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BENEFITS MARKETPLACE

Form 5500 Proposed Changes

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The US Department of Labor's Employee Benefits Security Administration (EBSA) issued a "Proposed Revision of Annual Information Returns/Reports" that would make changes to the Form 5500. If adopted, the proposed changes will be effective for plan years beginning on or after January 1, 2019 (filings due in 2020).

EBSA is requesting comments on the proposed changes due by October 4, 2016. Any comments received will be available for public review.

Background

An employee benefit plan established by a private employer must comply with the Employee Retirement Income Security Act (ERISA). ERISA requires pension, health and welfare plans to file an annual return, the Form 5500. The Form 5500 contains information related to an employee benefit plan's operation, funding, asset, and investment information. EBSA, federal and state agencies, private entities, and participants use the Form 5500 to obtain information related to the plan.

The proposed changes would serve five purposes:

1. to modernize financial reporting;
2. to provide greater information related to group health plans;
3. enhance data mineability;
4. improve service provider fee information; and
5. enhance compliance with ERISA and the Internal Revenue Code.

Proposed Changes

The following outlines the changes applicable to health and welfare plans only. However, a number of proposed changes apply to retirement plans, including defined contribution, defined benefit, profit sharing and ESOPs. These changes are not discussed in this summary.

All Health Plans Require a Form 5500 Filing

A small health and welfare plan is a plan with fewer than 100 participants on the first day of the plan year. Currently, small health and welfare plans are exempt from filing the Form 5500 if the plan is unfunded or fully insured.

Large health and welfare plans (those with at least 100 participants on the first day of the plan year) are subject to a Form 5500 filing. However, as noted in the preamble to the proposed rule, information reported in the Form 5500 is generally very limited (particularly for self-funded health plans).

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The proposed rule requires all health plans (regardless of size) to file the Form 5500 and required schedules. Small, insured health plans will have a limited reporting obligation as compared to large plans and self-funded plans.

All Health Plans Must Provide a Schedule J – Group Health Plan Information

According to EBSA, existing Form 5500 requirements related to group health plans fail to consider laws enacted after the initial reporting regulations, including:

- Health Insurance Portability and Accountability Act (HIPAA);
- Title I of the Genetic Information and Non-discrimination Act of 2008 (GINA);
- Mental Health Parity Act and Mental Health Party and Addiction Equity Act (MHPAEA);
- The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA);
- The Women's Cancer Rights Act of 1998 (WHCRA);
- Michelle's Law; and
- The Affordable Care Act (ACA).

Due to the number of laws enacted that affect group health plans governed by ERISA, EBSA determined changes to the Form 5500 are necessary to ensure proper documentation of compliance with these various laws. As such, the EBSA is proposing a new Schedule J.

The Schedule J would require the following information:

- **COBRA**
  information related to the COBRA coverage, including number of persons covered, eligibility (employees, spouses, children, retirees, etc.), and type of benefits (medical/surgical, pharmacy, prescription drug, mental health/substance use disorder, wellness program, preventive care, vision, dental, etc.).

- **Funding & Benefit Arrangements**
  information related to plan funding and benefit arrangements (insured, self-insured, trust, or general assets of employer), policy number, and employer and/or participant contributions.

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- **Group Health Benefit Design**
  information related to the grandfathered status and type of benefit offered (high deductible health plan, health flexible spending account (Health FSA), health reimbursement arrangement (HRA)).

- **Rebates**
  information related to the plan's receipt of rebates, refunds, reimbursements, or offsets (e.g. Medical Loss Ratio Rebates), including the amount received and distribution method to participants (check, premium holiday, payment of benefits, or other).

- **Service Providers**
  information related to service providers not already listed on Schedule A or C, including the name, address, contact information, employer identification number, and National Insurance Producer Registry (if applicable).

- **Stop Loss**
  information related to the premium paid and individual and aggregate claim limits.

- **Claims Payment Data**
  information related to pre and post service benefit claims submitted, claims approved, claims denied, claims appealed, claims upheld at denials, claims payable after appeals, and claims not adjudicated within the required time frames.

- **Inability to Pay Claims**
  information related to a plan's inability to pay claims at any time during the year; if fully insured, delinquent payments to an insurance carrier; and if a lapse of coverage occurred.

- **Plan Assets**
  information related to plan funding including trust, insurance company, or employer assets.

- **Plan Documents**
  information related to content requirements of plan documents, summary plan descriptions (SPD), summaries of material modifications (SMM), and summary of benefits and coverage (SBC).

- **Specific Legal Compliance**
  specific questions requesting certification of compliance with applicable federal laws (HIPAA, GINA, MHPAEA, NMHPA, WCRA, Michelle's Law, and ACA).

Claims Adjudication Data

In addition to the information to be collected on Schedule J, EBSA is specifically requesting comments on the collection of additional claims data that would provide information related to adjudication practices and policies.

Data to be collected would include:

- Dollar amount of claims denied;
- Denial codes;
- Benefits denied (e.g. mental health/substance abuse or medical/surgical benefits);
- Uniform classification of denial codes (for example, provider's point of service fee; schedule of negotiated fee; Medicare reimbursement rates; state prevailing fees; or other reasonable method.)

DFE Reporting – GIAs

A Group Insurance Arrangement (GIA) filing as a Direct Filing Entity (DFE) would have no changes to its Form 5500 requirements. The GIA must file the same forms, schedules and attachments required of a large group health with a trust. A fully insured group health plan participating in a GIA would continue to be exempt from the reporting requirements of the Form 5500 if the GIA files a Form 5500. In addition, the GIA would be required to file a Schedule J for each separate employer's participating plan.

Employer Action

These proposed changes are significant and, if adopted in the current form, will create a substantial burden on all employers, carriers and third-party administrators supporting group health plans.

For now, employers should review health and welfare plans to ensure compliance with all applicable federal regulations.

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