U.S. Department of Labor

Office of Inspector General—Office of Audit

REPORT TO THE EMPLOYEE BENEFITS SECURITY ADMINISTRATION

EBSA DID NOT HAVE THE ABILITY TO PROTECT THE ESTIMATED 79 MILLION PLAN PARTICIPANTS IN SELF-INSURED HEALTH PLANS FROM IMPROPER DENIALS OF HEALTH CLAIMS

Date Issued: November 18, 2016
Report Number: 05-17-001-12-121

U.S. Department of Labor
Office of Inspector General
Office of Audit

BRIEFLY…

November 18, 2016

EBSA DID NOT HAVE THE ABILITY TO PROTECT THE ESTIMATED 79 MILLION PLAN PARTICIPANTS IN SELF-INSURED HEALTH PLANS FROM IMPROPER DENIALS OF HEALTH CLAIMS

WHY OIG CONDUCTED THE AUDIT

Improper denials of health benefit claims can have catastrophic effects on the health and financial security of plan participants and their families. The Employee Benefits Security Administration (EBSA) is charged with regulating all Employee Retirement Income Security Act (ERISA) self-insured health plans and is thus responsible for protecting the estimated 79 million participants in those plans against improper denials of health benefit claims. Because ERISA affords only limited legal remedies against improper denials of health benefit claims to EBSA and health plan participants, it is essential that claims be properly decided and appeals fairly adjudicated.

WHAT OIG DID

OIG conducted a performance audit to determine the following:

> Did EBSA have the ability to protect the estimated 79 million participants in self-insured health plans from improper claims denials?

READ THE FULL REPORT

To view the report, including the scope, methodologies, and full agency response, go to: http://www.oig.dol.gov/public/reports/oa/2017/05-17-001-12-121.pdf

WHAT OIG FOUND

EBSA did not have the ability to protect the estimated 79 million participants in self-insured health plans from improper claims denials because EBSA lacked any primary knowledge of denials of health benefit claims in any of the plans under its oversight. In 1975, EBSA exempted health plans having fewer than 100 participants from reporting requirements because the agency did not want to create an undue administrative burden. As a result of this exemption, EBSA has collected no information about denials of health claims from self-insured health plans that cover about 79 million participants. Moreover, form 5500, EBSA's primary information collection tool, did not capture information on denials of health benefit claims. As a result, even the plans that were required to report to EBSA were not required to provide any information on their denials of health benefit claims.

Despite this lack of primary knowledge about denials of health benefit claims in self-insured health plans, EBSA has conducted only limited reviews of these self-insured plans for compliance with external review requirements, and it has yet to issue final guidance for independent review organizations (IRO) that decide appeals of denied claims.

WHAT OIG RECOMMENDED

We recommended the Assistant Secretary for Employee Benefits Security use the agency's existing authority to revisit and revise health plan reporting requirements, require aggregate claims data be reported for all reporting ERISA health and welfare benefit plans, use claims data to focus its health plan investigations, establish external review reporting requirements for IROs, and issue guidance to clarify the fiduciary status of IROs.

The Assistant Secretary for Employee Benefits Security generally agreed with our recommendations but disagreed that additional clarification regarding the fiduciary status of IROs was needed at this time.

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U.S. Department of Labor

Office of Inspector General
Washington, D.C. 20210

November 18, 2016

INSPECTOR GENERAL'S REPORT

Phyllis C. Borzi
Assistant Secretary
for Employee Benefits Security
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

The Employee Retirement Income Security Act of 1974 (ERISA) gave the Employee Benefits Security Administration (EBSA) enforcement authority over ERISA-covered, employer-sponsored group health plans' claims procedures, as well as the procedures related to internal claims appeals and external reviews of denied claims. Health plans can either be self-insured and pay their own claims or purchase insurance that pays claims on their behalf.

According to EBSA and industry estimates, 1.4 billion health benefit claims are filed each year, of which approximately 200 million are denied by plans or insurers. Of those, a Rand Corporation study[1] estimated less than 1 percent were appealed. A Yale Journal stated [2]about half of the appeals were resolved in favor of the participant. Improper denials occur when a plan refuses to pay claims for covered services or refuses to pay for a benefit deemed "essential" under the Patient Protection and Affordable Care Act of 2010 (ACA). Among other duties, EBSA has primary responsibility under ERISA for ensuring participants in self-insured plans receive full and fair reviews of claims they believe have been improperly denied.

We performed an audit to determine the following:

Did EBSA have the ability to protect the estimated 79 million participants in self-insured health plans from improper claims denials?

RESULTS IN BRIEF

EBSA did not have the ability to protect the estimated 79 million participants in self-insured health plans from improper claims denials because EBSA lacked any primary knowledge of denials of health benefit claims in any of the plans under its oversight.

[1] Unaudited, *Inside the Black Box of Managed Care Decisions*, RAND Corporation research brief, 2004. This brief was the latest information available to us at the time of our audit fieldwork.
[2] Unaudited, Delayed and Denied: Toward an Effective ERISA Remedy for Improper Processing of Healthcare Claims, Yale Journal of Health Policy, Law, and Ethics, March 3, 2013

In 1975, EBSA exempted health plans having fewer than 100 participants from many reporting requirements because the agency did not want to create an undue administrative burden. In 2014, exempt plans covered about 79 million participants. As a result of the reporting exemptions, EBSA collected no information from most plans over which it had exclusive oversight. Moreover, its primary information collection tool, form 5500, collected no information about denials of health claims. As a result, even plans that were required to report to EBSA were not required to provide any information on denials of health benefit claims.

In addition to this lack of primary knowledge about denials of health benefit claims, EBSA has conducted only limited reviews of these self-insured plans for compliance with external review requirements and has yet to issue final guidance for independent review organizations (IRO) that decide appeals of denied claims.

BACKGROUND

Under ERISA, EBSA is responsible for enforcing disclosure, reporting, fiduciary, and claims-filing requirements for self-insured health plans, as well as investigating allegations of improper denials of health benefit claims. ERISA-covered health plans are required by law to establish and maintain reasonable claims procedures. Claims procedures must be designed so participants are afforded appropriate written notice and reasons for denials of health benefit claims. Plans must also provide participants with the opportunity to receive a full and fair review of their claims and the right to appeal claim denials.

The primary function of any health plan is to pay claims for the covered medical expenses of their participants and beneficiaries.[3] According to EBSA and industry estimates, 1.4 billion health benefit claims are filed each year. Of this total, approximately 200 million claims are denied.

Improper denials of medical claims can have catastrophic consequences for the health and financial well-being of participants. Delays or refusals to pay legitimate claims can subject claimants to unexpected, large medical debt and, more significantly, prevent them from receiving necessary, potentially life-saving medical care. Conversely, plans suffer no significant consequences when they improperly delay or deny claims. For the most part, self-insured plans pay only the actual amount of the benefit. They pay no additional costs that might be sustained by participants whose claims are improperly denied.

In most cases, participants whose claims are denied must first appeal their claim within the plan. Once they have exhausted their internal appeals, they may then take their

[3] After this point, the term “participants” will be used to refer to both participants and beneficiaries.

claim to an IRO for an external review. Participants who do not prevail at the IRO level can then take their claim to federal court.

Under ACA, consumers have the right to appeal claim decisions made by health plans created after March 23, 2010. The law governs how insurance companies handle initial appeals and how consumers can request reconsideration of a decision to deny payment. If an insurance company upholds its decision to deny payment, the law provides consumers with the right to appeal to an outside, independent decision-maker, regardless of the type of insurance or the state where an individual resides. These external reviews play a critical role in helping participants obtain benefits to which they are entitled by providing an unbiased, independent re-evaluation of a claim that has been denied by a plan.

RESULTS

EBSA lacked critical information on the self-insured health plans it regulates. Form 5500, an important ERISA reporting and disclosure tool, did not capture sufficient information on claims and health plans to ensure regulators had access to enough information to protect the rights and benefits of health plan participants. Furthermore, even if form 5500 was amended to collect such information, EBSA still would not have been able to readily identify and target a majority of health plans for improper claims denials because the agency had exempted smaller health plans (those with fewer than 100 participants) covering approximately 79 million participants from annual reporting requirements.

EBSA also conducted only limited reviews of self-insured plans for compliance with requirements to ensure that IROs were free from conflicts of interest, properly contracted, and that IRO benefit determinations were binding and implemented by plans. EBSA has not issued guidance to clarify ACA regulations governing external reviews and has not established reporting requirements for plans to obtain information on IROs or clarified the fiduciary status of IROs.

EBSA HAS COLLECTED LIMITED DATA ON DENIALS OF HEALTH BENEFIT CLAIMS FOR SELF-INSURED HEALTH PLANS

To prevent small plans from being overwhelmed by administrative expenses and requirements, in 1975 EBSA exempted most plans with fewer than 100 participants from having to file an annual informational report.[4] As a result, health plans covering an estimated 79 million participants, were exempt from filing. Moreover, form 5500 does not require plans to report any statistical information on claims, such as the percentage of claims denied or the percentage of denied claims overturned on appeal, both of which could be useful to EBSA in discovering and focusing on plans that might have denied a greater than average percentage of claims.

Government Accountability Office Standards for Internal Control in the Federal Government require any organization overseeing any activity must assess the risk attendant on the activities it oversees, design control activities to deal with those risks, and communicate internally so information provided is accurate and useable.

Because of its decision to exempt most of the self-insured plans from filing form 5500 and because form 5500 does not capture information on health claims from those plans that are required to file, EBSA has collected very little information on health benefit claim denials. EBSA further has reported having no other compensating source of information on health plans, claims, or denial rates. The only data currently available for most ERISA-covered health benefit plans is based on information gathered by outside researchers from plans that provide information on a voluntary basis.

Serving as an expert witness in 2004,[5] EBSA's current Assistant Secretary Phyllis Borzi, who at the time was a Research Professor in the Department of Health Policy in the School of Public Health and Health Services at the George Washington University Medical Center, made the following points:

1. The current form 5500 requirements for health and welfare plans provide no useful information to plan participants, plan sponsors, consultants, advisors, or the Department of Labor;

2. Because the Department does not know how many health and welfare benefit plans exist, an annual filing by all plans would assist the Department in its enforcement activities;

3. If the Department revised the form 5500, it could compile more comprehensive and accurate data on these plans.

[4] 29 CFR 2520.104-20—*Limited exemption for certain small welfare plans*. However, all plans which have a trust, including small plans, must file form 5500.
[5] Advisory Council on Employee Welfare and Pension Benefit Plans, *2004 ERISA Advisory Council Health and Welfare Form 5500 Requirements Working Group Report,*(Washington, DC 2004)

As a result of this lack of information, EBSA was unable to effectively target its resources. EBSA was also unable to fully comply with the ACA requirement to report on national claim denial rates. The Secretary of Labor, in coordination with the Secretary of Health and Human Services, was required to conduct a study and collect information and analyze, among other things, claim denial rates. EBSA, however, was unable to comply with this requirement and reported to Congress in its 2011 *Study of the Large Group Market* that there was no data source that provided systematic, nationally representative data on claims denial rates.

Much information on claims, however, does exist. State insurance regulators with authority over fully-insured plans have access to significantly richer sources of data. The State regulators we interviewed stated they routinely conducted both comprehensive market conduct examinations of insurers and examinations that included the review of denied benefit claims. All of the states we surveyed had access to insurer financial information, and used it to assign risk ratings for their examinations. Forty-five states and the District of Columbia required insurers to submit financial information and claims data due in part to the National Association of Insurance Commissioners (NAIC) financial reporting model requirement for all state health insurers to submit an Underwriting and Investment Exhibit which includes an analysis of claims unpaid. Forty-four states reported to us that they conducted regular periodic examinations of insurers and benefit claims (see Exhibit 1).

Although ERISA prevents states from regulating self-insured plans, State regulators routinely received, compiled, and forwarded complaints from participants in self-insured plans to EBSA. States, however, find their access to claim information limited by ERISA. In March 2016, the U.S. Supreme Court decided against the state of Vermont, which was seeking to obtain claims information from a self-insured plan.[6] The Vermont law defined health insurer to include a "self-insured . . . health care benefit plan," as well as "any third party administrator" and any "similar entity with claims data, eligibility data, provider files, and other information relating to health care provided to a Vermont resident." The Court opined that federal authorities and not the states administer reporting requirements for self-insured plans under ERISA. In light of the Court's opinion effectively limiting states' authority to collect data, unless EBSA expands its reporting requirements for self-insured plans, oversight of denied claims would be reduced overall. ERISA makes clear that the Secretary of Labor is authorized to decide whether to exempt plans from ERISA reporting requirements or to require ERISA plans to report data such as that sought by Vermont.

Other than relying on third-party studies, and despite some opportunities to collect information, EBSA has little or no data on the universe of plans and claims. EBSA could expand filing requirements and reporting thresholds to obtain more information for use in focusing its investigative resources. EBSA has the authority to amend regulations governing filing requirements for form 5500 and change the exemptions that apply to

[6] Gobeille v. Liberty Mutual Insurance Co., 136 S. Ct. 936 (2016)

small plans. The lack of information on small plans takes on additional importance because, according to information gathered by EBSA through its investigations, improper health claim denials occur most often in small plans that lack the funds to pay their approved claims. In addition, even though EBSA collected some information for the approximately 24,500 plans that file form 5500, it has not analyzed broad denial of benefit claims data at the plan or insurer level for those plans, nor analyzed the over 68,000 participant health claim inquiries related to partially or fully denied benefit claims it received from 2012 – 2015. As a result, EBSA cannot target investigations on any pattern of denials that such analysis might identify. Focusing on high-risk areas, such as health plan claims denials, would enable EBSA to make more effective use of its enforcement resources.

ERISA allows the Secretary of Labor 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 the statute, §1024(a)(2)(B), and, when investigating a possible statutory violation, "…to require the submission of reports, books, and records, and the filing of data…" related to other requisite filings, §1134(a)(1). Thus, the Secretary has the general power to promulgate regulations necessary or appropriate to administer the statute, §1135, and to provide exemptions from any reporting obligations, §1024(a)(3).

In July 2016, the Department of Labor (DOL), the Internal Revenue Service and the Pension Benefit Guaranty Corporation jointly issued proposed regulations that would correct many of the issues we identified. Most notably, the proposed regulations would require all employer sponsors of health and welfare plans subject to ERISA to complete form 5500, regardless of the size of the employer or the number of employees enrolled in the plan. In addition to the removal of the small plan reporting exemption, the proposed regulations would add a new Schedule J to form 5500, which would be required to be filed by all group health plan sponsors. Among other things, Schedule J would collect claims processing and payment information, including the number of claims filed, paid, appealed, and denied.

Should the proposed regulations be finalized in their current form, EBSA will have access to a significantly larger amount of information regarding almost all health plans it oversees. However, form 5500 revisions, if adopted, generally would apply for plan years beginning on January 1, 2019, and EBSA would not begin processing the Plan Year 2019 form 5500 annual returns until 2020. Meanwhile, EBSA should begin reviewing the claims information it already collects from plans currently required to file form 5500 and analyzing the participant health claim inquiries it receives to better focus its enforcement efforts on improperly denied health claims.

EBSA HAS NOT PROVIDED SUFFICIENT GUIDANCE FOR EXTERNAL REVIEWS AND IROs

ACA provides consumers the right to appeal health plan decisions. Generally, consumers must first ask the health plan to reconsider its decision to deny payment for a service or treatment. New rules govern how plans must handle an appeal (usually

called an "internal appeal"). These rules apply to health insurance policies that were first sold or significantly modified after March 23, 2010.

If the plan still denies payment after considering the internal appeal, ACA permits consumers to have an outside independent decision-maker (IRO) decide whether to uphold or overturn the plan's decision. This additional step is often referred to as an "external review."
Regulations jointly issued by the Department of Health and Human Services (HHS), the U.S. Department of the Treasury, and DOL in July 2010 provide for three different external review processes. In some states, consumers use their state's external review process. The external review process used by states must, at a minimum, include the consumer protections set forth in the Uniform Health Carrier External Review Model Act issued by NAIC.

The July 2010 regulations set forth 16 minimum consumer protection standards from the NAIC Uniform Model Act that a State must include in its external review process. Among other requirements, the state must provide for external review of adverse benefit determinations, require plans to provide effective written notice to claimants of their rights to external review, assign IROs on a random basis or another method of assignment that ensures the independence and impartiality of the process, provide for the maintenance of a list of approved IROs qualified to conduct the external review based on the nature of the health care service that is the subject of the review, and provide that the IRO decision is binding on the claimant, as well as the plan or issuer. For a complete listing of the 16 standards, see Exhibit 2.

If a state's external review process does not meet these minimum standards, group health plans and health insurance issuers in that state are required to implement an external review process by choosing to use either the HHS-administered federal external review process or to contract with accredited IROs to review external appeals on their behalf.

EBSA, through its regulatory guidance and oversight, is responsible for ensuring that plans and issuers comply with the requirements governing the external review process. EBSA published a Request for Information (RFI) in 2010 to help it develop additional guidance for external reviews. EBSA sought input on the implementation of a federal external review process for health coverage in states that did not have an external review process that met the minimum federal standards. EBSA also sought input on data collected by IROs for tracking appeals, conducting analyses, and the specific requirements which should be applied to IROs to evaluate progress toward performance goals. The agency, however, has not yet made use of the input it received on this RFI to issue guidance to IROs.

In addition, EBSA has not finalized the interim final rule it published in 2010 or collected any information from plans to ensure they have effective and compliant external review processes. This lack of information made it difficult for EBSA to perform its oversight

role by using data to target its investigations. As a result, the agency cannot ensure that plans are complying with external review requirements.

THE FIDUCIARY STATUS OF IROs IS UNCLEAR

EBSA needs to issue further guidance clarifying the fiduciary status of IROs. The U.S. Supreme Court has established that the basic function of making benefit claim determinations falls under the ERISA definition of a fiduciary. As noted by the Court, "…the ultimate decision maker … regarding an award of benefits must be a fiduciary and must be acting as a fiduciary when determining a … claim."[7] As a result, IROs, which issue binding decisions on claims, would appear to fall under the Court's interpretation of ERISA's definition of fiduciaries, and could be liable as such. On the other hand, the primary guidance governing IROs, the NAIC Model Act, which has been substantially adopted by 46 states and forms the basis for EBSA guidance on the subject, maintains that IROs are generally insulated from fiduciary liability.[8]

Because these two premises are in conflict, EBSA needs to clarify its guidance regarding the fiduciary status of IROs. IROs have expressed a hesitancy to conduct external reviews for self-insured plans because they are unclear as to their potential liability as fiduciaries. As a result, the National Association of Independent Review Organizations has sought clarification from the DOL on the role of IROs in the federal external review process, and in particular, whether the DOL considers IROs to be fiduciaries when performing federal external reviews under ACA, and the extent to which IROs are insulated by the "hold harmless" provisions of the NAIC Model Act. EBSA has stated that it is examining the issue of IRO fiduciary liability in the federal external review process to determine if additional guidance is needed.

CONCLUSION

EBSA has not placed sufficient management emphasis or the resources required to target, examine, and correct health plans' improper claims processing. As a result, EBSA has not provided appropriate oversight and guidance to adequately protect an estimated 79 million self-insured health participants against the improper denial of health benefits.

Because improper denials of health benefit claims can have catastrophic effects on the health and financial security of plan participants and their families, it is crucial that claims be properly decided, appeals fairly determined, and meaningful relief provided where appropriate. Without a robust enforcement oversight and well-regulated external review process, plan participants may be forced to contend with potentially biased internal reviews and difficult, time-consuming litigation in which the decisions of plans and insurers may be given deference.

[7] Aetna Health Inc. v. Davila, 542 U.S. 200, 220 (2004)
[8] Section 14 of the Model Act provides for exceptions in cases of bad faith or gross negligence by IROs.

OIG RECOMMENDATIONS

We recommend the Assistant Secretary for Employee Benefits Security:

1. Reduce or eliminate exemption thresholds for small plans.
2. Require that aggregate claims information be reported for all reporting ERISA health and welfare benefit plans.
3. Use reported claims data to discover and focus investigations of health plans.
4. Establish external review reporting requirements for IROs through plan filings.
5. Issue guidance to clarify the fiduciary status of IROs.

MANAGEMENT RESPONSE

The Assistant Secretary for Employee Benefits Security generally agreed with our findings and recommendations and responded that proposed regulations issued by the Department on July 12, 2016, would reduce reporting thresholds and establish expanded reporting requirements for most health plans, as well as address in an alternative way the OIG's recommendation regarding reporting for IROs. In addition, the Assistant Secretary responded that EBSA would seek additional opportunities to share reported claims data, but that no additional clarification is needed for IRO fiduciary status at this time.

We appreciate the cooperation and courtesies EBSA personnel extended to the OIG during this audit. OIG personnel who made major contributions to this report are listed in Appendix C.

Elliot P. Lewis
Assistant Inspector General
for Audit

Exhibits

Exhibit 1

State Insurance Regulator Responses				
State/ Territory Contacted	**Insurers Required to Submit Unpaid Claims Information Yes / No**	**State has External Review Process Yes / No**	**Market Conduct Exams Focused, Comprehensive, Both or None**	**Has Memo of Understanding or any collaboration from EBSA**
1. AL	Yes	No	Both	No
2.AZ	Yes	Yes	Focused	No
3. CA	Yes	Yes	Both	No
4. CO	Yes	Yes	Focused	No
5. CT	Yes	Yes	Both	No
6. DC	Yes	No	None	No
7. DE	Yes	Yes	Focused	No
8. FL	Yes	Yes	Both	No
9. GA	Yes	Yes	Focused	No
10. HI	Yes	Yes	Focused	No
11. IA	Yes	Yes	Comprehensive	No
12. ID	Yes	Yes	Comprehensive	No
13. IL	Yes	Yes	Focused	No
14. IN	Yes	Yes	Both	No
15. KS	Yes	Yes	Focused	No
16. KY	Yes	Yes	Both	No
17. LA	Yes	Yes	Focused	No
18. MA	Yes	Yes	Focused	No
19. MD	Yes	Yes	Focused	No
20. ME	Yes	Yes	Focused	No
21. MI	Yes	Yes	Focused	Yes
22. MN	Yes	Yes	Both	No
23. MO	Yes	Yes	Focused	No
24. MS	Yes	Yes	Focused	No
25. MT	Yes	Yes	Focused	No
26. NC	Yes	Yes	Focused	No
27. ND	Yes	Yes	Focused	No
28. NE	Yes	Yes	Both	No
29. NH	Yes	Yes	Focused	No
30. NJ	Yes	Yes	Focused	No
31. NM	Yes	Yes	Both	No

32. NV	Yes	Yes	N/A *	No
33. NY	Yes	Yes	Focused	No
34. OK	Yes	Yes	Focused	No
35. OR	Yes	Yes	None	No
36. PA	Yes	No	Focused	No
37. RI	Yes	Yes	Focused	No
38. SD	Yes	Yes	Both	No
39. TN	Yes	Yes	NA	No
40. TX	Yes	Yes	Both	No
41. UT	Yes	Yes	Focused	No
42. VA	Yes	Yes	Focused	No
43. VT	Yes	Yes	Focused	No
44. WA	Yes	No	Focused	No
45. WV	Yes	No	Both	No
46. WY	Yes	No	Comprehensive	No
Totals	**46 Yes**	**40 Yes 6 No**	**43 reported regular periodic exam benefit claims - *NV did not respond to our request.**	**Michigan indicated MOU with EBSA**

Exhibit 2

Minimum Consumer Protection Standards NAIC Uniform Model Act
1. External Review of Adverse Benefit Decisions Based on medical necessity, appropriateness, healthcare setting, level of care, or effectiveness of a covered benefit.
2. Claimants must receive written notice of their rights to external review.
3. If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary if a-) the issuer or plan waives the exhaustion requirement b) the issuer or plan is considered to have exhausted the internal appeals process by failing to comply with the requirements except those failures that are based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant. or c) the claimant simultaneously requests an expedited internal appeal and an expedited external appeal.
4. The cost of an Independent review organization (IRO) to conduct an external review must be borne by the issuer or (plan), although the process may require a nominal fee from the claimant requesting external review.
5. There cannot be any restriction on the minimum dollar amount of a claim in order to be eligible for external review.
6. Claimant must be given 4 months to file a request for external review after receipt of adverse benefit determination or final internal adverse benefit determination.
7. The IRO must be assigned randomly by the State or independent entity or by another method such as rotational assignment that ensures the independence and impartiality of the assignment process.
8. The process must provide for the maintenance of a list of approved IROs (only those that are accredited by a nationally recognized private accredited organization).
9. Approved IROs must have no conflicts of interest that will influence their independence.
10. Claimants must be allowed at least 5 business days to submit to the IRO any additional information that the IRO must consider and the claimant must be notified of the right to submit additional information. Any additional information submitted by the claimant must be forwarded to the issuer or plan within 1 business day of receipt by the IRO.
11. The IRO decision must be binding on the claimant, as well as the plan or issuer (except to the extent that other remedies are available under State or Federal law).
12. For standard external review, the IRO must provide written notice to the issuer (or plan) and the claimant of its decision to uphold or reverse the adverse benefit determination within no more than 45 days after the receipt of the request
13. The process must allow for an expedited review in certain circumstances, in such cases notice of the decision must be provided no later than 72 hours after receipt of the request for external review. (and if notice of the IRO's decision is not in writing, the IRO must provide written confirmation of its decision within 48 hours after the date of the notice of the decision).
14. Issuers or plans must provide a description of the external review process in or attached to the summary plan descriptions, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to participants, beneficiaries, or enrollees.
15. The IRO must maintain written records and make them available upon request to the State, substantially similar to section 17 of the NAIC Uniform Model Act.
16. The process must follow procedures for external reviews involving experimental or investigational treatment, substantially similar to section 10 of the NAIC Uniform Model Act.

Appendices

APPENDIX A

OBJECTIVE, SCOPE, METHODOLOGY, AND CRITERIA

OBJECTIVE

The OIG conducted this performance audit to answer the following question:

> Did EBSA have the ability to protect the estimated 79 million participants in self-insured health plans from improper claims denials?

SCOPE

Our audit work covered EBSA enforcement actions for fiscal years 2012 through 2015.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective. Fieldwork was conducted at EBSA headquarters in Washington, D.C.

METHODOLOGY

To accomplish our audit objective, we reviewed EBSA's: (1) results of enforcement actions conducted for calendar years 2012 through 2015; (2) legal authority, rulemaking, and issued guidance; (3) Technical Assistance Inquiry System results and analyses; (4) contracted studies and mandated reports; and (5) collaboration with State insurance regulators. We also reviewed federal and state laws and regulations and EBSA policies related to claims processing and internal/external reviews and appeals. Additionally, we conducted interviews with EBSA officials, 45 State and District of Columbia Insurance Regulators that responded to our requests, 14 IROs, National Association of Insurance Commissioners, HHS, and employee benefit industry experts.

To determine the reliability of EBSA's enforcement case data, we: (1) identified specific data elements from ERISA Filing Acceptance System II (EFAST2) that were critical to supporting our audit analyses; (2) developed and completed steps to assess the completeness and accuracy (i.e., reliability) of the data; (3) traced data elements (i.e., Employer Identification Number, plan name, calendar/fiscal beginning and ending dates, participant count and total assets) to source documents (i.e., Forms 5500 and 5500-SF, financial statements; and (4) followed up with EBSA to clarify the meaning of the data and address discrepancies identified. We determined the data was sufficiently reliable for our testing purposes.

EBSA collects limited program data concerning health plans, participants, and benefit claims due to regulatory health plan filing exemptions and the lack of form 5500 data captured on denied claims and independent review organizations. As a result, we were unable to verify estimates provided by EBSA. In addition, we did not verify the reliability of data on EBSA's Technical Assistance Inquiry System results as it did not track the resulting health plan investigations into claims processing.

In planning and performing our audit, we considered EBSA's internal controls that were relevant to our audit objective by obtaining an understanding of those controls and assessing control risk for the purposes of achieving our objective. The objective of our audit was not to provide assurance on the internal controls. Therefore, we did not express an opinion on the internal controls as a whole. Our consideration of EBSA's internal controls relevant to our audit objective would not necessarily disclose all matters that might be reportable conditions. Because of the inherent limitations on internal controls, noncompliance may nevertheless occur and not be detected.

CRITERIA

We used the following criteria to accomplish our audit:

- 29 CFR Part 2590 Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act; Interim Final Rule

- 29 CFR 2590.715-2719 - Internal claims and appeals and external review processes

- 29 U.S. Code §1132 - Civil enforcement

- 29 CFR 2520.104-20 - Limited exemption for certain small welfare plans

- 29 CFR 2560.503-1 - Claims procedure

- Section 2550.404(c)-1 – ERISA Section 404(c) plans.

- 29 U.S. Code §1109 - Liability for breach of fiduciary duty

- Technical Release 2010-01: Interim Procedures for Federal External Review Relating to Internal Claims and Appeals and External Review Under the Patient Protection and Affordable Care Act

- Technical Release 2011-02: Guidance on External Review for Group Health Plans and Health Insurance Issuers Offering Group and Individual Health Coverage, and Guidance for States on State External Review Processes

- Technical Release 2013-01: Extension of the Transition Period for the Temporary NAIC-similar State External Review Process under the Affordable Care Act

APPENDIX B

EBSA'S RESPONSE

U.S. Department of Labor

Assistant Secretary for
Employee Benefits Security Administration
Washington, D.C. 20210

DATE: SEP 22 2016

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

FROM: 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

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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.*,[1] 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."[2] 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.[3] 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*.[4] 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

[1] 136 S. Ct. 936 (2016).
[2] Id. at 947.
[3] See Public Health Service Act (PHS Act) §§ 2715A and 2717, incorporated in ERISA section 715 and Internal Revenue Code section 9815.
[4] 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.

APPENDIX C

ACKNOWLEDGEMENTS

Key contributors to this report were Nicholas Christopher (Audit Director), Fernando Paredes (Audit Manager), Jason Jelen (Audit Manager), Lewis Leung, Richard Donna Jr., Timothy Kerschen, Angela Stewart, and Mary Lou Casazza.

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