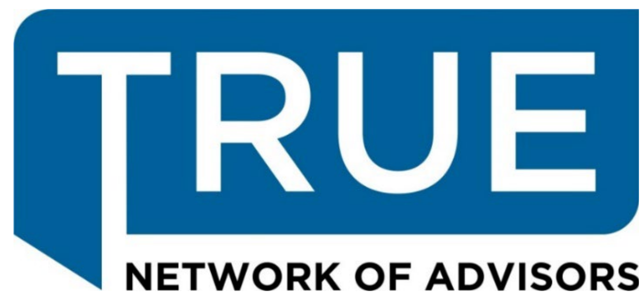
Forms 5500 & Other Benefits Reporting Requirements



Presented By:
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June 4, 2024

Agenda

- Transparency in Coverage (TiC) Reporting Requirements
- Consolidated Appropriations Act, 2021 (CAA) Reporting Requirements
- PCOR / PCORI Fee Filings
- Medicare Part D Creditable Coverage Reports and Disclosures
- Form 5500 Filings
  - Who, What, When, Where, How?
- ACA Employer Mandate Reporting (Forms 1094 / 1095)
- *Extra Credit*: Form M-1 Filings for MEWAs

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Transparency in Coverage: Public Disclosures

- Transparency in Coverage ("TiC") regulations require plans/ insurers to publish in 3 separate machine-readable files ("MRFs"):
  - Payment rates negotiated between plan and in-network providers for all covered items and services ("in-network" file)
  - Amounts plan allowed, plus associated billed charges, for covered items or services furnished by out-of-network providers ("out-of-network" file)
  - Negotiated rates for prescription drugs ("prescription drug" file)
- Departments originally deferred enforcement of prescription drug MRF requirement due to overlap with CAA RxDC reporting; however, on 9/27/23, Departments published FAQs Part 61, rescinding deferred enforcement of prescription drug MRF
- Does ***not*** apply to grandfathered plans, account-based plans, excepted benefits, STLDI, or retiree-only plans

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Transparency in Coverage: Participant Disclosures

- Plans/insurers must provide to participants and beneficiaries certain personalized cost-sharing information and underlying negotiated rates for all covered services and items:
  - Estimated cost-sharing liability
  - Accumulated amounts toward deductibles and OOP limits
  - INN negotiated rates & OON allowed amounts
  - Items and services subject to bundled payment arrangements
  - Notice of prerequisites (e.g., prior authorization)
  - Disclaimer notice
- Provide through an internet-based self-service tool with search capabilities, or paper format, if requested
- Model notice is available on the DOL's website
- Effective for plan years beginning on or after 1/1/24, must include all covered services and items

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CAA – Gag Clause Attestations

- CAA, 2021 prohibits group health plans and insurers from entering into agreements with providers, networks, TPAs, or other service providers offering access to a network, which contain "gag clauses" that restrict the plan/insurer from:
  - Furnishing provider-specific cost or quality of care info to referring providers, plan sponsors, participants/beneficiaries
  - Electronically accessing de-identified claims info for a participant or beneficiary, and/or
  - Sharing the above info with business associates
- CAA also requires plans/insurers to submit annual filings attesting to the absence of gag clauses in their agreements
- Prohibition went into effect December 27, 2020, but annual attestation filing requirement was delayed until 2023

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CAA – Gag Clause Attestations

- Next attestations of compliance due December 31, 2024
  - First filing that was due by 12/31/2023 covered compliance from 12/27/2020 through filing date
  - This year's filings will attest to compliance from date of last year's filing through this date on which you file this year
- Agencies issued FAQ guidance (Part 57), along with instructions, a user manual, and an Excel template file (Note: Excel file not needed for single employer submissions)
- Annual attestations are to be submitted through newly created "GCPCA webform" portal on CMS's Health Insurance Oversight System (HIOS) website

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CAA – Gag Clause Attestations

- Reporting Entity Type:
  - ERISA Plan – Unless your organization is a church/church-affiliate or a state/local governmental entity, then you should select this option
  - Church Plan – Only if church/church-affiliate, taking the position that its plan(s) are exempt from ERISA under the church plan exemption
  - Non-Federal Governmental Plan – Only if state/local government entity (including some quasi-governmental), taking the position that its plan(s) are exempt from ERISA under the governmental plan exemption
  - Health Insurance Issuer

- "Are you attesting for all provider agreements? Medical, PB, BHN, Other"
  - Medical
  - PB (Pharmacy Benefits)
  - BHN (Behavioral / Mental Health Benefits)
  - Other (Benefits offered under any other type of ERISA group health plan that contracts with providers/networks)

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CAA Prescription Drug (RxDC) Reporting

- **Which plans/benefits are subject to reporting on prescription drug and health care spending (*aka*, the "prescription drug data collection" or "RxDC" requirements)?**
  - **Group health plans (including grandfathered plans)**
- **Which group health plans are not subject to RxDC reporting?**
  - **Excepted benefits (*e.g.*, limited-scope dental or vision offered under separate policies, many EAPs, and fixed indemnity plans)**
  - **Account-based plans (*e.g.*, HRAs and most gap/bridge plans)**
  - **Short-term limited-duration insurance (STLDI)**
  - **Retiree-only plans**
- **DEADLINE → 2023 calendar year data was due June 1, 2024**

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CAA Prescription Drug (RxDC) Reporting

- New RxDC reporting instructions and templates available on the CMS RxDC website
  - Important relief provided in the first reporting cycle has not been renewed, including the general good faith effort relief
- Some key flexibilities:
  - Vendor coordination not required
    - Multiple vendors may submit same data file type (*e.g.*, D1) on behalf of the same plan, eliminating the need for plans to combine the data of multiple service providers into one file
  - Aggregation rule suspended
    - Data submitted in files D1 and D3–D8 may be submitted at plan or aggregate level regardless of how D2 file is submitted
  - Multiple submissions per reporting entity allowed
    - Reporting entity can make multiple submissions, so long as the content of the submissions is mutually exclusive

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CAA Prescription Drug (RxDC) Reporting

- **Key Change: Aggregation Restriction No Longer Suspended**
  - **Previously, data submitted in files D1 and D3–D8 could be submitted at plan or aggregate level regardless of how D2 file was submitted**
  - **Now, CMS plans to enforce the "aggregation restriction"**
    - **Prohibits plans from having vendors submit premium and life years data files (D1) and pharmacy benefit data files (D3–D8) "at a less granular level" than the medical benefit data reported on D2**
    - **Thus, if D2 is submitted at the plan level, then D1 and D3–D8 must also be submitted at the plan level**

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PCOR / PCORI Fees

- Patient-Centered Outcomes Research Institute (PCORI) fees for self-insured group health plan sponsors
  - For plan years ending 10/1/2023 through 9/30/2024 = $3.22
  - 2023 PCORI fee = $3.22 x Average Number of Covered Lives
  - Reported annually on Form 720 no later than 7/31 of subsequent calendar year

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PCOR / PCORI Fees

- **Plans subject to PCORI Fees**
  - **Self-insured plans, including HRAs**
  - **Does not apply to excepted benefits (*e.g.*, most FSAs)**
  - **Employers maintaining more than one self-insured arrangement can be treated as single plan for purposes of calculating fee if arrangements have same plan year**
- **Calculating Average Number of Covered Lives**
  - **Regulations provide plan sponsors of self-insured plans three alternative methods:**
    1. **Actual Count Method**
    2. **Snapshot Method**
    3. **Form 5500 Method**

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Medicare Part D Creditable Coverage Reports

- **Group health plan sponsors must submit annual notice of creditable and/or non-creditable coverage to Centers for Medicare and Medicaid Services (CMS)**
  - **ERISA and non-ERISA plans must certify to CMS that prescription drug coverage offered under the plan is either creditable or non-creditable for Medicare Part D purposes**
- **Filing is made on the CMS.gov website**
- **Deadline:**
  - **Must notify CMS within 60 days after the beginning date of the plan year (renewal year, contract year, filing year, etc.)**
  - **March 1 for calendar year plans**

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Medicare Part D Creditable Coverage Disclosures

- Notices disclosing to Part D-eligible individuals whether coverage is creditable must be provided prior to start of the Annual Coordinated Election Period (ACEP) for Part D each year (*i.e.*, before October 15 each year)
- Notices must also be provided to Part D-eligible individuals:
  - Prior to an individual's initial enrollment period (IEP) for Part D
  - Prior to the effective date of coverage for any Part D eligible individual that enrolls in employer's Rx coverage
  - Whenever employer no longer offers prescription drug coverage or changes it so that it is no longer creditable or becomes creditable
  - Upon request by the Part D eligible individual

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Form 5500 – Annual Report

- Filed on a *plan year* basis
- Calendar year in which the plan year begins dictates which Form 5500 to use
  - For example, if the plan year begins on October 1, 2023, then the 2023 version of Form 5500 should be filed for that year
- Due Date:
  - Due the last day of the 7th month following the end of the plan year (July 31 of the following year for calendar year plans)
  - Up to 2½ month *automatic* extension available with Form 5558
- There must be no gaps between ending date of one filing and beginning date of the next filing
  - Thus, changes in plan year generally require an additional "short plan year" filing

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Form 5500 – Who Must File?

- ERISA "employee welfare benefit plans" – 3 basic elements:
  1. Plan, fund or program;
  2. Established or maintained by an employer;
  3. For the purpose of providing one or more of the following listed benefits to participants and beneficiaries:
     - Medical, surgical or hospital care or benefits;
     - Benefits in the event of sickness, accident, disability, death or unemployment;
     - Vacation benefits;
     - Apprenticeship or other training benefits;
     - Daycare centers;
     - Scholarship funds;
     - Prepaid legal services;
     - Holiday and severance benefits; and
     - Housing assistance benefits.

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ERISA Plan Examples

- Health (*i.e.*, Major Medical) Plan
- Dental Plan
- Vision Plan
- Prescription Drug Plan
- Life and Accidental Death & Dismemberment (AD&D)
- Long Term Disability Benefit
- Short Term Disability Benefit
- Health Flexible Spending Arrangement (FSA)
- Health Reimbursement Arrangement (HRA)
- Health "Gap" or "Bridge" Plan (or other supplemental medical plan)
- Cancer (or other Specific Disease), Hospital, Critical Illness, or other Fixed Indemnity Coverage
- Wellness Program
- Employee Assistance Program (EAP)
- Disease-Management Program
- Telemedicine Program
- On-Site Medical Clinic
- Prepaid Legal Plan

ERISA Plan Examples – Group Health Plans

Health (*i.e.*, Major Medical) Plan

Dental Plan

Vision Plan

Prescription Drug Plan

Life and Accidental Death & Dismemberment (AD&D)

Long Term Disability Benefit

Short Term Disability Benefit

Health Flexible Spending Arrangement (FSA)

Health Reimbursement Arrangement (HRA)

Health "Gap" or "Bridge" Plan (or other supplemental medical plan)

Cancer (or other Specific Disease), Hospital, Critical Illness, or other Fixed Indemnity Coverage

Wellness Program

Employee Assistance Program (EAP)

Disease-Management Program

Telemedicine Program

On-Site Medical Clinic

Prepaid Legal Plan

Maybe, if they provide significant benefits in the nature of medical care

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ERISA Plans – Common Misconceptions

- **Cafeteria (Code § 125) Plans**
  - Cafeteria plans are merely funding vehicles that allows employees to pay for certain benefits on a pre-tax basis and avoid constructive receipt tax issues
  - Cafeteria plans, themselves, are not subject to ERISA; however, many of the benefits they fund are subject to ERISA
- **Dependent Care Assistance Programs (DCAPs)**
  - Unlike Health Flexible Spending Accounts (Health FSAs), DCAPs are not subject to ERISA but are governed primarily by the rules under Code § 129
- **Health Savings Accounts (HSAs)**
  - Generally not subject to ERISA, and the rules governing HSAs are found primarily under Code § 223
- **Fixed Indemnity Plans**

Form 5500 – Who Must File?

- Possible ERISA exemptions:
  - Church plans
  - Non-federal (*i.e.*, state & local) governmental plans
  - Voluntary plan safe harbor
  - Payroll practice safe harbor
- Also depends on PLAN SIZE and FUNDING METHOD
  - Large Plans: Yes
  - Funded Plans: Yes
  - Small AND Fully Insured, Unfunded, or Combination Fully Insured and Unfunded: No
- Unfunded plans are exempt from some, but not all, 5500 requirements
  - E.g., HRAs and Health FSAs
  - Generally will be exempt from all Schedules

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Form 5500 – Who Must File?

Must File if EITHER of these is true		
Plan Size		Funding Method
Large Plan – 100+ participants on first day of plan year	AND /OR	Funded Plan – Essentially meaning benefits are NOT paid from general assets (*e.g.*, paid from a trust)

Exempt from Filing ONLY IF BOTH are true		
Plan Size		Funding Method
Small Plan – Fewer than 100 participants on first day of plan year	AND	Unfunded Plan – Essentially meaning benefits are paid from general assets
		Fully Insured Plan
		Combination Fully Insured / Unfunded

How Many 5500s Must You File?

- A separate Form 5500 must be filed annually for each ERISA employee welfare plan that is not otherwise exempt from the reporting obligation
  - Employers can set the annual contribution amount for each employee
- Solution: WRAP PLANS
  - When multiple plans are bundled under a wrap plan document, only one Form 5500 is required each year for the bundled benefits
  - However, separate Schedule As still required for each insured benefit

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Wrap Plan Documents

Three Primary Purposes:

One Plan	Supplemental Language	Centralization
• Allows plan sponsor to treat all benefits as a single "employee welfare benefit plan" for ERISA purposes, including for purposes of filing 5500s	• Supplements benefits contracts / documents with missing provisions that are required under ERISA for plan documents and SPDs	• Consolidates welfare benefits information under central document for ease of administration

Form 5500 - Schedules

- <u>Schedule A</u>:
  - Plans that are partially or totally insured must file a separate Schedule A for each insurance policy
  - Schedule A will contain info provided by the insurance company, regarding total premiums paid, total year-end covered lives, commissions/fees paid to third parties, and claims amounts (for experience-rated contracts)
  - REMEMBER: Plans that are not insured are not required to file Schedule A
- <u>Schedules C, H, and Others</u>:
  - In general, health & welfare plans are not required to file Schedules C, H, or other 5500 Schedules, unless the plans are “funded”

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Summary Annual Reports (SARs)

- Plans that file 5500s must also distribute Summary Annual Reports (SARs) to participants, and to others entitled to receive SPDs
  - Employers can set the annual contribution amount for each employee
- SARs summarize data in 5500 filings
- Distribute SARs within 9 months after the end of the plan year (or, if the plan files for an extension, within 2 months after the end of the extension period).
  - For calendar year plans, the normal SAR distribution deadline is September 30, and the extended deadline is December 15.

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ACA Reporting & Employer Mandate

- ACA reporting is its own requirement and has its own penalties but has significant implications for employer mandate penalties
- Applicable Large Employers: 50 or more full-time employees (including full-time equivalents) in the preceding calendar year
  - ALE Group Considerations
  - Full-Time Employees = 130 or more hours/month
  - Don't forget Full-Time Equivalents
- Form 1094-C and Forms 1095-C
  - Penalties: Increased to $310 per form (x2)
  - Electronic Filing Required for all ALEs beginning in 2024

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ACA Employer Mandate – By The Numbers

	For 2024 Plan Years
Code Section 4980H(a) Penalty	$2,970 ($247.50/month)
Code Section 4980H(b) Penalty	$4,460 ($371.67/month)
Affordability %	8.39% Coverage not *affordable*—and employee may be eligible for PTC for exchange coverage—if employee's required contribution for self-only coverage exceeds 8.39% of the employee's household income. Employer avoids 4980H(b) penalty if it satisfies *Affordability Safe Harbors* using 8.39%

Form M-1 Filings for MEWAs

- MEWA = Multiple Employer Welfare Arrangement
- Does more than one company's employees (or independent contractors) participate in your ERISA health and welfare benefits? If so, are those companies in the same controlled group ("CG") or affiliated service group ("ASG")?
  - Note: ASG status, alone, may not be enough to avoid MEWA status
- MEWA with <25% common ownership among participating employers must file Form M-1
  - Registration Form M-1: At least 30 days before beginning operation, and at least 30 days before beginning to operate in new state
  - Annual Form M-1: March 1 each year (automatic 60-day extension available upon request.

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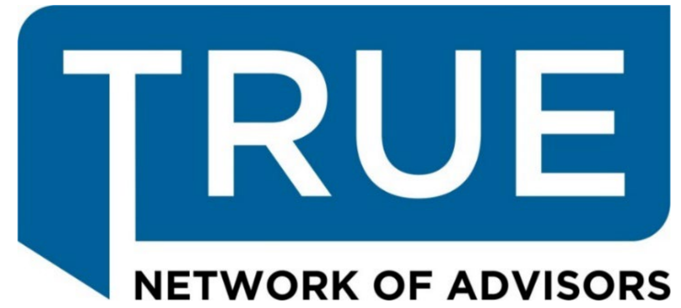

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