TIC International Corporation
Benefit Administrators and Consultants

2016-41

July 29, 2016

CLIENT BULLETIN

Proposed Revisions to Form 5500 and Schedules Published

The Department of Labor (DOL), the Internal Revenue Service (IRS), and the Pension Benefit Guaranty Corporation (PBGC) (collectively "Agencies") are seeking public comments on *proposed revisions to the Form 5500 Annual Return/Report* filed by private-sector employee benefit plans. The DOL also published a related notice of *proposed changes to its annual reporting regulations* under Title I of the *Employee Retirement Income Security Act (ERISA).* The changes are tied to the Form and Schedule revisions.

Under the proposal, the Form and Schedule revisions would begin to be used with the Plan Year 2019 Form 5500 series returns/reports. There are *many* "New" items. Comments are due by October 4, 2016. Contact information is listed at the front of the proposed revisions/regulations.

The proposed Form and Schedules have been annotated by the Agencies to note "New" line items. A rough count of "New" lines is about:

- Form 5500 - 30 line items
- Schedule A – 6 line items
- Schedule C – 12 line items
- Schedule H - Well over 150 lines and sublines – detailed breakouts of assets and investments
- Schedule MB – 11 line items
- Schedule R - 25 lines or subline
- Schedule J – all new over 100 line and sublines

To help identify the "New" line items, we have redacted out just the "New" lines for the Form 5500, Schedules A, C, H, MB, and R in a separate 16-page document available by "*clicking here*." We did not look at Form 5500-SF, Schedules D, E, G or SB. Schedule I will be deleted.

One of the biggest changes is the addition of a new *Schedule J – Group Health Plan Information and we* will discuss it in detail herein.

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Background

Under Titles I and IV of *ERISA* and the Internal Revenue Code, pension and other employee benefit plans are generally required to file annual returns/reports concerning, among other things, the financial condition and operations of the plan. Filing a Form 5500 Annual Return/Report of Employee Benefit Plan, or a Form 5500-SF Annual Return/Report of Small Employee Benefit Plan – together with any required schedules and attachments – generally satisfies these annual reporting requirements.

The Form 5500 is the primary source of information about the operations, funding and investments of private-sector, employment-based pension and welfare benefit plans in the U.S. The proposed revisions are intended to:

- Modernize the financial statements and investment information filed about employee benefit plans.
- Update the reporting requirements for service provider fee and expense information.
- Enhance accessibility and usability of data filed on the forms.
- Require reporting by all group health plans covered by Title I of *ERISA*.
- Improve compliance under *ERISA* and the Internal Revenue Code through new questions regarding plan operations, service provider relationships and financial management of the plan.

The proposed regulations also would make changes to the certification requirements for the limited scope audit requirements under 29 CFR 2520.103-8, and allow group health plans to use the Form 5500 to satisfy certain reporting requirements in the *Affordable Care Act* and implement the Form revisions. The Form improvements and regulatory changes are generally being coordinated with updates to the EFAST2 electronic filing and processing system.

The proposed Form/Schedule language begins at PDF page 37 and the instructions begin at PDF page 67: The proposed Form/Schedule revisions have been marked up as follows to show what changes are being made:

Meaning of descriptions of codes describing changes.

Next to the data elements, the Agencies have, to the extent feasible, indicated in brackets:

(1) "**[Current]**" if it is the same question with the same line number on both the proposal and the current form or schedule; "[Current (2016)]" indicates IRS changes and/or PBGC changes that would first be made part of the forms and schedules for the 2016 form year, respectively.

(2) "**[Current Line X]**" if the item is already on the form or schedule, but is renumbered in the proposal, to show where the item appears on the current form or schedule;

(3) "**[Current with revisions]**" to indicate, with a short explanation, that the item is already on the form or schedule, but would be revised; and

(4) "**[New]**" if the item is a new question or new to that form or schedule.

Dates generally are shown in the data element sheets (as well as the instructions) as "20**XX**" for the Form filing year; "20**XX-1**" for the prior year, etc.

A Closer Look at Schedule J - Group Health Plan Information

In this section, we will be spotlighting the new *Schedule J – Group Health Plan Information, applicable to single and* *multiemployer* *health plans*. Plan administrators will want to be aware of the new data elements that will be needed to complete the plan's 5500, once the changes are finalized.

A copy of proposed Schedule J is available by "*clicking here*." A copy of the Schedule J Instructions is available by "*clicking here*." The remaining pages of this *Client Bulletin* will take a closer look at Schedule J.

Schedule J - Overview

The proposed revisions include a NEW *Schedule J—Group Health Plan Information.* The Schedule J asks for the name of the Plan, plan number, plan sponsor's name and EIN, as well as information grouped into the following five 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*

We will take a look at the highlights of these five sections, omitting any items that do not pertain to multiemployer plans.

Part I—Group Health Plan Characteristics

This Part asks for information on the type of coverage available under the Plan and the number of persons (including participants, beneficiaries and dependents of participants) covered under the Plan at the end of the Plan Year.

- ***Who is offered coverage*** - employees, spouses, children, retirees or retirees only.

- ***What types of benefits are provided*** - medical/surgical benefits, mental health/substance use disorder benefits, pharmacy or prescription drug benefits, wellness program, preventive care services, emergency services, pregnancy benefits, vision or dental.

- ***What health funding and benefit arrangements are used–*** insured, employer assets, trust.

- ***Plan design options*** - any "grandfathered" options under the *ACA,* a high deductible health plan, a health reimbursement arrangement (HRA) or plan includes an HRA, or a health flexible spending account (FSA) or plan includes an FSA.

- ***COBRA usage*** - how many persons were *offered* COBRA benefits during the plan year, how many persons *elected* COBRA and how many persons *were receiving coverage* under the plan through COBRA during the plan year.

- ***Service Provider Rebates, Reimbursements or Refunds*** - whether the plan or plan sponsor received any rebates, reimbursement, or refunds other than those reported on Schedule A from service providers during the plan year. If so, details on such and information on the type of service provider involved - health insurance issuer, third-party administrator (TPA), pharmacy benefit manager (PBM) or other. For each rebate, reimbursement, or refund the plan received, the plan must disclose how it was used: amount returned to participants, premium holiday, payment of benefits or other.

Part II—Service Provider and Stop Loss Insurance Information

Part II has questions about service providers and stop loss.

- ***Service Providers***
  For each service provider, the filer is asked to list the provider's: name, address, and phone number, EIN, NAIC NPN.

  Examples of service providers listed include: Third Party Administrator/Claims Processor, Mental Health Benefits Manager, Substance Use Disorder Benefits Manager, Pharmacy Benefit Manager/Drug Provider, Independent Review Organization or Wellness Program Manager.

  Filers are instructed to repeat as many line entries as necessary to report all service providers under each category that have not already been reported on Schedule A or Schedule C.

- ***Stop Loss Coverage***
  Part II also has questions concerning any stop loss policy the plan may have in place. If the plan had stop loss coverage the filer needs to provide the name of insurance carrier, EIN, NAIC NPN, and the
  - ☐ Total premium,
  - ☐ Attachment point of coverage: Individual attachment point of coverage (if applicable), Aggregate attachment point of coverage (if applicable),
  - ☐ Claim Limit: Individual claim limit (if applicable); Aggregate claim limit (if applicable).
  - ☐ Policy or contract year from _______ to _______.
  - ☐ Who was insured?

Part III—Financial Information

Plans that complete Schedule H skip to Part IV. Otherwise, Part III asks for employer and participant contribution information and the timeliness of such contributions.

Part IV—Health Benefit Claims Processing and Payment

Part IV focuses on the number of benefit claims, appeals and denials; the prompt payment of such claims and the amount of claims paid. A "pre-service" claim is defined as any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. A "post-service" claim is defined as any claim for a benefit under a group health plan that is not a pre-service claim. In the proposal, ''claims'' includes both pre-service and post-service claims.

- ***Post Service Claims Submitted During the Plan Year***
  These questions ask the number of **post-service** benefit claims:
  - *submitted* during the plan year?
  - *approved* during the plan year?
  - *denied* during the plan year?
  - *pending* at the end of the plan year?
  - the number of post-service benefit claim *denials appealed* during the plan year, the number of those appeals that were *upheld* as denials and the number of those appeals that were *overturned on appeal.*

- ***Pre-Service Claims Appealed During The Plan Year***
  These questions ask the number of **pre-service** claims appealed during the Plan Year that:
  - were *upheld* during the plan year as denials, and/or
  - were *approved* during the plan year after appeal?

- ***Timeliness of Claims Payments and Amount of Claims Paid***
  In checking on the timeliness of claim payments, Part IV asks if there were any claims for benefits or appeals of adverse benefit determinations that were not adjudicated within the required timeframes? If so, the filer must provide the number of such claims and the number of such appeals.

If the Plan failed to pay any claims during the plan year within one month of being approved for payment, the filer must provide the number and dollar amount of claims not paid within one month and the number of claims not paid within three months or longer.

Finally, Part IV asks for the total dollar amount of benefits paid pursuant to claims during the plan year.

Part V—Compliance Information

Part V focuses on compliance information and asks how the Plan holds its assets and if the participant-oriented documents such as the plan's summary plan **description** (SPD), summary of material of modifications (SMMs), and summary of benefits and coverage (SBC) are in compliance with the applicable content requirements.

Part V closes by asking the plan to self-report on whether Plan coverage is in compliance with the provisions of the following statutes and regulations:

- the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)(not HIPAA Privacy and Security),*
- the provisions of Title I of the *Genetic Information Nondiscrimination Act of 2008 (GINA),*
- the *Mental Health Parity Act of 1996 (MHPA)* and the Paul Wellstone and Pete Domenici *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA),*
- the *Newborns' and Mothers' Health Protection Act of 1996* (*Newborn's Act*),
- the *Women's Health and Cancer Rights Act of 1998 (WHCRA),*
- with *Michelle's Law*, and
- the *Affordable Care Act (ACA)*

Conclusion

Big changes are in the works for the Form 5500 and schedules. Now is the time for 5500 preparers and data compliers to review the changes to the Form 5500 and Schedules to allow adequate time to prepare before the changes are implemented.

If the proposed changes would be an administrative burden, we would encourage administrators to submit comments and alternative suggestions by the October 4, 2016 deadline.

We will report on future developments as they occur. We will also take a look at some of the proposed changes to the Form 5500 and other Schedules in future newsletters.

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LEGAL DISCLAIMER: Information contained in this publication is not legal advice, and should not be construed as legal advice. If you need legal advice upon which you can rely, you should seek a legal opinion from your attorney.