



American Benefits Council

Proposed Form 5500 Changes and Implications for H&W Plans

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Seth Perretta & Via Boppana

Overview

- Background
- Highlights:
 - Schedule J
 - Small Plan Reporting
 - Schedule C
- Q&A

Background: ERISA section 104

**Requires the
filing of an
annual report**



(a) FILING OF ANNUAL REPORT WITH SECRETARY

(1) The administrator of any employee benefit plan subject to this part shall file with the Secretary the annual report for a plan year within 210 days after the close of such year (or within such time as may be required by regulations promulgated by the Secretary in order to reduce duplicative filing). The Secretary shall make copies of such annual reports available for inspection in the public document room of the Department of Labor.

(2)

(A) With respect to annual reports required to be filed with the Secretary under this part, he may by regulation prescribe simplified annual reports for any pension plan which covers less than 100 participants.

(B) Nothing contained in this paragraph shall preclude the Secretary from requiring any information or data from any such plan to which this part applies where he finds such data or information is necessary to carry out the purposes of this subchapter nor shall the Secretary be precluded from revoking provisions for simplified reports for any such plan if he finds it necessary to do so in order to carry out the objectives of this subchapter.

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**Grants DOL
broad powers
over reporting**



Background: Form 5500

- Last round of changes was effective in 2009
- Recent proposed changes were published on 7/21/16
- The proposed changes would be effective beginning with 2019 plan year reporting
- **NO** corresponding revised forms/schedules have been provided
- Comment deadline extended to 12/5/16

Background: Form 5500

- Stated goals for the changes:
 - Modernize financial statements and investment information
 - Update reporting requirements for service provider fee and expense information
 - Require Form 5500 reporting by all group health plans covered by ERISA Title I
 - Improve compliance and oversight

Schedule J: Overview

- NEW!!
- Would require reporting of information on GHP operations, ERISA compliance, and compliance with certain ACA provisions
- Stated reason: DOL is considering whether a GHP could satisfy requirements under PHSA 2715A and 2717 (incorporated into ERISA) through the Schedule J

Schedule J: PHSA Section 2715A

- What does PHSA section 2715A require?
 - Group health plans offered on the Exchange must comply with the requirements applicable to issuers of qualified health plans offered through Exchanges.
 - Plans that are not offered through the Exchange are required to submit the information required to the **Secretary of HHS** and the **State insurance commissioner**, and make such information available to the public.

Schedule J: PHSA Section 2717

- What does PHSA section 2717 require?
 - The **Secretary of HHS** (in consultation with experts in health care quality and stakeholders) must develop reporting requirements
 - Annual reporting to **Secretary of HHS**
 - Reports also must be made available to enrollees during each open enrollment

Schedule J: Plan Demographic Information

- Approximate number of participants and beneficiaries covered under the plan at the end of the plan year
 - *Current Rule*: Plan demographic information is sought on the main Form 5500 and Schedule A



Schedule J: Which Plans Are Subject?

- Applies to **any** GHP that is an ERISA plan, regardless of whether HIPAA-excepted or otherwise



Schedule J: Which Plans Are Subject?

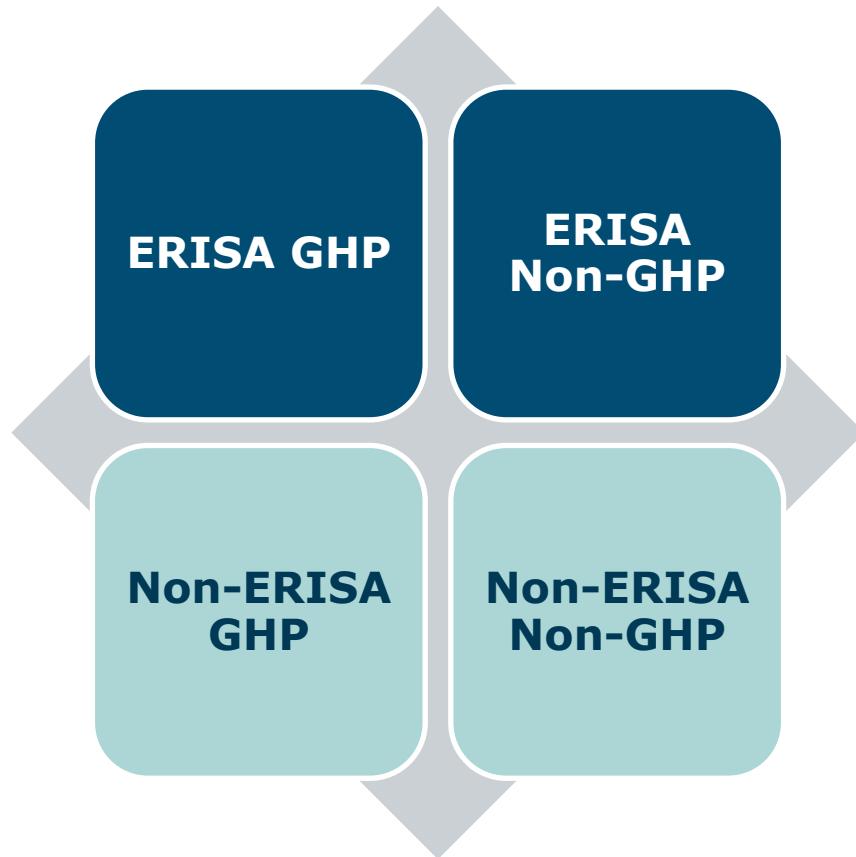
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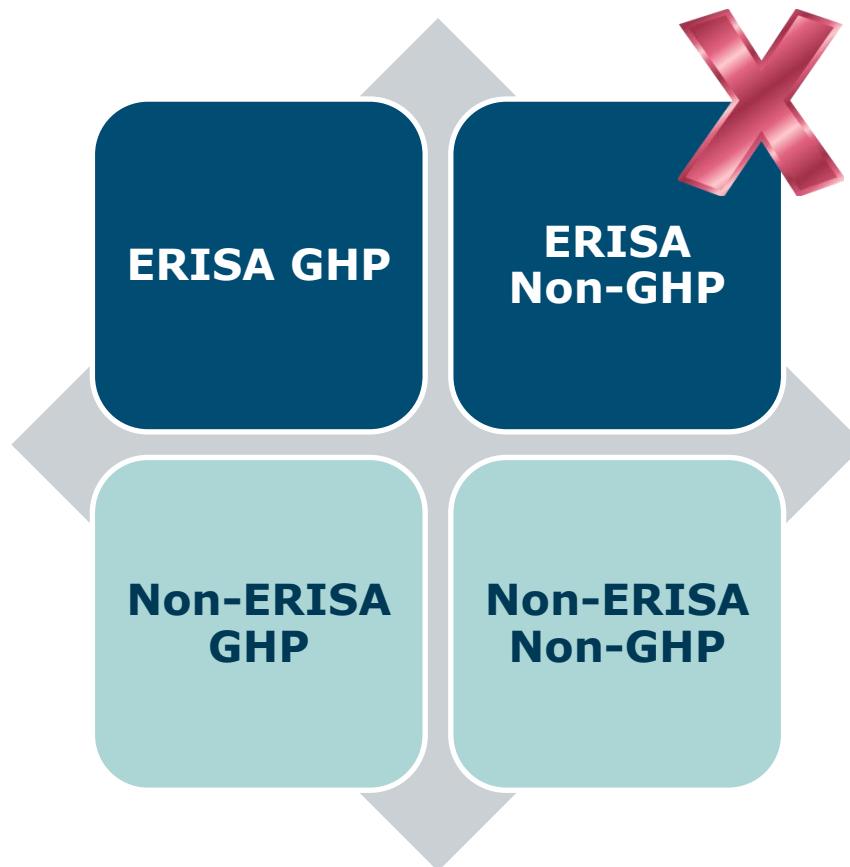
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 - GHP is defined to mean “ an employee welfare benefit plan to the extent that the plan provides [IRC section 213] medical care”

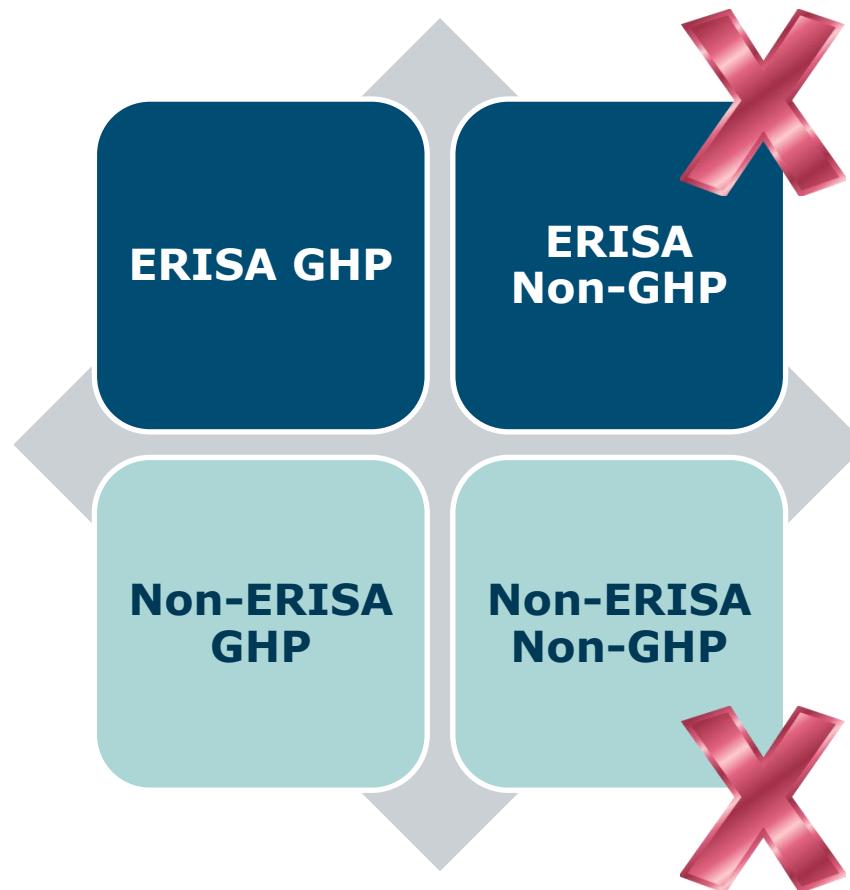
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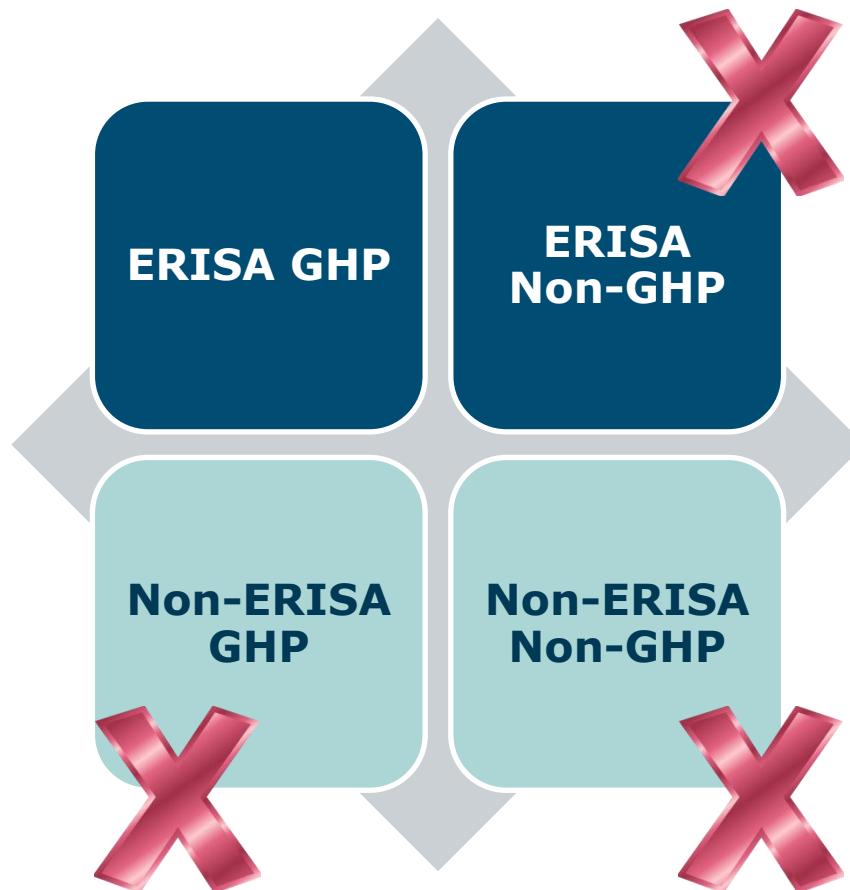
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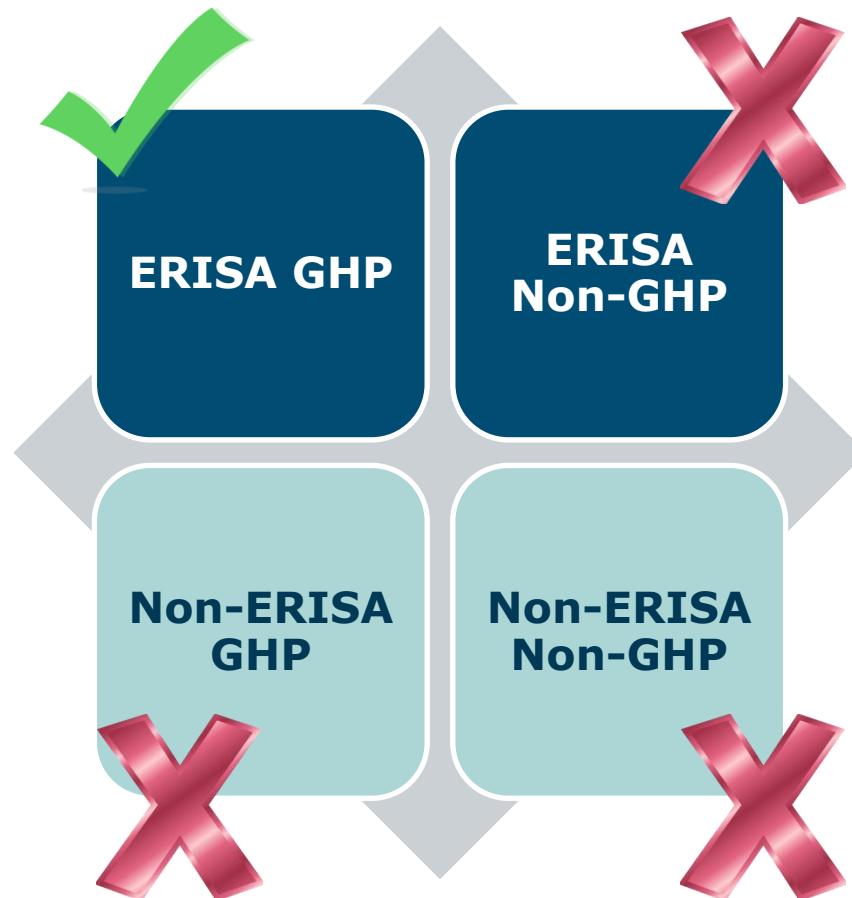
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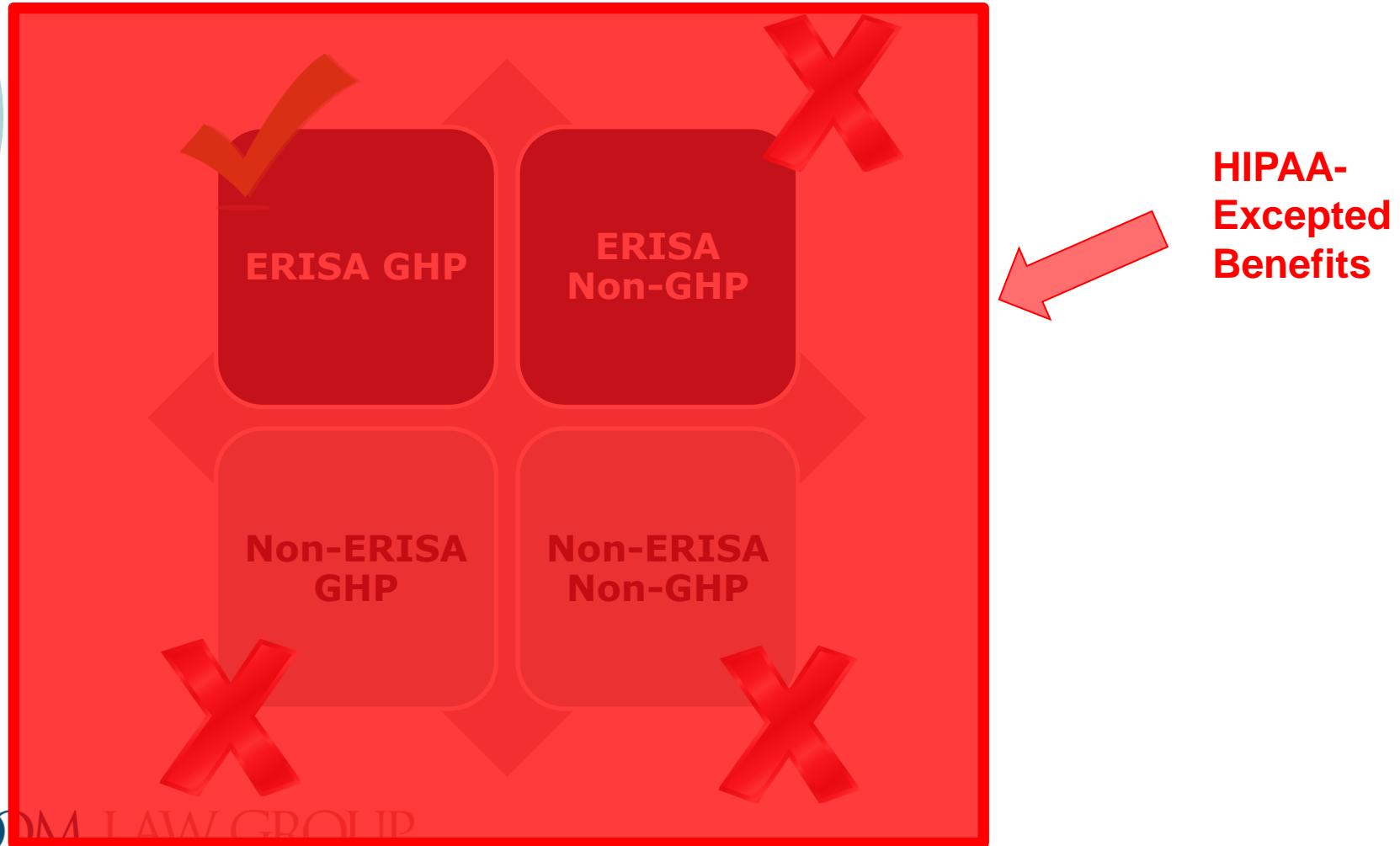
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Examples:

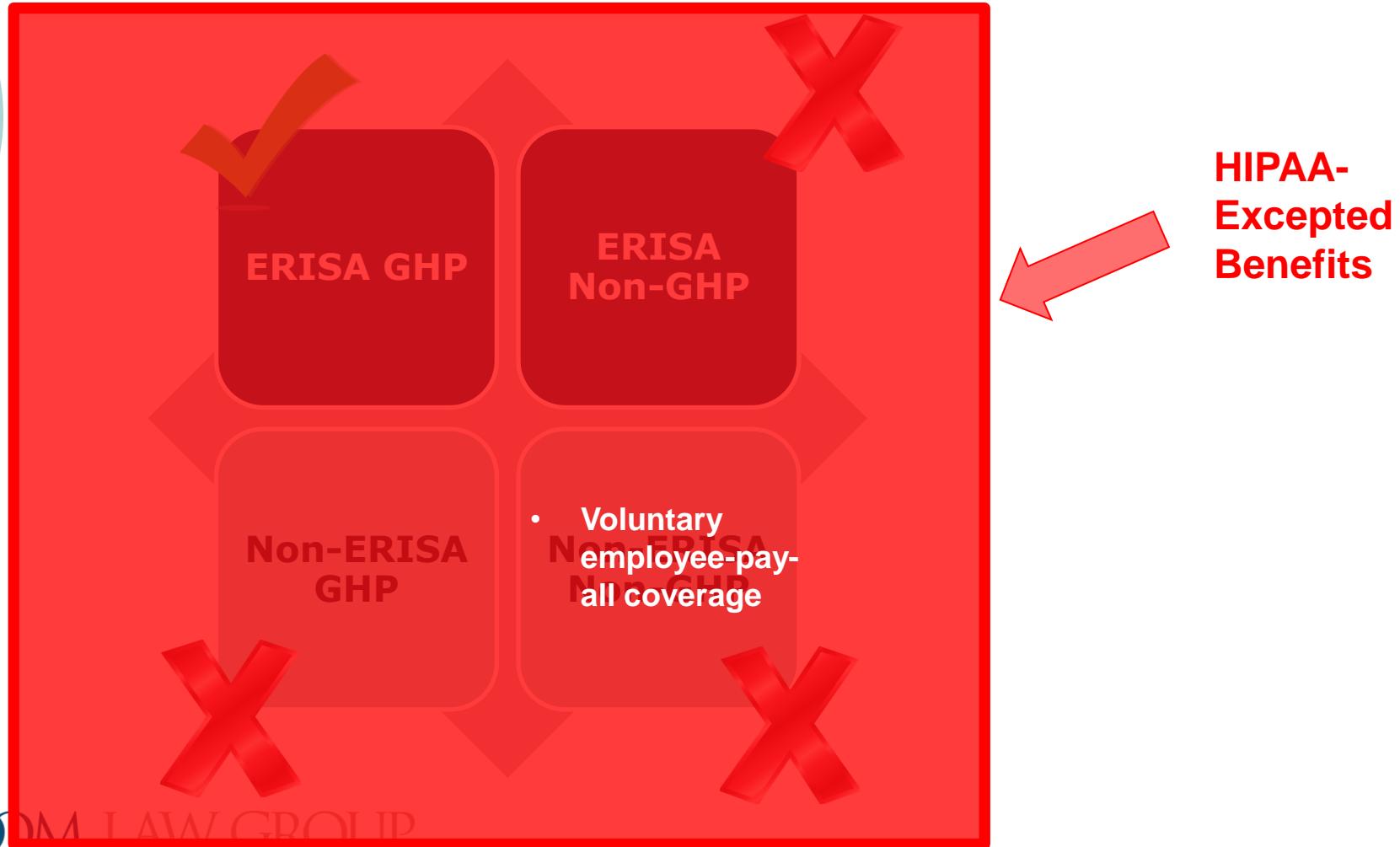
- Active Major Medical
- Retiree-Only Major Medical
- HRAs



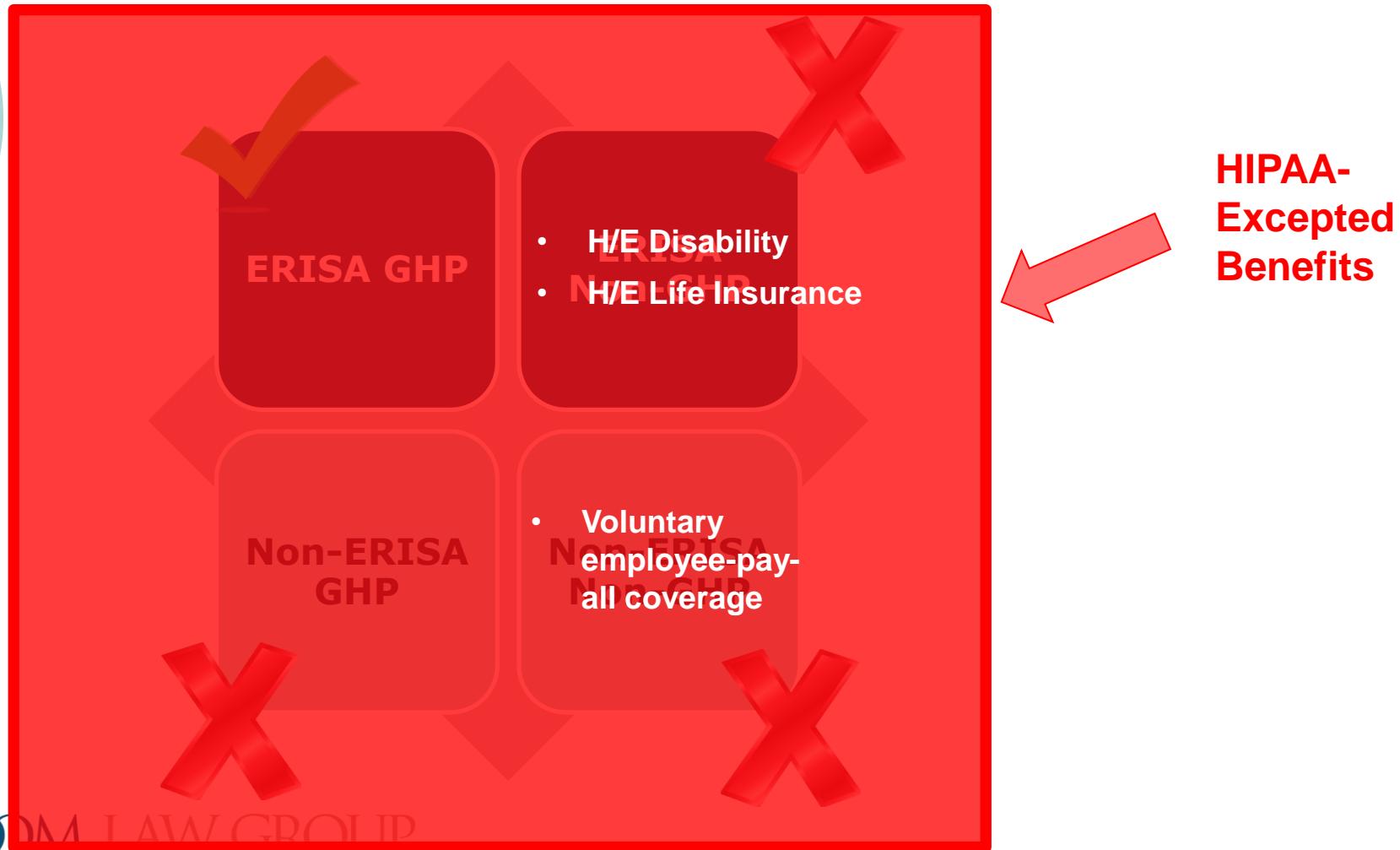
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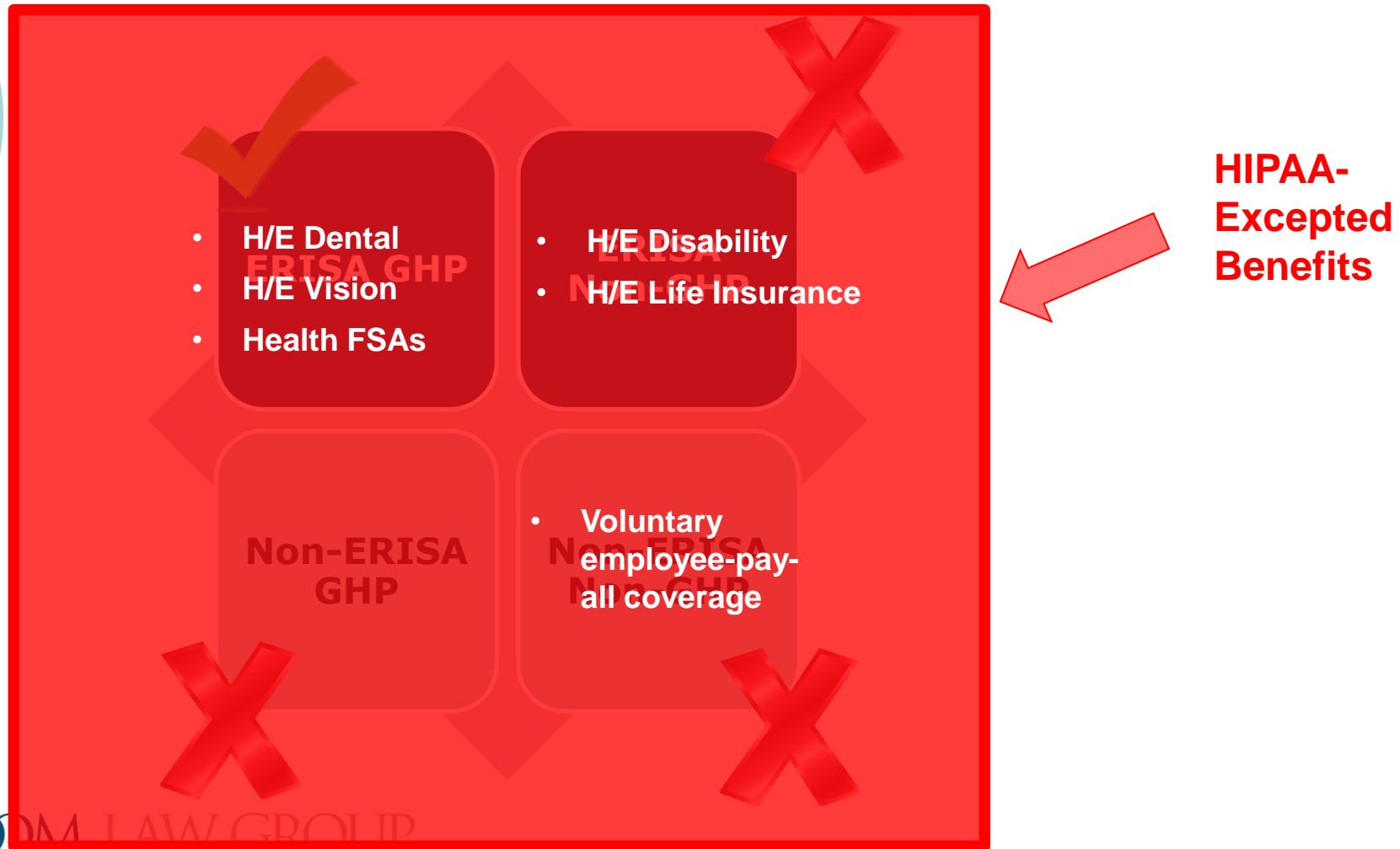
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Schedule J: Which Plans Are Subject?



Schedule J: Which Plans Are Subject?

- HIPAA Excepted Plans

- Dental-Only
- Vision-Only
- Health FSAs



Schedule J: Which Plans Are Subject?

- HIPAA Excepted Plans

- Disability 
- Life Insurance 
- Accident 
- Specified Disease Policies 
- Hospital or Fixed Indemnity Policies 



Schedule J: Which Plans Are Subject?

- HIPAA Excepted Plans
 - Long-Term Care – May depend on nature of coverage
 - Onsite Clinic – May depend on employer treatment as provider under medical plan and nature of services
 - EAPs – Appear to be excluded if meet HIPAA-excepted definition

Schedule J: Which Plans Are Subject?

- Other
 - **HSAs** – Likely depends on whether they satisfy DOL FABs
 - **Wellness Plans** – Likely depends on extent of medical care and whether treated as part of major medical plan

Schedule J: Plan Demographic Information

- The number of persons offered or receiving COBRA
 - *Current Rule:* No separate reporting of COBRA beneficiaries is required
- Whether the plan offers coverage for employees, spouses, children, and/or retirees
 - *Current Rule:* No such reporting required

Schedule J: Plan/Benefit Package Info

- Type of group health benefits offered under the plan
 - *Current Rule*: Some of this information is gathered on the main Form 5500, where plans have to report if they provide, *inter alia*, health, dental or vision benefits
- Funding and benefit arrangement (Insured? Funded? Unfunded?)
 - *Current Rule*: This is reported on the main Form 5500, where plans must report their funding arrangement and benefit arrangement (Insurance? Trust? General assets of the sponsor?)

Schedule J: Plan/Benefit Package Info

- Were there participant or employer contributions?
 - If so, must report amounts received and receivable (including non-cash contributions)
 - *Current Rule*: Information on participant and employer contributions is reported on Schedule H. Not all H&W plans file Schedules H
- Whether there was a failure to timely transmit participant contributions to the plan
 - *Current Rule*: Not such reporting required

Schedule J: Plan/Benefit Package Info

- Unique identifying information for prototype/off-the-shelf policies or arrangements
 - *Current Rule:* No such reporting required
- Grandfathered benefit options?
 - *Current Rule:* No such reporting required
- HDHP? Health FSA? HRA?
 - *Current Rule:* No such reporting required
- Service providers not already listed on Schedules A or C
 - *Current Rule:* No such reporting required

Schedule J: Financial Information

- Did plan receive rebates, refunds or reimbursements from a service provider (including MLR rebates) or offset rebates from favorable claims experience? If so, must report:
 - Type of service provider (issuer, TPA, PBM, other)
 - Amount received
 - How rebates were used
- *Current Rule:* No such reporting required

Schedule J: Financial Information

- Did the plan utilize stop loss coverage? If so, must report:
 - Total premium payment
 - Attachment points
 - Individual and aggregate claim limits
- *Current Rule:* No such reporting required

Schedule J: Financial Information

- How assets are held?
 - Are all plan assets held in trust, by an insurance company, or as insurance contracts?
 - Where plan assets are not held in trust, is this based on reliance on Technical Release 92-01?
- *Current Rule:* The first question is currently answered on the main Form 5500, where plans must report their funding arrangement and benefit arrangement (Insurance? Trust? General assets of the sponsor?)

Schedule J: Claims Information

- Number of post-service benefit claims that were submitted, approved, denied, and appealed
 - *Current Rule:* No such reporting required
- Number of post-service benefit claims upheld as denials on appeal or became payable after appeal
 - *Current Rule:* No such reporting required
- Whether any post-service benefit claims were not adjudicated within required timeframes
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Schedule J: Claims Information (Cont'd!)

- Total dollar amount of claims paid during plan year
 - *Current Rule:* Reported as a liability on the Schedule H.
Not all H&W plans file Schedules H
- Number of pre-service claims that were appealed, upheld as denials on appeal, approved on appeal
 - *Current Rule:* No such reporting required
- Whether unable to pay claims at any time during the plan year (and if so, number of unpaid claims)
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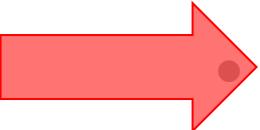


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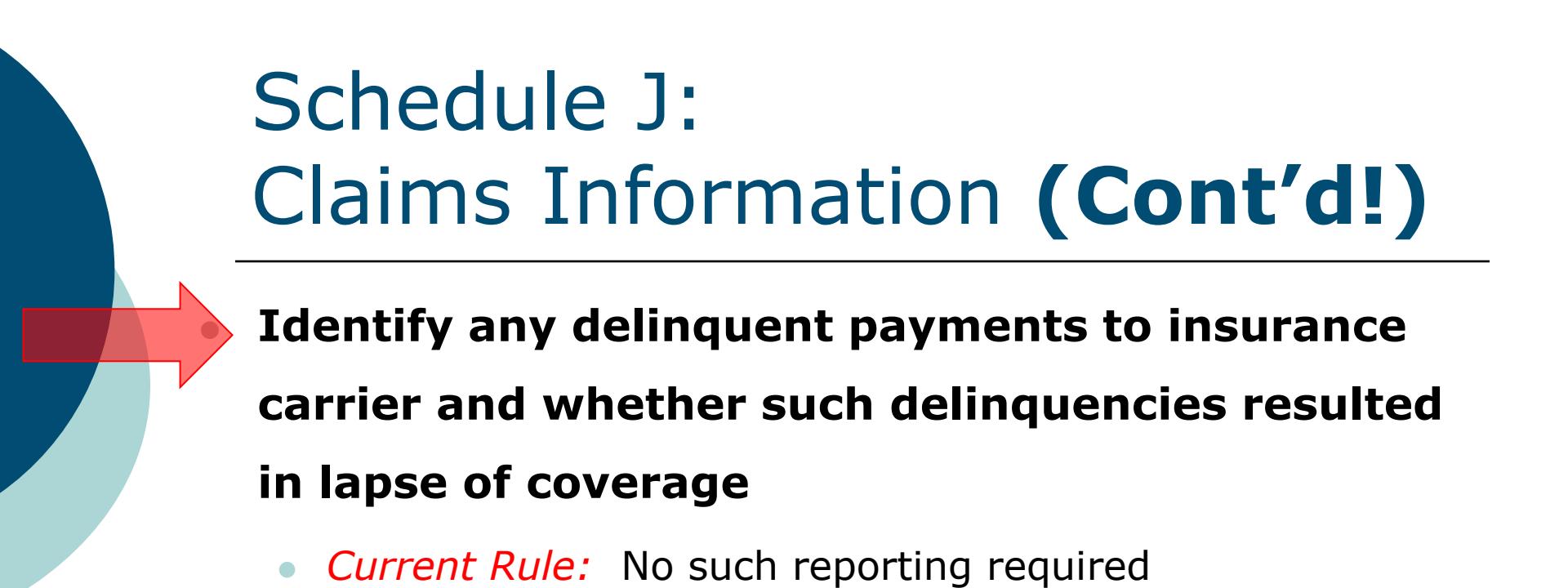


Whether unable to pay claims at any time during the plan year (and if so, number of unpaid claims)

- *Current Rule:* No such reporting required

Schedule J: Claims Information (Cont'd!)

- Identify any delinquent payments to insurance carrier and whether such delinquencies resulted in lapse of coverage
 - *Current Rule:* No such reporting required



Schedule J: Claims Information (Cont'd!)

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Schedule J: Legal Compliance Information

- Compliance with SPD, SMM, SBC content requirements
 - *Current Rule:* No such requirement

Schedule J: Legal Compliance Information

- Compliance with other applicable federal laws and DOL regulations, including:
 - HIPAA
 - GINA
 - MHPAEA
 - Newborns' and Mothers' Health Protection Act
 - Women's Health and Cancer Rights Act
 - Michelle's Law
 - ACA
- *Current Rule:* No such requirement

Small Plan Reporting: Generally

- All ERISA-covered plans that provide **group health benefits** would be required to file Form 5500 regardless of size, funding structure, and insured status
 - *Current Rule*: Welfare plans with fewer than 100 participants at the beginning of the plan year that are fully-insured, unfunded, or a combination of both are exempt from the Form 5500 filing requirement

Schedule C Reporting

- Indirect compensation must be reported for **covered service providers** (service providers of pension plans that are subject to Code section 408(b)(2))
 - *Current Rule*: Indirect compensation information is reported for all service providers listed on the Schedule C, including H&W plan service providers.
- Identify a person or office for the service provider that the plan administrator may contact regarding the information disclosed on the Schedule C
 - *Current Rule*: No such reporting required
- Report any relationship of the service provider to the plan (including fiduciaries and “other”)
 - *Current Rule*: Types of services provided to the plan are reported. Relationship to employer, employee, employee organization, or person known to be a party in interest is reported.
- Disclose termination of any service provider for material failure to meet terms of service agreement or ERISA Title I (moving to Schedule H)
 - *Current Rule*: Only terminations of accountants and enrolled actuaries reported

Questions?

Via Boppana
(202) 861-6338
sboppana@groom.com

Seth Perretta
(202) 861-6335
sperretta@groom.com