year, denial code, and type of claim.

As your report states, your audit focused on the following question: “Did EBSA provide adequate oversight of safeguards against the improper denial of health claims.” Your report did not explain the basis for including other welfare plans in your recommendation when your audit only covered group health plans. Accordingly, we do not believe we can rely on the report as a basis for extending your data collection recommendation to the full array of other diverse types of ERISA-covered welfare benefits, such as benefits in the event of disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services. Rather, as with the expansion of group health benefit reporting that is part of the Department’s current proposal and public notice and comment process, the Department would need to be able to estimate the cost and burden of such new reporting requirements for other welfare plans and articulate expected benefits from the collection of that data which would warrant the imposition of such costs and burdens. We would be interested in receiving any data or information that you believe would be helpful in such a regulatory impact analysis.

We note that your report at page 6 states that the proposed revisions to the Form 5500 and related ERISA annual reporting regulations “would require all employer sponsors of health and welfare plans subject to ERISA to complete annual form 5500, regardless of the size of the employer or the number of employees enrolled in the plan.” The proposed changes in this area were limited to plans that provide group health benefits. We also note that your report elsewhere on page 6 indicates that section 104(a)(2)(B) of ERISA gives the Secretary the authority to “require any information or data from any plan where he/she finds such data or information is necessary to carry out the purposes of” Title I of ERISA. In EBSA’s view, Section 104(a)(2)(B) is not a separate grant of annual reporting authority, but rather is a statement that the authority the Department has under section 104(a)(2)(A) to establish simplified reports for small pension plans does not limit our authority to require small plans filing a simplified report to provide any other information that we are authorized to collect under ERISA.

**3. Use reported claims data to discover and focus investigations of plans denying benefit claims.**

As noted above, the Form 5500 proposed revisions include a new Schedule J that will collect claims data for plans that provide group health benefits. Your report states that the proposal would correct many of the issues it identifies, but urges EBSA to begin reviewing claims information it already collects before the proposal is finalized. EBSA already obtains and analyzes claims data during investigations as a routine part of its enforcement program. EBSA is committed to conducting focused yet robust health investigations that seek global corrections of violations and restoring losses to participants who were harmed. As described above, EBSA will continue its HBSP in FY 2017. These investigations will generally include an operational review to determine compliance (e.g., by conducting claims analysis to identify improper claims processing or improper benefit denials). In light of our limited resources and the vast size of the plan universe (less than 500 investigators with responsibility for overseeing approximately seven million plans), we believe it is critically important that our investigations are focused, targeted, and results-driven.

An integral part of EBSA’s HBSP investigations is a comprehensive check sheet which is publicly available as the Self Compliance Tool for Part 7 of ERISA: Health Care-Related Provisions. This 70-page check sheet is comprised of 93 multifaceted questions covering all aspects of ERISA part 7 to determine compliance. Section J of this document contains six pages dealing exclusively with evaluating a plan’s compliance with the internal claims and appeals and external review. EBSA believes that the leads obtained from this check sheet, along with operational reviews of the claims process, identify appropriate areas for investigative focus. Although the OIG report focuses primarily on claims affected by faulty claims procedures, it should also be noted that as a result of using the check sheet, EBSA frequently encounters plan structures that fail to provide the benefits and protections participants are entitled to under the Health Insurance Portability and Accountability Act, Newborns’ and Mothers’ Health Protection Act, Mental Health Parity and Addiction Equity Act, and the Affordable Care Act. If plans deny benefits improperly, EBSA seeks re-adjudication of the affected claims.

The report also suggests that EBSA use claims data reported to states through state-specific All Payer Claims Databases (APCDs) to detect and focus investigations on plans denying benefit claims. This recommendation appears to suggest that EBSA systematically seek to obtain and analyze voluminous claims data collected from plans, without suggesting any particular methodologies, techniques, or targeting strategies that are likely to generate actionable cases or promote better participant outcomes. According to a study conducted by the Robert Wood Johnson Foundation, “The Basics of All-Payer

Claims Databases” published in January 2014, the typical information collected by states excludes a number of data elements such as denied claims which would appear to be critical to any such approach. Instead, the states typically collect patient demographics, provider codes, clinical, financial, and utilization data. Moreover, the Supreme Court recently ruled, in *Gobeille v. Liberty Mutual Insurance Co.*,<sup>1</sup> that “ERISA’s express pre-emption clause requires invalidation of the Vermont [APCD] reporting statute as applied to ERISA plans. The State statute imposes duties that are inconsistent with the central design of ERISA, which is to provide a single uniform national scheme for the administration of ERISA plans without interference from laws of the several States even when those laws, to a large extent, impose parallel requirements.”<sup>2</sup> In a concurrence, Justice Breyer raised the possibility that the government could nonetheless delegate some of its reporting authority to the States.

The Departments of Labor, Health and Human Services, and the Treasury have since been moving forward to implement federal transparency and quality reporting provisions as part of the Affordable Care Act.<sup>3</sup> Among other initiatives, the Department published the proposed revisions to the Form 5500 reporting requirements, discussed above under Recommendations 1 and 2. In the preamble to the proposed rule, public comments were specifically requested on the proposed annual reporting requirements for plans that provide group health benefits in light of the Supreme Court’s recent decision in *Gobeille*.<sup>4</sup> Written comments on the proposed rule are due by December 5, 2016.

We believe a more effective approach is to focus on targeted areas of concern based on leads EBSA receives from participant complaints, recommendations from outside experts such as advocacy groups, private litigation, states and other federal agencies. In fact, the majority of EBSA’s successful health cases were based on participant complaints. Currently, our Form 5500 is only utilized to target self-insured plans, since claims data is not required on the form. Once targeted areas of concern have been identified, EBSA investigators can then obtain claims data to analyze and quantify the harm to participants. EBSA believes such targeted investigations are a sound and strategic approach to allocating enforcement resources. As noted above, EBSA has a total of about 464 investigators who are responsible for enforcing the legal obligations of approximately seven million plans. Given the sheer size of the task, and the limits on EBSA resources, the Agency can ill-afford to divert investigators to projects that are not carefully targeted or reasonably designed to identify violations of ERISA’s protections. A general recommendation that we obtain and analyze broads claims data, without much more, fails to provide actionable guidance.

Finally, the report estimates that of the more than one billion claims that are filed each year, 200 million claims are denied. However, as previously discussed with OIG, not all denials are improper. There are many reasons for claim denials that are legitimate (e.g., the claimant is ineligible, the claimant has not met the annual deductible or out-of-pocket maximums, the medical provider submitted insufficient information on the claim form or a duplicative claim, or a benefit is simply not covered by the plan terms).

As described to the OIG throughout the audit, EBSA collaborates extensively with the states. Three times a year, EBSA staff attend the National Meeting of the National Association of Insurance

<sup>1</sup> 136 S. Ct. 936 (2016).

<sup>2</sup> *Id.* at 947.

<sup>3</sup> See Public Health Service Act (PHS Act) §§ 2715A and 2717, incorporated in ERISA section 715 and Internal Revenue Code section 9815.

<sup>4</sup> 81 CFR 47496 at 47500 (Jul 21, 2016).

Commissioners (NAIC). During these meetings, EBSA participates in the ERISA Working Group meetings where state regulators and EBSA discuss oversight and concerns relating to the insured group market. Also, EBSA is in frequent contact with the NAIC to provide technical assistance and enforcement discussions regarding discreet issues that crop up in individual states or nationwide. Since 2009, EBSA has entered into ten Common Interest Agreements (CIAs) with individual state departments of insurance related to specific cases. These states include Arkansas, California, Connecticut, Hawaii, Iowa, Maine, Massachusetts, Pennsylvania, South Carolina, South Dakota, and Utah. These CIAs facilitate information sharing and allow EBSA to better coordinate enforcement efforts with states. In 2015, EBSA entered into a Memorandum of Understanding (MOU) with the New York Attorney General's Office Health Care Bureau to share information. Also, EBSA has an MOU with the NAIC and the states to share information on multiple employer welfare arrangements that may be defrauding plans and participants. EBSA will continue to foster its relationships with states and, as appropriate, seek additional CIA and MOU opportunities to share information and coordinate enforcement efforts relating to health insurance products purchased by ERISA plans. Although EBSA believes that raw claims data collected by the states (currently unavailable to EBSA) may not enhance its focused targeting strategy, it will nevertheless work with the States to determine whether the data can be used or supplemented in a way that would promote the efficient detection of violations.

**4. Establish external review reporting requirements for IROs through plan filings.**

As we informed the OIG, EBSA has no authority to enforce a reporting requirement directly with respect to an IRO. Any requirement to do so would require a legislative change and could not be done administratively. However, the proposed new Schedule J described above would require health plans to report more information in Part II about their service providers, including IROs, and would provide in Part IV more information about health benefit claims processing and payment, including information about denials.

**5. Issue guidance to clarify the issue of fiduciary status for IROs**

The issue of IRO fiduciary status and fiduciary liability under Title I of ERISA was considered in consultation with the HHS and the Department of the Treasury in the context of finalization of the rules for ACA external review. EBSA has spoken with representatives from the National Association of Independent Review organizations and understand they are of the view that no additional guidance is needed at this time. If new concerns arise, EBSA may consult again with the Departments of HHS and the Treasury, and could consider soliciting additional public input from affected stakeholders, such as state insurance regulators, and may decide to address the issue in the context of a regulation rather than in subregulatory guidance.