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May 22, 2019

The Honorable R. Alexander Acosta
Secretary
U.S. Department of Labor
200 Constitution Ave NW
Washington, DC 20210

Dear Secretary Acosta:

We write regarding continued delays by the Department of Labor (Department) in implementing the transparency in coverage requirements of the Affordable Care Act (ACA). The Department's failure to comply with these provisions undermines Congressional intent and serves as a serious impediment to efforts to enforce federal law and improve coverage for the more than 150 million Americans enrolled in employer-sponsored health plans.[1] In light of the continuing growth in health care costs and the many challenges that consumers face in navigating the complexities of the health care system, particularly the growing problem of surprise medical bills, we urge you to take immediate action to collect all data and other information required by the ACA.

As you are aware, Section 1311(e)(3) of the ACA establishes standards to increase transparency in health coverage by giving the public access to information regarding commercial health insurance. Specifically, as part of the qualified health plan (QHP) certification process, Section 1311(e)(3)(A) of the law requires health insurers to make public and provide to the Health Insurance Marketplaces, state insurance commissioners, and the Secretary of Health and Human Services the following information for each plan: (1) claims payment policies and practices; (2) periodic financial disclosures; (3) data on enrollment; (4) data on disenrollment; (5) data on the number of claims that are denied; (6) data on rating practices; (7) information on cost-sharing and payments with respect to out-of-network coverage; (8) information on enrollee and participant rights under title I of the ACA; and (9) other appropriate information.[2] In addition,

[1] *See* Kaiser Family Foundation, Employer Health Benefits 2018 Annual Survey, http://files.kff.org/attachment/Summary-of-Findings-Employer-Health-Benefits-2018.
[2] 42 U.S. Code § 18031(e)(3)(A).

the law requires all certified QHPs to provide information directly to consumers about the cost-sharing owed with respect to specific items or services furnished by participating providers.[3]

On March 27, 2012, the Department of Health and Human Services (HHS) published a final rule establishing standards for the Health Insurance Marketplaces.[4] Among other provisions, this rule implemented Section 1311(e)(3)'s transparency requirements for individual market plans that are certified as QHPs, specifying the manner and content of required disclosures, as well as the entities to which the information must be submitted.[5] Subsequent HHS guidance[6] and a final rule entitled *Notice of Benefit and Payment Parameters for 2016* clarified that this information would need to be submitted by issuers only after the conclusion of a full benefit year.[7] These actions were a significant step toward fulfilling HHS's statutory mandate with respect to QHPs; however, additional efforts are needed, as HHS continues not to collect required data regarding consumer liability for out-of-network claims, such as costs arising from surprise medical bills.[8]

The ACA also added Section 2715A to the Public Health Service Act,[9] which provides that the transparency requirements of Section 1311(e)(3) of the ACA apply not only to plans that are certified as QHPs but also to all non-grandfathered group health plans and health insurance issuers offering group or individual coverage.[10] Furthermore, Section 1311(e)(3)(D) of the ACA specifies that the Department of Labor must "update and harmonize the Secretary's rules concerning the accurate and timely disclosure to participants by group health plans of plan disclosure, plan terms and conditions, and periodic financial disclosure with the standards established by the Secretary [of Health and Human Services]."[11]

Pursuant to these requirements, on July 21, 2016, the Department, along with the Internal Revenue Service and the Pension Benefit Guaranty Corporation, published a proposed rule to revise and improve the Form 5500 that is filed annually for employee pension and welfare benefit plans.[12] Among other reforms, this proposal would have expanded disclosure requirements for group health plans such that all ERISA-covered group health plans regardless of size would be required to file annual reports to the Department.[13] In addition, the proposed rule would have created a new Schedule J for the Form 5500, and the Department solicited comment on the feasibility of relying on this submission to collect information in compliance with the ACA's transparency in coverage requirements.[14] However, to date the proposed Schedule J has not yet been implemented, and the Office of Information and Regulatory Affairs

[3] 42 U.S. Code § 18031(e)(3)(D).
[4] 77 Fed. Reg. 18310 (Mar. 27, 2012) https://www.govinfo.gov/content/pkg/FR-2012-03-27/pdf/2012-6125.pdf.
[5] *See* 45 CFR §§ 155.1040(a) and 156.220.
[6] Affordable Care Act FAQs – Set 15 https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html.
[7] 80 Fed. Reg. 10750 (Feb. 27, 2015) https://www.govinfo.gov/content/pkg/FR-2015-02-27/pdf/2015-03751.pdf.
[8] *See* Karen Pollitz, Cynthia Cox, and Rachel Fehr, Claims Denials and Appeals in ACA Marketplace Plans (Feb. 25, 2019) https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/.
[9] 42 U.S.C. § 300gg–15a.
[10] Note that ERISA Section 715(a)(1) incorporates all provisions of Part A of Title XXVII of the Public Health Service Act insofar as they apply to group health plans, including Section 2715A.
[11] 42 U.S. Code § 18031(e)(3)(D).
[12] 81 Fed. Reg. 47534 at 47556 https://www.govinfo.gov/content/pkg/FR-2016-07-21/pdf/2016-14893.pdf.
[13] *See id.* at 47556-47560.
[14] *Id.* at 47557.

currently states that the status of the rulemaking is "undetermined."[15] This inaction has created confusion among plans as to current disclosure requirements and deprives the public of needed transparency regarding group health coverage.

We are deeply troubled by recent reports suggesting that the Department is unlikely to finalize this proposed rule in the foreseeable future.[16] We further note that references to the proposed Schedule J have been omitted from the *2019 Annual Report to Congress on Self-Insured Group Health Plans*,[17] in contrast to the Department's *Report* for the prior year.[18] Moreover, to date no efforts have been announced that would allow for collection of required information from group health plans through an alternative platform, such as the Health Insurance Oversight System through which issuers that offer coverage through healthcare.gov currently submit data to HHS.

In enacting Section 1311(e)(3) of the ACA and Section 2715A of the Public Health Service Act, Congress evinced its clear intent to increase the public's understanding of health coverage. In addition to supporting transparency in the commercial insurance market and shining a light on health spending, this information could have direct benefits to many consumers. For example, an improved understanding of cost-sharing and payments with respect to out-of-network coverage could be particularly beneficial to the millions of patients who face devastating surprise medical bills arising from unanticipated out-of-network expenses.[19] Implementation of these provisions is long overdue, and we urge you to take immediate action to come into full compliance with the Department's statutory obligations.

We appreciate your prompt attention to this important matter. If you have any questions, please do not hesitate to contact Daniel Foster of the House Committee on Education and Labor staff at daniel.foster@mail.house.gov or 202-225-3725.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman
Committee on Education and Labor

FREDERICA S. WILSON
Chairwoman
Subcommittee on Health, Employment, Labor, and Pensions (HELP)
Committee on Education and Labor

[15] Office of Information and Regulatory Affairs, Revision of the Form 5500 Series and Implementing Related Regulations Under the Employee Retirement Income Security Act of 1974 (ERISA), Accessed May 22, 2019, https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201810&RIN=1210-AB63.

[16] Madison Alder, Bloomberg Law, April 29, 2019, Regulators in Dark With Obamacare Data Rule Stuck in Limbo, Bloomberg Law, https://news.bloomberglaw.com/health-law-and-business/aca-transparency-data-stuck-in-limbo-at-labor-department.

[17] Report to Congress, Annual Report on Self-Insured Group Health Plans, March 2019.

[18] Report to Congress, Annual Report on Self-Insured Group Health Plans, March 2018 at 8 ("the proposed revisions would 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 funding and benefit offerings").

[19] These bills may arise in about 20 percent of inpatient admissions following an emergency department visit and 14 percent of all emergency outpatient visits. Christopher Garmon and Benjamin Chartock, *One In Five Inpatient Emergency Department Cases May Lead To Surprise Bills*, Health Affairs, Jan. 2017. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.0970.