Sweeping Changes to How Employers Report Group Health Plan Info

Have a group health plan? The government wants to hear from you.

The government wants more information from more employers (even ones who haven't had to file information in the past) about the group health plans they offer. Why? To make sure the plans are meeting fiduciary standards and to gather information for research about employer-sponsored health coverage.

We're talking about **Form 5500 from the Department of Labor ("DOL")**. The DOL is proposing to overhaul some of the regulations governing the annual reporting requirements for group health coverage under Title I of the Employee Retirement Income Security Act ("ERISA"). The proposed changes would not only increase the information group health plans need to report. They would also require **all employers** with group health plans[1] to file Form 5500, including employers who are currently exempt from filing, such as employers with fewer than 100 participants and whose plans are insured, unfunded[2], or a combination of the two. (By unfunded, the government means a plan that pays benefits solely from the employer's general assets. A plan funded by participant contributions under a section 125 cafeteria plan may also be deemed to be unfunded for purposes of the Form 5500 exemption in accordance with DOL Technical Release 92-01.)

Employers will want to keep an eye on the progress of these proposed changes in case they either have to start filing Form 5500 or have to report a lot more information. One solution employers may want to consider is something called a "wrap document". A wrap document would create a single ERISA plan where multiple benefits and lines of coverage are offered (if not already in existence) to minimize the number of Forms 5500 an employer may need to file. Insurance carriers and claim payers will need to gather and report a significant amount of plan-level participant and financial data, as well.

The DOL anticipates the changes to become effective for plan years that begin on and after January 1, 2019. The public may submit comments through October 4, 2016. More information can be found on the DOL's website.

Background

Under Titles I and IV of ERISA and the Internal Revenue Code (the "Code"), pension and other employee benefit plans are generally required to file annual returns (Form 5500 and appropriate attached schedules) to report the financial condition and operations of the plan. Form 5500 serves a number of purposes, including to:

- Be a source of information to plan participants and beneficiaries;
- Be a critical enforcement, compliance, and research tool for the DOL and the Internal Revenue Service ("IRS"); and
- Provide information and data for use by other federal agencies, Congress, and the private sector in assessing employee benefit, tax, and economic trends and policies.

The changes are being proposed, because as the notice states in the Executive summary, the Form 5500 "has not kept pace with market developments and changes in the laws covering employee benefit plans" (p. 47496). The DOL aims to collect substantially more financial and claims information from group health plans, as well as remove the small employer filing exemption to enable better oversight of these arrangements. According to the proposed rule, "The current lack of information collected on the Form 5500 Annual Return/Report from group health plans impairs the effectiveness of EBSA's [Employee Benefits Security Administration] ability to develop health care regulations and complicates the DOL's ability to enforce such regulations and educate plan administrators regarding compliance" (p. 47499).

Under the proposed changes, all group health plans that meet the definition in 733(a) of the Act are required to file some or all of the Form 5500 Annual Return/Report and applicable schedules, including the Schedule J, regardless of whether such plans are exempt from certain market reform requirements under ERISA § 732(a) (exemption for certain small group health

plans that have less than two participants who are current employees) or ERISA § 733(c) (group health plans consisting solely of excepted benefits). This includes plans that claim grandfathered status under 29 CFR 2950.715–1251. Employee welfare benefit plans as defined in ERISA § 3(1) that do not meet the definition of a group health plan under 733 of the Act (i.e., they do not provide benefits for medical care) are not subject to the proposed enhanced reporting requirements applicable to group health plans.

Proposed Changes

Among the proposed changes, the revised Form 5500 would include a new **Schedule J** to report group health plan information in five general categories:

- Part I: Group Health Plan Characteristics
- Part II: Service Provider and Stop Loss Insurance Information
- Part III: Financial Information
- Part IV: Health Benefit Claims Processing and Payment
- Part V: Compliance Information

Fully insured group health plans with fewer than 100 participants would only report Part I basic participation, coverage, benefit and insurance company information. Plans must complete one Schedule J for all health benefit coverages they provide. Specific information reported on Schedule J would include the following:

Part I: Group Health Plan Characteristics

- Number of persons covered under the plan at the end of the plan year
- To whom coverage is offered during the year: employees, spouses, children, retirees, and/or retirees only
- Type of benefits the plan provides: medical/surgical benefits, mental health/substance use disorder benefits, pharmacy or prescription drug benefits, wellness program, preventive care services, emergency services, pregnancy benefits, vision, and dental
- Funding and benefit arrangements that apply
- How premiums and/or benefits are paid: employer and/or employee contributions
- Indicate whether any benefit or plan is considered to be grandfathered, a high deductible health plan, a health flexible spending account (FSA) or a health reimbursement arrangement (HRA)
- COBRA statistics: how many persons were offered, elected, and are receiving COBRA during the plan year
- Rebates received during the plan year: vendor information, date and amount of the rebate, and how the rebate was used
- Premium payment delinquencies, if any

Part II: Service Provider and Stop Loss Insurance Information

- Identify service providers such as Third-Party Administrators (TPAs) and stop loss carriers for self-funded arrangements, pharmacy benefit managers, wellness vendors, etc., not reported on other Form 5500 schedules
- Stop-loss details for the policy year: premiums paid, attachment points (individual and aggregate), and claim limits (if applicable)

Part III: Financial Information

- Employer and employee contributions received during the plan year or receivable as of the end of the plan year
- Contributions not remitted in a timely fashion

Part IV: Health Benefit Claims Processing and Payment

- Number of claims submitted during the plan year: approved, denied and pending

- Number of claim denials appealed: how many were upheld and overturned during the plan year
- Number of claims and appeals not adjudicated within the required timeframes
- If the plan paid claims in a timely manner
- Total dollar amount of benefits paid pursuant to claims during the plan year

Part V: Compliance Information

- Attest to compliance with a number of federal statutes and implement regulations, such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Title I of the Genetic Information Nondiscrimination Act of 2008 (GINA), Mental Health Parity Act of 1996 and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), Women's Health and Cancer Rights Act of 1998 (WHCRA), Michelle's Law, and the Affordable Care Act (ACA)
- Attest that the summary plan description (SPD), including any summary descriptions of modifications, and summary of benefits and coverage (SBC) is in compliance with applicable content requirements
- Indicate whether the plan is a Multiple Employer Welfare Arrangement (MEWA) subject to the Form M-1 filing requirements during the plan year

As you can see from this synopsis, there will be a lot of information to report in the Form 5500. So keep an eye out for developments during the comment period for these proposed changes. And keep in touch with your Cherry Bekaert Benefits Consulting adviser to stay up to date on the changes and to ask questions about your specific situation.

[1]Under the proposed changes, all group health plans that meet the definition in 733(a) of the Act are required to file some or all of the Form 5500 Annual Return/Report and applicable schedules, including the Schedule J, regardless of whether such plans are exempt from certain market reform requirements under ERISA § 732(a) (exemption for certain small group health plans that have less than two participants who are current employees) or ERISA § 733(c) (group health plans consisting solely of excepted benefits). This includes plans that claim grandfathered status under 29 CFR 2950.715–1251. Employee welfare benefit plans as defined in ERISA § 3(1) that do not meet the definition of a group health plan under 733 of the Act (i.e., they do not provide benefits for medical care) are not subject to the proposed enhanced reporting requirements applicable to group health plans.

[2]An unfunded plan pays benefits solely from the employer's general assets. A plan funded by participant contributions under a section 125 cafeteria plan may be deemed to be unfunded for purposes of the Form 5500 exemption in accordance with DOL Technical Release 92-01.

For additional information about our services, please contact Kyle Frigon at 404-733-3256 or via email at: kfrigon@cherrybekaertbenefits.com.