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CAB 16-5

Milliman

CLIENT ACTION Bulletin
Employee Benefits

Agencies Propose New, Expanded Form 5500 Group Health Plan Reporting

SUMMARY **Group health plan sponsors would be required to provide significant amounts of information about the plans when filing the annual Form 5500 with the Department of Labor, under a recently released proposed rule from the agency, along with a separate proposed rule from the DoL, Treasury/IRS, and the Pension Benefit Guaranty Corporation. (For simplicity, this *Client Action Bulletin* refers to both sets of rules as the DoL's proposed rule.) The DoL's proposal, which affects only ERISA-covered plans, would amend the reporting and disclosure requirements for other welfare benefits and retirement plans, but this *CAB* focuses only on group health plan information, including from sponsors of grandfathered group health plans and from sponsors of certain small plans that to date have been exempt from filing. The DoL anticipates applying the new requirements to plan years starting in 2019 (i.e., filings made in 2020).**

DISCUSSION

Background on the Filing of Form 5500 by Group Health Plans

In general, ERISA-covered group health plan sponsors with 100 or more participants are required to file Form 5500 Annual Return/Report and applicable Schedules with the DoL and make them available to plan participants. Smaller plans file Form 5500-SF. The information reported helps in the DoL's and the IRS's review of a plan's financial and operational compliance, and also provides data used for research. Plan sponsors are subject to significant civil penalties for failing to comply with the reporting and disclosure requirements.

Current regulations exempt from the Form 5500 filing requirement certain plans, including those that have fewer than 100 participants (counting retirees and primary beneficiaries receiving COBRA healthcare continuation coverage but excluding spouses or dependents) at the start of the plan year and are fully insured, unfunded (i.e., self-insured), or a combination of unfunded and insured. (Filing is required for: plans that are funded (e.g., through a trust such as a voluntary employees' beneficiary association (VEBA)), regardless of the number of participants; and small plans that are multiple employer welfare arrangements with less than 25% common ownership.)

Plan sponsors that use a "wrap" plan document covering medical, dental, vision, life, disability, and other benefits may file a Form 5500 as a single plan.

Proposed Reporting on New Schedule J

The DoL's proposed rule would eliminate the small-plan filing exemption, but would retain the existing exemption for this group to provide financial transaction information on the Form 5500 Schedule G. It also would continue the exemption for filing Schedule G, as well as Schedules H and C (relating to financial and service provider information, respectively) for self-insured plans of any size. Schedule I, which currently is used to report financial information for small plans, would be eliminated.

Most notably, the proposed rule calls for all group health plans to file a new Schedule J (Group Health Plan Information). This Schedule seeks information to help the DoL improve oversight of plans' compliance with the Affordable Care Act (ACA) and other federal laws (e.g., portability under HIPAA, genetic nondiscrimination under GINA, mental health/substance abuse parity under MHPAEA), as well as to standardize data that can be used for research purposes. New Schedule J would require reporting of information about:

- *Plan characteristics,* including: the number of persons covered (broken down into employee and nonemployee categories); types of benefits (e.g., high deductible health plan, health flexible spending or reimbursement account (health FSA or HRA)); funding/benefit

arrangement; receipt of rebates/refunds (including medical loss ratio (MLR) rebates) from service providers, and use of rebates/refunds;

- *Service provider and stop-loss insurance,* including premiums, attachment point, and individual and aggregate claim limits;
- *Financial information,* including contributions received from the employer and plan participants; and
- *Health benefit claims processing and payment,* such as: post-benefit and pre-service claims submitted, denials, appeals, and appeals overturned; number of claims not paid within one month of payment approval; number of claims not paid within three months or longer; and total dollar amount of benefits paid pursuant to claims.

Other Information Reporting under Consideration

The preamble to the proposed rule also indicates that the DoL is contemplating the reporting of other significant information on Schedule J. For example, the agency is considering whether to require plans to report such additional information on denied claims as the dollar amount, the denial code, and/or whether the claims were for mental health and substance use disorder benefits or for medical/surgical benefits. Recognizing that plans may encounter definitional and data collection challenges, however, the DoL seeks comments on the reasonableness of collecting such information and, if so, the methodology a plan would employ to determine and report such information. The DoL notes that while grandfathered group health plans are not required to report such information, the proposed rule would require them to file Schedule J.

The ACA's new reporting requirements include disclosure of a broad range of information for nongrandfathered group health plans, such as enrollment, disenrollment, rating practices, out-of-network cost-sharing and payments, and quality-of-care metrics. It also calls for annual reporting of whether: the benefits under the plan improve health outcomes through various activities (e.g., quality reporting, care coordination); the plan implements activities to prevent hospital readmissions or to improve patient safety and reduce medical errors; and the plan implements wellness and health promotion activities. The DoL's proposed rule would allow for compliance with these ACA reporting requirements via the Form 5500 filings.

In addition, the DoL notes the U.S. Supreme Court's decision (*Gobeille v. Liberty Mutual Ins. Co.*) that Vermont's and, consequently, all other state-mandated all-payer health claims databases are preempted by ERISA, and seeks comments on the annual reporting requirements in light of that ruling.

ACTION All employers that sponsor a group health plan should review the DoL's proposed rule and consider the additional information they would be required to obtain, report, and disclose if the rule becomes final. In most cases, sponsors will find that the data collection will be administratively burdensome (and thus costly), requiring in many cases significant coordination with the plans' service providers to report accurate information in a timely fashion. The DoL estimates the new group health plan reporting would add 2.2 million annual burden hours at an addition cost of $241.6 million, with small plans shouldering the bulk of the burden ($223.9 million). The DoL encourages comments on the potential costs and the feasibility of providing the proposed group health plan data, as well as on the practicability of completing the new Schedule J. The deadline to submit comments to the DoL is Oct. 4, 2016.

Plan sponsors also should be mindful of the increased, inflation-adjusted civil penalties applicable to Form 5500 filing failures (and other reporting/disclosure penalties for noncompliance with the DoL's rules) that became effective as of Aug. 1, 2016. A failure or refusal to file the Form 5500, for example, increased to up to $2,063 per day (up from $1,100).

For additional information about the DoL's proposed rule on group health plan reporting on Form 5500, please contact your Milliman consultant.

