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June 17, 2024

The Honorable Julie A. Su  
Acting Secretary  
U.S. Department of Labor  
200 Constitution Avenue, NW  
Washington, D.C. 20210

The Honorable Lisa M. Gomez  
Assistant Secretary  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue, NW  
Washington, D.C. 20210

Dear Acting Secretary Su and Assistant Secretary Gomez:

We write to encourage the Department of Labor (the Department) to take action to strengthen disclosure requirements under the *Employee Retirement Income Security Act (ERISA)*<sup>1</sup> for group health plans. Improved transparency is urgently needed in light of recent investigations that have uncovered widespread denials of health benefits by insurers and third-party administrators and the devastating consequences that these denials have for workers and their families.<sup>2</sup> The Department's upcoming consideration<sup>3</sup> of improvements to the annual report for employee benefit plans presents an opportunity to meaningfully improve transparency for the more than 130 million individuals who receive health benefits from ERISA-covered plans.<sup>4</sup>

***Form 5500 Data Collection Currently Provides Inadequate Information Regarding the Operations of ERISA-Covered Group Health Plans***

As you know, the administrators of employee benefit plans, including group health plans, are required under ERISA to submit an annual report to the Department.<sup>5</sup> This report, known as the Form 5500, serves as "the primary source of information about the operations, funding and investments of [ERISA-covered] benefit plans," and allows for the creation of datasets that provide a centralized source of information on the health benefit plan landscape for Congress, federal regulatory agencies, and the general public.<sup>6</sup> Form 5500 filings also directly inform the

<sup>1</sup> Pub. L. No. 93-406 (1974).

<sup>2</sup> Robin Fields, *How Often Do Health Insurers Say No to Patients? No One Knows*, ProPublica (June 28, 2023), <https://www.propublica.org/article/how-often-do-health-insurers-deny-patients-claims>.

<sup>3</sup> *Improvement of the Form 5500 Series and Implementing Related Regulations Under the Employee Retirement Income Security Act of 1974 (ERISA)* (last visited May 31, 2024), <https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=202310&RIN=1210-AC01>.

<sup>4</sup> U.S. Department of Labor, *FY 2025 Congressional Budget Justification Employee Benefits Security Administration* (2024), <https://www.dol.gov/sites/dolgov/files/general/budget/2025/CBJ-2025-V2-01.pdf> at 15.

<sup>5</sup> 29 U.S.C. § 1024(a).

<sup>6</sup> U.S. Department of Labor, Employee Benefits Security Administration, *Form 5500 Series* (last visited May 31, 2024), <https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/reporting-and-filing/form-5500>.

Department in fulfilling its obligation under the *Affordable Care Act* (ACA)<sup>7</sup> to report annually to the House Committee on Education and the Workforce and the Senate Committee on Health, Employment, Labor, and Pensions regarding the coverage provided by self-insured plans.<sup>8</sup>

Regrettably, serious deficiencies in the current regulations governing the Form 5500 have provided an excessively broad exemption for the vast majority of health plans. Under regulations issued by the Department in 1975, millions of plans with fewer than 100 participants are completely exempt from filing even a partial version of the Form 5500.<sup>9</sup> As a result, only 81,800 plans—approximately 3 percent of all ERISA-covered group health plans—submitted an annual report in 2021, the most recent year for which reliable data is available.<sup>10</sup> An audit by the Office of the Inspector General (OIG) found that this gap in data collection prevents the Department from performing basic oversight duties on behalf of tens of millions of Americans, prompting the OIG to recommend the Department issue regulations to revise or eliminate this exemption.<sup>11</sup> This recommendation remains unimplemented after nearly eight years.

Moreover, the current design of the Form 5500 is inadequate for fully understanding the funding and operations of large health plans that are required to submit annual reports. For example, despite a longstanding recommendation from the OIG,<sup>12</sup> plans are not required to submit any information regarding denials of claims for health benefits, including the number of claims submitted, the number of claims approved or denied, the number of claims appealed, or the outcomes of those appeals. In addition, other important information is not collected through the Form 5500, including details regarding stop loss insurance purchased by self-funded plans (such as the attachment point for such policies) or, in many cases, whether a plan is covered by a stop loss policy at all. Failure to collect this fundamental information deprives participants of information regarding their plans and undermines the ability of both the Department and Congress to perform necessary oversight.

### ***Increased Oversight of Benefit Denials is a Critical Issue for Workers and their Families***

We are especially concerned that the secrecy surrounding denied claims for health benefits harms workers and their families and we urge you to prioritize improvements in the collection of data regarding such denials. Improper claim denials impose health and financial hardships on individuals, leading to delays in necessary treatments, deterioration of one's health, and high out-of-pocket costs.<sup>13</sup> In some instances, the consequences are even more dire. In April, the Committee heard testimony from Karen L. Handorf, former Deputy Associate Solicitor in the

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<sup>7</sup> Pub. L. No. 111–148 (2010).

<sup>8</sup> 42 U.S.C. § 18013. See, e.g., U.S. Department of Labor, *Annual Report to Congress on Self-Insured Group Health Plans* (Mar. 2024), <https://www.dol.gov/sites/dolgov/files/EBSA/researchers/statistics/retirement-bulletins/annual-report-on-self-insured-group-health-plans-2024.pdf>.

<sup>9</sup> See 29 C.F.R. § 2520.104-20, <https://www.ecfr.gov/current/title-29/subtitle-B/chapter-XXV/subchapter-C/part-2520/subpart-D/section-2520.104-20>

<sup>10</sup> U.S. Department of Labor, *supra* note 8 at 5.

<sup>11</sup> U.S. Department of Labor, Office of the Inspector General, *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* (Nov. 18, 2016), <https://www.oig.dol.gov/public/reports/oa/2017/05-17-001-12-121.pdf>.

<sup>12</sup> *Id.*

<sup>13</sup> Karen Pollitz et al., *Consumer Survey Highlights Problems with Denied Health Insurance Claims*, Kaiser Family Foundation (Sept. 29, 2023), <https://www.kff.org/affordable-care-act/issue-brief/consumer-survey-highlights-problems-with-denied-health-insurance-claims/>.

Plan Benefits Security Division, who recounted the tragic death of Kyree, a 27-year-old flight attendant, who was denied prior authorization for a heart transplant because he was told he failed to “meet certain alcohol-abuse criteria allegedly required by the plan.”<sup>14</sup> Almost a month after Kyree’s death, an “external reviewer overturned the previous claims denials, finding that the plan document did not contain the alcohol abuse exception” the plan had relied upon to deny Kyree lifesaving care.<sup>15</sup> However, this decision came too late to save his life and his family has been unsuccessful in efforts to achieve accountability under ERISA.<sup>16</sup>

We are gravely concerned by this tragic incident as well as numerous media reports of plans and their service providers who have engaged in conducting arbitrary, improper, and mass denials of health claims.<sup>17</sup> A recent ProPublica investigation, for example, found that Cigna constructed a claims review system that allowed “its doctors to instantly reject a claim on medical grounds without opening the patient file,” spending, on average, just over a single second reviewing each claim.<sup>18</sup> Other exposés have unveiled the lengths insurance companies will go to avoid covering vital treatments.<sup>19</sup> Unfortunately, without additional action by the Department to improve the collection of data regarding claims denials, the public and policymakers remain unable to engage in necessary oversight and enforcement activities to address these issues.

### ***The Department Can and Should Move Forward to Implement ACA Requirements that Were Blocked by the Trump Administration***

As you are aware, the ACA required the Department to issue regulations to harmonize certain group health plan reporting requirements with those that apply to qualified health plans offered through the Marketplaces.<sup>20</sup> In 2016, the Department took an important step to implement this requirement when it issued a Proposed Rule that would have revised and improved the Form 5500.<sup>21</sup> Had these changes been finalized, the regulatory exemption for small group health plans would have been eliminated to ensure that all ERISA-covered group health plans regardless of size would be required to file Form 5500 annual reports (consistent with the recommendation of the OIG).<sup>22</sup> In addition, the Proposed Rule would have created a new Schedule J that would have dramatically improved data collection from group health plans by requiring detailed information of claims payment data such as the number of approved and denied claims, appeals, unpaid claims, and the annual dollar value of paid claims, among other information.<sup>23</sup>

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<sup>14</sup> Testimony of Karen L. Handorf, Hearing on “ERISA’s 50th Anniversary: The Path To Higher Quality, Lower Cost Health Care” U.S. House of Representatives, Committee on Education & the Workforce Subcommittee on Health, Employment, Labor, and Pensions (Apr. 16, 2024), [https://democrats-edworkforce.house.gov/imo/media/doc/karen\\_testimony41624.pdf](https://democrats-edworkforce.house.gov/imo/media/doc/karen_testimony41624.pdf) at 6.

<sup>15</sup> *Id.*

<sup>16</sup> See *Rose v. PSA Airlines*, 80 F.4th 488, 505 (4<sup>th</sup> Cir. 2023).

<sup>17</sup> Patrick Rucker et al., *How Cigna Saves Millions by Having Its Doctors Reject Claims Without Reading Them*, ProPublica (Mar. 25, 2023), <https://www.propublica.org/article/cigna-pdx-medical-health-insurance-rejection-claims>.

<sup>18</sup> *Id.*

<sup>19</sup> See, e.g., David Armstrong et al., *UnitedHealthcare Tried to Deny Coverage to a Chronically Ill Patient. He Fought Back, Exposing the Insurer’s Inner Workings*, ProPublica (Feb. 2, 2023), <https://www.propublica.org/article/unitedhealth-healthcare-insurance-denial-ulcerative-colitis>; T. Christian Miller, *Big Insurance Met Its Match When It Turned Down a Top Trial Lawyer’s Request for Cancer Treatment* ProPublica, (Nov. 7, 2023), <https://www.propublica.org/article/blue-cross-proton-therapy-cancer-lawyer-denial>.

<sup>20</sup> 42 U.S.C. § 18031(e)(3)(D).

<sup>21</sup> Proposed Revision of Annual Information Return/Reports, 81 Federal Register 47534 (July 21, 2016),

<https://www.federalregister.gov/documents/2016/07/21/2016-14893/proposed-revision-of-annual-information-returnreports>.

<sup>22</sup> *Id.* at 47,536.

<sup>23</sup> *Id.* at 47,636.

However, these improvements were ultimately not finalized following the change of political leadership by the incoming Trump Administration, despite the strong urging of Committee Democrats.<sup>24</sup> Although steps have been taken to improve price transparency in recent years,<sup>25</sup> other necessary transparency efforts have stalled and, to date, “the federal government has collected only a fraction of what it’s entitled to [from health plans and insurers].”<sup>26</sup> Without further action, the public remains largely uninformed regarding the full extent to which plan practices may result in patterns or practices of potentially improper denials of health benefits.

### ***Conclusion***

We strongly urge the Department to strengthen the Form 5500 to enhance the collection of data from group health plans, including the improvements originally proposed in 2016. Specifically, the Department should: require all ERISA-covered group health plans to file a Form 5500; disclose claims payment data in a manner consistent with the Schedule J proposal; and provide other vital information on the operations and characteristics of group health plans to ensure that participants receive “full and fair review” of their benefit claims, as guaranteed by ERISA.<sup>27</sup> Additionally, to the extent practicable, the Department should ensure claims denial information is disaggregated by type of service (such as treatment for mental health and substance use disorder) and is provided with details regarding the utilization of artificial intelligence and automated processes in making adverse benefit determinations.

Thank you for your leadership on this issue. We look forward to working with you on these and other efforts to advance our shared goal of improving access to benefits and implementing the Department’s mission “to foster, promote, and develop the welfare of the [nation’s] wage earners...and assure [their] work-related benefits and rights.”<sup>28</sup>

Sincerely,



**ROBERT C. “BOBBY” SCOTT**  
Ranking Member  
Committee on Education and the Workforce



**MARK DESAULNIER**  
Ranking Member  
Subcommittee on Health, Employment,  
Labor, and Pensions

<sup>24</sup> Letter from Representative Robert C. “Bobby” Scott and Frederica S. Wilson to the Honorable R. Alexander Acosta (May 22, 2019), <https://democrats-edworkforce.house.gov/imo/media/doc/2019-05-22%20-%20Scott%20Wilson%20Letter%20to%20Acosta%20re%20Transparency%20Implementation.pdf>.

<sup>25</sup> See, e.g., *Transparency in Coverage*, 85 Fed. Reg. 72,158 (Nov. 12, 2020), <https://www.federalregister.gov/documents/2020/11/12/2020-24591/transparency-in-coverage>

<sup>26</sup> Fields, *supra* note 2, <https://www.propublica.org/article/how-often-do-health-insurers-deny-patients-claims>.

<sup>27</sup> 29 U.S.C. § 1133.

<sup>28</sup> 29 U.S.C. § 551.