Final Report of the
2004 ERISA Advisory Council
Working Group

Health and Welfare Form 5500
Requirements

November 10, 2004

This report was produced by the Advisory Council on Employee Welfare and Pension Benefit Plans, which was created by ERISA to provide advice to the Secretary of Labor. The contents of the report do not necessarily represent the position of the Department of Labor.

2004 ERISA Advisory Council
Health and Welfare Form 5500 Requirements
Working Group Report

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Executive Summary

The 2004 ERISA Advisory Council formed a Working Group (Working Group) on Health and Welfare Form 5500 Requirements to assess whether the current Form 5500 is a practical and useful form of reporting for health and welfare plans to the Employee Benefits Security Administration (EBSA).
The following issues were addressed:

- Assessing the usefulness of Form 5500 data by the Department of Labor
- Exploring the possibility of establishing Forms 5500 uniquely for health & welfare plans, separate from pension plans
- Examining costs incurred and efforts made by plan sponsors and third-party administrators to prepare Form 5500
- Assessing the value provided by the existing audit requirements in the current environment

Testimony to the Working Group was provided on August 3rd and September 22nd by 4 employees of the Department of Labor, an insurance company executive, 3 service providers/plan advisors, a research professor and a representative of the accounting profession. There were no representatives who testified who are currently acting as a plan administrator. (The witnesses and their testimony are provided in the appendix and transcripts.)

After thoughtful debate and analysis of the issues and transcripts, the Working Group submits the following recommendation to the Secretary of Labor for consideration:

I. Form 5500 Short-Term Recommendations

1. Enhance Form 5500 instructions to provide more specific guidance on health and welfare requirements
    a. Publish health and welfare Q&A's or FAQ's on WWW.DOL.GOV to provide further clarification and examples.

2. Revise Form 5500 and Summary Annual Report to include such questions that would specifically capture relevant plan data focusing solely on health and welfare plans.

3. Enforce existing requirements requiring insurance companies to provide Form 5500 Schedule A to plan sponsors within 120 days after year-end.
    a. Provide mechanism for direct filing of Schedule A by insurance companies using existing EFAST system.

4. Consider providing formal guidance on reporting multiple health and welfare plans at one plan sponsor on a single Form 5500.

II. Form 5500 Long-Term Recommendation

1. Form a Department of Labor Advisory Group to research the costs/benefits of completely revamping or eliminating the existing health and welfare Form 5500 requirements.

III. Audit Requirement Recommendations

1. Maintain existing audit requirements (per Form 5500) for multi-employer health welfare plans.

2. Apply lesser reporting requirements or consider eliminating the audit requirement for health and welfare plans that have a trust but are otherwise not accumulating assets.

The Working Group believes that these recommendations will further enable the DOL to meet its goal of providing plan participants and plan sponsors with useful information to support the voluntary employee benefit plan structure for Americans and their families.

Respectfully submitted

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Introduction

The ERISA Advisory Council (Council), in a report dated November 8, 2002, studied electronic reporting of the Form 5500. One of the fundamental recommendations of the Council at that time was that the Department of Labor should expedite work to implement a next generation electronic filing system that maximizes the benefits and cost savings achieved by other best-in-class government electronic filing systems. It was recommended to:

a) Base the system structure on real-time data from stakeholders who will be participating and who benefit from use of the system

b) Develop a rough framework for the system by surveying the stakeholders for their desires with regard to the specifics of electronic filing system and

c) Form an Advisory Group consisting of stakeholders and include other agencies and vendors as well other agencies (i.e. PBGC and IRS) that will use the data collected.

In the event that implementing the above recommendations would be a lengthy process, the Advisory Council suggested a number of items to improve the current system in the interim.

Since 2002, it has been brought to the Council's attention that there are a number of issues with respect to the Form 5500 that are specifically related to health and welfare plans. The Form 5500 was initially designed as an annual report to collect information about the activity of retirement plans and has not been specifically tailored for health and welfare plans. The last time major a redesign was performed for the Form 5000 relating to health and welfare plans was for the 1999 filing year. Since then there have been minor revisions to the instructions.

The 2004 ERISA Advisory Council formed a Working Group on Health and Welfare Form 5500 Requirements to study these issues bearing in mind the recommendations noted in the November 2002 report. The Working Group's objective to study the existing Form 5500 requirements encompassed a review of health and welfare plans that require an audit as well as those that don't. The goal of the Working Group was to assess whether the current Form 5500 is a practical and useful tool for reporting health and welfare plans. Differences between health and welfare plans and pension plans led the Working Group to consider the possibility of a new separate health and welfare plan Form 5500.

The Working Group wanted to better understand

1. The use of the Form 5500 information by the Department of Labor,
2. The cost (in dollars) effort incurred by plan sponsors and third-party administrators to prepare Forms 5500 and
3. The value of the existing audit requirements (especially given the new health care regulations.)

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Definitions

- H&W plan: A health and welfare plan as defined in ERISA §3(1).
- Unfunded H&W plan: A plan whereby benefits are paid from the general assets of the employer or employee organization that sponsors the plan.
- Self-insured H&W plan: A plan that retains full obligation for plan benefits.
- Fully insured H&W plan: A plan whereby benefits are covered by the insurance company.
- Multi-employer H&W plan: A plan in which more than one employer is required to contribute that is maintained pursuant to one or more collective bargaining agreements.
- Trusteed H&W plan: A plan that has assets that are held in a trust.

Form 5500 Requirements

In general terms, all H&W plans (e.g. medical, dental, life insurance, apprentice training, scholarship funds, severance, disability, and multiple employer welfare arrangement, etc.) covered by the Employee Retirement Income Security Act of 1974 (ERISA) are required to file a Form 5500 with certain exceptions. Plans with under 100 participants that are unfunded, fully insured or a combination thereof are not required to file a Form 5500 and represent the most common exception to the general rule.

The rules result in three categories of Forms 5500 generally being filed for H&W plans.

1. A H&W plan that is unfunded completes only the three-page Form 5500. No schedules are attached, nor is an auditor's opinion and report required. These plans do not provide summary annual report information to covered participants.
2. A welfare plan that is insured or a combination of unfunded and insured typically requires a three-page Form 5500 and Schedule A prepared by the insurance carriers and a Summary Annual Report (SAR).
3. A welfare plan that is funded using (typically) an IRC §501(c)(9)VEBA trust or other type of trust requires a complete Form 5500 with an opinion and report of the independent accountant, Schedules A, C, H, and a separate SAR.

Mr. Joseph Piacentini, head of the Department of Labor’s (DOL or Department) Office of Policy and Research, testified that there are approximately 6 million ERISA covered welfare plans; of which 2.5 million provide health benefits. The number of such plans filing Form 5500s in 2001 was 89,000 and 49,000 respectively. In each case, this represented less than 2% percent of the total H&W plan universe.

Use of Information by the Department of Labor

The Council requested that representatives from the Department of Labor testify regarding how the Department uses the information in a health and welfare plan's Form 5500. Mr. Piacentini testified that The Office of Policy and Research uses the data to develop statistics and conduct economic research on relevant employee benefit topics. However, it was noted that H&W Forms 5500 are just one of the many data resources accessed by the DOL research staff. Historically, the DOL staff has used Form 5500 to supplement other data sources, rather than as a sole or primary basis for statistics or research. The uses generally have been occasional and driven by specific data needs. The DOL views the entire inventory of filings as a database that might be used to answer some statistical and research questions.

Mr. Piacentini testified that he does recognize that the DOL is only able to obtain such information for a fraction of all welfare plans because most H&W plans are not required to file or are required to file and mistakenly do not file the Forms 5500. Mr. Piacentini testified that the use of this database is additionally influenced by the nature of the policy questions that confront DOL staff, as well as by the scope and content of alternative data sources. There are a number of data sources well-suited to addressing such questions, some developed at least in part for the express purpose of addressing them.

The Office of Policy and Research from time to time has used the Form 5500 data set in conjunction with other sources to fill certain information gaps and in conjunction with other sources for several purposes. Overall, Mr. Piacentini testified that the Form 5500 information is only used occasionally (every year for one purpose or another) by the Office and that they probably look at other data sources with greater frequency and constancy. Much of the information that's in the data set is not used very often for research or other purposes.

Mr. Dennis Quigley from the Department of Labor's Office of Enforcement testified that during fiscal years 2001 through 2003, his office completed 13,940 civil investigations with monetary results of nearly $2.8 B. Of that total number of investigations, over 30 percent related to H&W plans that provided a broad range of welfare-type benefits. Twenty-five percent of that total involved those plans providing medical benefits.

Mr. Quigley noted that EBSA has traditionally always had a presence in H&W plans, particularly in multi-employer collectively bargained plans. In recent years, as a result of rising healthcare costs and changes to the traditional healthcare delivery system, EBSA has increased its commitment of enforcement resources to targeting an investigation of health benefit plans. The agency's focus in this area is to ensure that plans are paying benefits, are being operated prudently, and in the participant's sole interest. In addition, EBSA looks to validate that plans that are funded are financially and actuarially sound.

Investigations are identified through a variety of sources, including complaints from participants or others, media reports, referrals from the national office or other governmental agencies, computer targeting, and reviews of the Form 5500. Therefore, depending on the issues to be reviewed, they may or may not use the Form 5500 as the basis for initiating an investigation. Mr. Quigley testified that in most instances the Form 5500 is not the primary source of identification for targeting purposes.

Use of Information by the Department of Labor (continued)

Oftentimes they do not use the Form 5500 to make a decision to open an investigation. Mr. Quigley testified that the most common abuse for H&W plans is in the area of small unfunded medical plans that are not required to file Form 5500s that find themselves in a position not to be able to pay benefits at some point in time, either because of the economics of the business itself going bad or some other reason. It is not uncommon for people to contact the DOL and complain when they have not been receiving benefits, and that initiates the reviews.

Since the single employer plan filing universe is not complete (because most plans are exempted from filing), EBSA had to select a target sample for a 2001 Health Disclosure and Claims Issue ("HDCI") project by going through a Dun & Bradstreet listing and comparing the list with the filers, and then calling these employers to inquire if they had a health plan. It was noted that this was a very difficult process as it was time consuming and resource intensive.

Mr. Quigley testified that reviewing Form 5500 data for multi-employer plans is particularly helpful in deciding to review their operations because the range of potential issues is much broader than for single employer plans. In addition to reviewing disclosure and benefit payment issues, they may also look at investment practices, trustee expenses and specific items like insurance rebate issues.

In a study that the Office started in 2001, of the 1,300 investigations, about one-fourth to one-third (approximately 400 investigations) were of multi-employer plans. This has always been an area of concern because of the unique nature of multi-employers plans, and the large amount of money that they take in and pay out, and have to handle from year-to-year.

Mr. Quigley also testified that his office gets some very substantial information from the Schedule A about the insurance arrangements, the premiums being paid, the commissions being paid, the agencies being used to provide the insurance, and if there is any financial information on the backside for rate refunds.

The Department of Labor was also asked their thoughts regarding the usefulness of the health and welfare audit requirement. Mr. Quigley testified that he believes the audit requirement serves as a discipline to ensure that the data that is filed with the DOL on the Form is reliable and accurate for the agencies that use the data for enforcement, disclosure, or research purposes.

Plan Sponsor Issues

There was much witness testimony regarding plan sponsor confusion surrounding the Form 5500 requirements for health and welfare plans. ERISA §3(1) defines an employee welfare benefit plan as a plan, fund, or program established or maintained by an employer or employee organization to provide certain benefits for participants or their beneficiaries.

Plans providing the following types of health and welfare benefits, whether insured, funded, or self-funded, are subject to ERISA:

- medical, surgical, or hospital benefits
- some employee assistance programs,
- sickness or accident benefits
- disability benefits
- death benefits
- supplemental unemployment or vacation benefits
- apprenticeship, or other training programs
- day care centers
- scholarship funds
- prepaid legal services
- severance pay
- life
- prescription drug
- vision

Janice Wegesin, JMW Consulting Inc., testified that many employers are not aware that their benefit program(s) constitute an ERISA plan and as a result, Form 5500 filings are not prepared when required. Welfare plans vary greatly in design and operation affecting the Form 5500 filing requirements. Whether or not a plan is considered funded has significant impact on the Form 5500 requirements. There are certain DOL exceptions under technical releases and regulations that have limited the number of plans that are considered funded. The witness testified that many employers don't know these rules exist and have difficulty interpreting them and their effect on their plans.

Ms. Wegesin also noted that many plan sponsors and administrators are unaware that annual reporting may be required for an uninsured and non-contributory welfare plan. Section 2520.104-20 of the Department's regulations exempts from the annual reporting requirements those welfare plans that cover fewer than 100 participants and which provide benefits from the employer's general assets, or from insurance contracts if certain specified conditions are met, or from both of those sources.

Sponsors and administrators of uninsured non-contributory plans that would qualify for this exception, but for the fact that the plan covers 100 or more participants, are frequently unaware of the filing obligation. Those who are aware of the filing obligation generally question the usefulness of a report for such plans. This is particularly the case with respect to plans that provide benefits on an infrequent basis, such as a severance plan. The lack of awareness of a filing obligation may be understandable.

Plan Sponsor Issues (continued)

Mr. Jeffrey Capwell, McGuire Woods LLP, noted in his testimony, for example, the sponsor of a typical severance plan arrangement does not generally consider an employee to be a participant in the plan unless the employee has had a termination of employment that would entitle him or her to receive benefits. However, the Department's regulations defining participant status make it clear that all employees who could qualify for severance benefits if they were terminated must be treated as participants covered under the plan, and thus count towards the 99 participant ceiling for the annual filing exemption.

Another issue with which plan sponsors struggle noted by several witnesses is determining the definition of the H&W plan. This is typically done through the collection of the plan documents, summary plan descriptions, and Form 5500 filings for those plans. According to testimony of Ms. Wegesin a plan sponsor typically has no difficulty presenting the documentation and filings relating to its qualified retirement plans. However, it is frequently an entirely different story for its welfare benefit plans. Although an IRC §125 cafeteria plan document may exist, the documents for the medical, dental, and life insurance plans may consist solely of the employee booklet issued by the insurance carrier. For some benefits, the only document may be the information presented in the employee handbook. Further complicating the identification of the H&W plan subject to Form 5500 reporting is the ease with which welfare benefit plans change over the years.

A common question among sponsors and administrators is whether multiple H&W plans can be reported on a single annual report. As one witness testified that, prior to 2002, many advisors counseled clients that all of the welfare plans that provided substantive benefits under an IRC §125 cafeteria plan could be reported on a single report because the plans had a common relationship. They were all funded, and related to, and could provide benefits under that plan. At that time, Schedule F was used to report the information covering a cafeteria plan.

This approach provided little relief for plans for which there was no common relationship. There is also no guidance or official position for the DOL that this approach is reasonable. Thus, many plan sponsors have drafted a plan document that acts as a “wrap” document for the purpose combining their H&W plans into a single entity for Form 5500 reporting purposes. Mr. Capwell testified that plan sponsors who do not have sophisticated advisors/vendors are generally unaware of this plan-drafting technique and file separate reports for each one of their welfare plans. This process generally takes longer than the preparation of a single report, and can lead to more errors and omissions in the preparation process.

Typically, plan sponsors review the Form 500 instructions to assist in determining the requirements, but in many cases the instructions are focused only on pension plan information, thus, making it difficult to determine specific H&W requirements.

Another issue is the question regarding covered participants on the Form 5500 specifically as it related to health and welfare plans. Many witnesses testified that sponsors and administrators of H&W plans are frequently confused by the instructions for completing the questions regarding number of participants and there is little specific guidance for H&W plans. Reporting “participant count” is offered as an example of areas in which clarity is needed and for which confusion exists. The Form 5500 instructions go into great detail about the kind of information that pension plans (defined benefit, defined contribution, etc.) need to

Plan Sponsor Issues (continued)

report. In contrast, H&W plan sponsors are instructed to review the regulations to determine which employees qualify as participants and are required for inclusion on the Form 5500.

Collection of Schedule A data is another significant problem for the plan sponsor. Insurance companies are required to provide Schedule A data to plan sponsors under ERISA, but this rule does not appeared to be enforced. Plan sponsors that are unable to obtain Schedule A data are being left to decide what information to provide and directed by Form 5500 instructions to note on Schedule A any refusal on the part of the insurance company to provide the data. It is unclear how you note that on the form given its current format and the way in which you have to prepare that filing. Ms. Janice Wegesin testified that clients tell her that Schedule A is not being sent to them automatically and that it takes multiple calls and follow-up with the vendors to receive this information.

Often, participant counts or other data are missing. Schedule information is sometimes mistakenly forwarded to the broker involved in the sale of the insurance and it is the broker's failure to forward that information to the plan sponsor that causes the gap in data collection. One witness testified that their client had attempted to collect approximately 160 Schedules A from the various insurance carriers. Collecting all of the required Schedules A can be quite labor intensive and costly. Many carriers will not provide Schedule A if that portion of the plan covers less than 100 participants. ERISA requires insurers to provide the plan administrator with the information required to be reported on the Schedule A, to certify its accuracy within 120 days of the close of the plan year, and requires plan administrators to attach the insurer's statement to Form 5500.

Ms. Bauserman, Mercer Consulting, testified that the process doesn't really track what the statute seems to require. The Schedule A does not include a place for the insurer to attest to the accuracy of the information on the form and, in fact, the insurers typically don't actually complete a form Schedule A and send it to their clients. Instead, they send the information that they think the employer needs to report using their own format. Witnesses testified that in certain instances information that's not needed on the Schedule A is sent, information in the pre-1999 format is sent or improper/inadequate information is sent. Some insurers do not meet the 120-day deadline or never report the information at all.

The preparation of Form 5500s for H&W plans can be costly for plan sponsors with multiple plans, taking away from precious monies to fund health care benefits. Ms. Wegesin testified that costs for Form 5500 filings generally start at $500, with higher fees being charged depending upon the complexity of the arrangement and the number of Schedules A required to be filed. Internal costs, including time spent gathering and organizing information needed to prepare information including the financial statements and time associated with the administration of an audit, if applicable, can be quite high.

Service Provider /Plan Advisor Issues

Many of the issues affecting plan sponsors also affect service providers who are preparing the Forms. Service providers who are knowledgeable regarding H&W plan Form 5500 requirements spend a significant amount of time educating plan sponsors on the requirements. One witness testified that often times service providers find themselves struggling to validate the need to file or defending the value of filing other than replying "it's the law." They also must discuss the risk of not filing including explaining the IRS Voluntary Compliance Programs and other amnesty-type programs. Service providers who are not knowledgeable struggle with the requirements just like the plan sponsors. Many tax form preparers do not have the skills necessary to properly advise the plan sponsor about welfare plan reporting, so merely continue to prepare only those Form 5500 filings that the sponsor has historically filed.

The Schedule A issue also affects the service providers in that the practitioner preparing Form 5500 usually has little or no influence with either the broker or the insurance company and must rely on the plan sponsor to obtain the Schedule A data.

The difficulty aggregating the financial information for the H&W plan is exacerbated, as one witness testified, because the H&W plan itself is an "unnatural reporting entity." Financial information is not available from a single source nor accumulated in a single place, such as the employer's general ledger (which accumulates the employer's records for the financial statements). This results from the various forms of H&W programs within a plan (e.g. funded versus unfunded, insured versus self-insured) and the multiple service providers being used. This is contrary to the typical defined benefit pension or defined contribution plan that uses an outside trustee/recordkeeper to process all transactions and maintains a de facto "general ledger" for the plan.

Participant Issues

Ms. Alice Wunderlich, AICPA, testified and it is the sense of the Working Group that participants find little use for the Form 5500 or financial statements for H&W plans. Such filings provide no information regarding the plans' ability to pay benefits when due, because the plans are not required to be funded, nor are plan sponsors required to fund or maintain benefits (unless required under a collective bargaining agreement).

In a single-employer defined benefit H&W plan, both participants and the plan sponsor often contribute to the plan. Usually a set dollar amount is withheld from a participant's paycheck for employee and dependent coverage. This employee withholding plus the plan sponsor contribution are used to purchase insurance coverage or otherwise pay for benefits. Any shortfall is paid by the plan sponsor. In a single-employer corporate-sponsored plan, the plan's financial statements may not necessarily be an indication of the future probability of the plan's ability to pay benefits because the plan sponsor eliminates the deficit for plan costs in excess of plan assets, including participant contributions and sponsor contributions previously made to the plan. The plan's financial statements may well show a deficit position when, it is in fact, a financially healthy plan.

Participant Issues (continued)

As further noted by Ms. Wunderlich, since the ultimate obligation to pay benefits rests with the corporate plan sponsor, it is the financial health of the plan sponsor, not the funded status of the plan itself, that determines the likelihood of participants receiving benefits they were promised. Thus, the representation by the financial statements of a single-employer corporate-sponsored plan, while reflecting plan liabilities and obligations and contributions made by the sponsor and employees, may not be fully meaningful in assessing whether the plan has the ability to pay current and future benefits. Unlike audited financial statements for defined contribution or defined benefit pension plans (which provide important information on investment returns or funding levels for benefits), decisions of health benefit elections involve information that is not included in the statements, such as benefit coverages, deductibles, preexisting condition limitations, etc.. Neither participants nor plan sponsors particularly care about the investment returns in the H&W plan context.

These funded H&W plans must provide an SAR to covered participants. However, as noted above, the information does not really provide data that affects participants' benefit choices or assures them of continued coverage.

Ms. Wunderlich further commented that often times for single employers, several different plans are used to provide different kinds of welfare benefits to employees. For example, medical benefits may be provided from one H&W plan while dental benefits are provided by another. One H&W plan may be funded and require an audit while the other is not. While each H&W plan has its own separate ERISA reporting requirement, employees may view their health and welfare benefits as all part of the same menu of employee benefits, even though they may in fact be participating in 4 or 5 different H&W plans. This disaggregating arrangement is rare in 401(k) savings plans and defined benefit pension plans, where an employee typically does not participate in more than one 401(k) plan or pension plan during employment by one employer. A participant would need to look at the financial statements of all the H&W plans to get the full financial picture of the collective H&W plans in which all of the different health and welfare benefits are being provided to the participants.

In multi-employer plans, H&W plan financial statements indicate the plan's ability to provide benefits to participants. Payments of current and future benefits depend on the amount of the plan's net assets and obligation (e.g. funded status) and on the ability of the plan to bill and collect future employer contributions. Because multi-employer plans have assets against which plan obligations may be measured, they provide an indication of the plan's ability to pay benefits when due. As such, the financial statements of multi-employer plans provide exceptional value to readers and users of the H&W plan’s financial statements

Audit Issues

Ms. Bauserman, Ms. Wunderlich and Ms. Wegesin all commented on numerous difficulties in performing the audit of the health and welfare plans. Most single employer defined benefit H&W plans are unfunded and do not require audits. However, there are a number of such plans that are funded by the sponsor or the employees or both and do require an audit. The common way a single employer may become subject to

Audit Issues (continued)

the ERISA audit requirement is by using a voluntary employees beneficiary association IRC §501(c)(9) trust, ("VEBA trust") or another type of trust as a funding vehicle for some or all of its H&W benefits. A typical use of a VEBA trust is to pre-fund benefits and then deduct the pre-funding amount on the company's tax return, thereby gaining an accelerated tax deduction. Often there are few assets in a VEBA trust because of the limitations on such accelerated deductions. Funded plans also include multi-employer plans, sometimes referred to as union plans, in which more than one employer is required to contribute to the plan pursuant to one or more collective bargaining agreements. There are many issues with respect to the audit that are unique to H&W plans.

The audit requirement is for the H&W plan not the trust. However, this requirement is often times misinterpreted by the plan sponsor and/or auditor and they inappropriately produce a report for the trust, rather than the H&W plan, or do not reflect activity that may have occurred outside of the trust.

Also, many of the H&W plans under audit have activity that does not flow through the tax-exempt trust. A significant portion of audit time is spent determining that activity and in most cases auditing it. One auditor reported that in many cases, H&W plan audit work involves transactions and issues that are not related to the tax-exempt trust, which is the reason that they have the audit.

Preparing the financial statements is time-consuming. It requires a thorough understanding of the H&W plan, its insurance arrangements, claim payment process and the resulting accounting, and collection of data for many outside service providers, as well as sources within the plan sponsor. Because the financial statements are complex and there is generally a lack of readily available information, and the preparation requires significant accounting knowledge, the auditor is often relied on to prepare the financial statements. Even when the plan sponsor drafts the statements, in many cases the auditor spends a considerable amount of time assisting the plan sponsor in the drafting.

In some situations, companies use the VEBA trust or another type of trust as a conduit to make benefit payments, which triggers an audit requirement. But, in fact, those companies maintain nominal or zero assets in the trust nor do they establish a portfolio strategy because of the limitations on accelerated tax deductions. It is not uncommon to see only cash or a short-term investment instruments in the VEBA trust while the plan is being funded on a pay-as-you-go basis without accumulating assets. In these situations, witnesses testified and it is the sense of the Working Group that the audit does not provide any value in protecting participant contributions or benefits.

It is clear that an audit itself requires a significant amount of time and resources. Because of the complex nature and constant changes to our U.S. medical delivery and insurance programs, auditing medical expenses incurred by a plan participant is a complicated process that requires specialized knowledge of various payment and accounting systems, and medical information.

When detailed health information such as provider invoices, data from the administrator, and explanation of benefits is provided to the audit team, the auditors rarely receive sufficient corresponding descriptions with which to interpret that information, making it extremely difficult to verify the correctness of the information. For example, auditors have limited capacity to recognize

Audit Issues (continued)

procedural codes on an outpatient service, determine the propriety of the pricing of the service codes given the geographical location of the provider, and ensure adequate network discounts were provided to the plan sponsor.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") also significantly affects H&W plan audits. Audits of medical plans necessitate auditor access to protected health information, such as support for paid claims. Outside service providers require the auditor and the plan sponsor to sign confidentiality agreements. The plan sponsor is also required to sign a business associates agreement with the auditor. Several different accounting firms reported that it often takes months for the attorneys of the service provider, auditor, and plan sponsor to agree on the wording of these agreements. The service providers often withhold needed claims information from the auditors, claiming HIPAA restrictions. There is significant negotiation among the parties before reaching agreement on what information is to be made available to the auditors. Witnesses testified that as much as 30% of the cost of the audit can be a result of negotiating these agreements.

To comply with HIPAA privacy provisions, auditors are required to maintain the privacy of any protected health information in their working papers. This means identifying every work paper, both electronic and hard copy, that contains protected health information, and implementing and monitoring restrictions on access to those working papers for as long as those working papers are retained, generally five years. The auditing firm must have firm-wide policies and procedures in place to meet compliance requirements, which can be quite burdensome.

All of these issues are multiplied by the number of service providers involved. Outside service providers change frequently requiring the agreements to be renegotiated each year.

Costs for a health and welfare audit, as one witness testified based on their survey costs for audits, range from $8,000 up to $50,000. One accounting firm noted that their auditing fees for H&W plans are three to four times that of 401(k) plans and that these fees have increased dramatically the past several years. The witness testified that one of her clients reported the annual cost relating to its welfare plans is approximately $30,000 for one audited welfare plan and 9 insured arrangements. Each of those insured arrangements has no more than three Schedule As and perhaps only one for most of them. That $30,000 cost does not include any time attributable to employees of the plan sponsor who are involved in compiling data or working through the issues during the audit. It also did not cover the actuarial costs that are associated with developing the other benefit obligation information.

Fees have dramatically increased over the past several years because of changes in our U.S. health care system delivery and payment systems, and the impact of HIPAA. Factors affecting the audit fee include the size of the plan, the number of participants, the types of benefits offered in the plan, the number of outside service providers, quality of plan record-keeper, and the plan sponsor's ability to prepare the financial statements.

Working Group Observations and Discussion

The Working Group discussed the objective of the Form 5500 in the context of witness testimony.

Mr. Canary of the DOL testified that the objective of the information provided on the Form 5500 has multiple purposes for consistency of meeting the requirements in Title I of ERISA.

The first is information collection, where that information is collected for enforcement purposes, research purposes, and public disclosure purposes. Mr. Canary also commented that the Form 5500 is an annual report that serves as a discipline in terms of plan management where, as part of the statute, commits the H&W plan administrators and other parties involved at least annually to prepare this report and do the work that would be necessary to prepare the report, which imposes sort of an annual discipline to manage the plan, keep the plan's data, and be able to put that into an annual report. The Working Group noted that it did not appear that the objectives were being met since only 2% of health and welfare plans were filing Form 5500s.

Based on testimony from the Department of Labor, it is currently not clear that the information gathered from H&W Form 5500 filings is used in an extensive manner. Some of the information is used in a limited manner to fill gaps in research information or to target plans for enforcement purposes. However, it was noted by Mr. Piacentini of the DOL that the gaps in research information could be filled by other means. It was also noted by Mr. Quigley of the DOL that most of the targeting of H&W plans originates from participant complaints, not from using Form 5500 as a reference tool. The question arises whether or not the limited use by the Department of Labor justifies the cost of preparation of the Form. One witness testified that the cost of filing these Forms is a minimum of $500 per Form. Based on approximately 90,000 filings per year, it appears plan sponsors may be spending an estimated amount of a least $45,000,000 each year to file these Forms. It is likely that this estimate is conservative as there are many plans with Form 5500 fees in excess of $500 due to multiple Schedule As and other plan complexities. In addition, there are in-house costs incurred by plan sponsors to pull together information for the Form 5500s and costs incurred by the DOL to support the process.

It was unanimously agreed by the Working Group that the Form 5500 requirements for H&W plans need some type of revision.

The Working Group explored the following three alternatives:

1. Starting from scratch and completely overhauling the Form 5500
2. Revising the Form 5500 in its current state or
3. Eliminating the Form 5500 requirement completely.

Complete Overhaul of Form 5500

The Working Group noted from an "information collection" standpoint, the best alternative would be for the DOL to start from scratch and completely reinvent the Form based on comments and guidance received from the end users, i.e., Department of Labor, plan sponsors and participants. If the Form is going to be

Working Group Observations and Discussion (continued)

revised extensively to include additional information regarding benefits and plan design, then plan sponsors, participants and the DOL would be interested in this kind of information. In order to obtain the best data, all H&W plans would need to be required to file. This alternative while providing the most information would be costly for the Department of Labor to implement especially given the constraints of the existing EFAST software. It would also be costly for service providers who would have to completely revamp their systems for reporting purposes. Plan sponsors would also incur a great burden as the percent of health and welfare plans required to file Form 5500s would increase from 2% to 100%. The Department of Labor would have to ensure that the benefits outweighed the costs prior to considering this alternative.

Revising Form 5500

Revising Form 5500 would be a band-aid approach to fixing some of the items that cause the most confusion and cost to plan sponsors and service providers. For example, expanding areas in the instructions to provide specific guidance for completing questions for health and welfare plans such as the number of participants. The Working Group agreed that while this would reduce some of the confusion experienced by H&W plans on a short-term basis, a longer-term approach was still necessary. An area of concern commented on by all witnesses was the Form 5500 Schedule A requirement. There are a number of short-term approaches that could be considered to streamline the Schedule A process to make it less burdensome for plan sponsors and third party administrators preparing Form 5500s.

Eliminating Form 5500 Completely

The Working Group also discussed the possibility of completely eliminating the Form for all H&W plans if the information is not being used extensively by the Department of Labor. The cost savings on behalf of plan sponsors could be used to provide more health and welfare benefits. Also, as several witnesses testified there are other existing avenues right now where that information could be obtained rather than adding to the 5500, or revising the 5500. However, most of the information is shared on a voluntary basis and it is not comprehensive.

Audit Requirements

Lastly the Working Group discussed the audit requirement for H&W plans. Unlike audited financial statements of multi-employer H&W plans, defined contribution plans such as a 401(k) savings plans or defined benefit pension plans in which the investment returns funding levels are relevant to a participant's benefit, single employer H&W plan financial statements do not provide all the information necessary upon which participants may predict the likelihood that they will receive current and future benefits.

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Working Group Recommendations – Form 5500

Four Short-Term Recommendations
1. Enhance the existing Form 5500 instructions to provide more specific guidance on health and welfare requirements (e.g. definition of a plan, definition of a participant, etc.). Consider publishing health and welfare Q&As or FAQ's to be included on the Department of Labor web site to provide further clarification and examples.

2. Consider revising Form 5500 and Summary Annual Report to include such questions to allow the DOL to continue to meet its goal of protecting plan participants. One witness suggested that a separate health and welfare schedule should be created that would specifically capture H&W plan data focusing solely on H&W plans.

a) A suggestion is made to review Form M-1, for multi-employer welfare plans ("MEWAs") for a series of questions about compliance with the mandates that apply to health plans.

b) Review new requirements under the Medicare modernization act to prevent duplicative reporting.

3. Enforce existing requirements requiring insurance companies to provide Form 5500 Schedule A to plan sponsors within 120 days after year-end. The Department's reporting regulations require the administrator of a plan to include in an annual report the insurance contract information which carriers are required to provide pursuant to ERISA §103(a)(2). Consider providing mechanism for direct filing of Schedule A information with DOL by insurance company keeping in mind limitations of existing EFAST system.

4. Consider providing formal guidance on reporting multiple welfare plans on a single Form 5500. The DOL should indicate when and under what circumstances multiple welfare plans can be filed on a single report. Specifically, formalize the position on this issue in guidance that would generally be available to plan sponsors and administrators.

One Long-Term Recommendation
Form a Department of Labor Advisory Group to research the costs/benefits of completely revamping or eliminating the existing H&W plan Form 5500 requirements.

- Actively seek guidance from end users (participants, plan sponsors and DOL) to determine the specific information (and population of plans) which would be useful to be included on the Form.
- Coordinate with the plan sponsors and service providers regarding the burdens of system revisions.
- Consider "negotiated rule making" as part of the process.
- Consider a one-time filing similar to a top-hat plan whereby an updated filing is only required for plan changes if it is determined that all H&W plans must file.
- Re-examine the SAR format in light of participant concerns and consideration given to providing more useful data to participants in H&W plans.

Working Group Recommendations-Audit Requirements

1. Maintain existing audit requirements for multi-employer health and welfare plans.

2. Evaluate whether the current financial reporting and audit requirements for single employer defined benefit health and welfare plans cost effectively meets the needs of DOL participant protection and the needs of other potential users of plan financial statements.

   - Consider applying lesser audit requirements (e.g. claims audits) or eliminating the audit requirement for H&W plans that are funded but are not accumulating assets. (This could be accomplished by expanding the relief afforded by the non-enforcement policy provided by technical releases 88-1 and 92-01.)

   - Consider limiting the audit requirement to include only the components of the plan that are funded by the trust.

Summary

It is important for the DOL to fulfill its responsibilities under Tile I of ERISA and its obligation to protect plan participants by collecting data about health and welfare plans. However, the DOL should consider identifying the data that is useful and meaningful specifically relating to health and welfare plans and weigh the cost/benefits of collecting that data, as well as alternative sources. The current requirement that results in Form 5500 filings being prepared for a small percentage of the population with limited data appears to be more bothersome and costly to plan sponsors and the information does not appear to be particularly useful to participants, plan sponsors and to some extent regulatory agencies.

Summary of Witness Testimony – August 3, 2004

Summary of Testimony of Joseph Piacentini, Deputy Director for Research and Regulatory Analysis, US Department of Labor, Washington DC

Mr. Piacentini testified that there are three main functions of the Office of Policy and Research. First, in the satisfaction of a statutory mandate contained in ERISA Section 513, the Office of Policy and Research develops statistics and conducts economic research on policy relevant employee benefit topics. Second, the office supports the Assistant Secretary and other agency and administration officials in pension and health benefits policy formulation, and legislative activity. Third, the office lends economic perspective to the formulation of agency regulations in order to promote economically beneficial policies.

The witness further testified that in order to carry out these functions successfully, the office requires access to detailed data on employee benefit programs. Form 5500 filings are just one of the many data sources that are tapped. Historically, they have used the filings to supplement other data sources, rather than as a sole or primary basis for statistics or research. The uses generally have been occasional and driven by specific data needs. The Office of Policy and Research uses data to develop statistics and conduct economic research. They focus their attention not so much on individual filings, as on large compilations of filings that represent large classes or populations of welfare plans viewing the entire inventory of filings as a database that might be used to answer some statistical and research questions.

Mr. Piacentini testified that the use of this database is influenced by its scope. Small welfare plans, meaning those with fewer than 100 participants that are fully insured or unfunded are not required to file Form 5500s. As a result, filers represent only a fraction of all welfare plans. He estimated that there are approximately 6 million ERISA covered welfare plans; two and a half million of which provide health benefits. The number of such plans filing 5500s in 2001 were 89,000 and 49,000 respectively. In each case, less than 2 percent of the total.

He further testified that the use of this database is additionally influenced by the nature of the policy questions as well as by the scope and content of alternative data sources. For example, policy questions often pertain exclusively to health benefits, to the exclusion of other welfare benefits. They often involve the circumstances and choices of plan sponsors, employees, or both. There are a number of data sources well-suited to addressing such questions, some developed at least in part for the express purpose of addressing them. These include surveys of employers, such as the Medical Expenditure Panel Survey Insurance component which is carried out by the Census Bureau in collaboration with the Agency for Healthcare Research and Quality. Also, the National Compensation Survey, carried out by the Bureau of Labor Statistics. The surveys also include household surveys, such as the Census Bureau's Current Population Survey, and Survey of Income and Program Participation. While these and other survey data sets provide detailed information about employers, households, and their health insurance choices, welfare plan Form 5500 filings provide information on the internal financial operations of welfare plans.

Mr. Piacentini said that the Office of Policy and Research has used the Form 5500 data set in conjunction with other sources to fill certain information gaps. In one example, when EBSA undertook a project recently to measure health plans compliance with certain provisions of ERISA, it was necessary to identify a representative sample of all plans to study. The Form 5500 data set provided an effective basis to draw a sample of multi-employer plans. Additionally, in the past they have relied on the Form 5500 data set in conjunction with other sources for several purposes. In one such example, the Regulatory Flexibility Act requires federal agencies to analyze the economic impact of its regulatory actions on small entities. EBSA defines small entities as employee benefit plans with fewer than 100 participants. There is no single data source that directly identifies small health or welfare benefit plans. They have used the Form 5500 data set to characterize the large plan universe, and thereby back-out from other data sources measurements of the small plan universe.

In another example, they have used the Form 5500 data set together with employer survey data to help assess the incidence of insured and self-insured health benefits, a distinction with implications for the applicability of state law. In a third example, they have used the data set together with 10-K filings with the Securities and Exchange Commission, and other sources, to examine welfare benefit plan cost trends in certain stressed and declining industries.

Summary of Testimony of Dennis Quigley, Chief, Division of Field Operations, Office of Enforcement, US Department of Labor, Washington DC

Mr. Quigley testified that the Office of Enforcement oversees the investigative operations of 15 field offices across the country. The staff is responsible for ensuring by oversight that field offices are being consistent in application of the statute, and following policies and procedures, and to provide some national guidance in establishing national enforcement priorities. EBSA is responsible for administering the provisions of ERISA as they relate to nearly 730,000 pension and 6 million welfare plans, principally those that are providing medical benefits. And EBSA conducts investigations of plans through its 10 regional offices, and 5 district offices located in major cities around the country.

The witness said that during fiscal years 2001 through 2003, EBSA completed 13,940 civil investigations with monetary results of nearly 2.8 billion dollars. Of that total number of investigations, over 30 percent related to Health and Welfare plans. Twenty-five percent of that total involved those providing medical benefits. EBSA leverages its enforcement resources by emphasizing efficient targeting, and protection of at-risk populations. Targeting allows EBSA to focus its resources on issues and individuals where the most serious potential for ERISA violations exist, and on situations that present the greatest potential for harm.

Mr. Quigley said that EBSA has traditionally always had a presence in health and welfare plans, particularly in multi-employer collectively bargained plans. And in recent years, as a result of rising healthcare costs and changes to the traditional healthcare delivery system, EBSA has increased its commitment of enforcement resources to targeting an investigation of health benefit plans. The agency's focus is to ensure that plans are paying benefits are being operated prudently, and in the participant's sole interest. They also look to see that plans that are funded are financially and actuarially sound.

EBSA's role in the healthcare area has also expanded as a result of the enactment of legislation that included regulatory and enforcement requirements to be implemented by EBSA. A new Part 7 was added to ERISA in `96, and included the Health Insurance Portability and Accountability Act, the Mental Health Parity Act I, the Newborn and Mothers Health Protection Act and the Women's Health and Cancer Rights Act.

In fiscal year 2001, EBSA initiated a special project focusing on health disclosure and claims issues, called the HDCI project to establish a statistically valid baseline of compliance with the new requirements under Part 7. During this project, EBSA regional offices conducted nearly 1,300 investigations, and the results of these investigations have provided us with a clearer picture of the state of overall compliance with the new Part 7 requirements, as well as providing us with specific information about areas that need special enforcement and compliance assistance attention.

Mr. Quigley testified that investigations are identified through a variety of sources, including complaints from participants or others, media reports, referrals from the national office, or other governmental agencies, computer targeting, and reviews of the Form 5500.

The requirements for health and welfare plans to file 5500s differ depending on the size of the plan, and its funding status. The majority of small under 100 participant plans file nothing at all, and the larger plans file only limited information if they are unfunded or fully insured. Plans that are funded and provide benefits through a trust mechanism file substantial financial information that is used to make decisions to investigate or not. Therefore, depending on the issues to be reviewed, the agency may or may not use the 5500 as the basis for initiating an investigation.

When they began the HDCI project in 2001, they selected the sample by going through a Dun & Bradstreet listing, and then comparing that with the filers, and then calling them and asking them if they had a health plan, a very hard process; time consuming and resource intensive.

Reviewing 5500 data for multi-employer plans is particularly helpful in deciding to review their operations because of the range of potential issues is much broader than for single employer plans. In addition to reviewing disclosure and benefit payment issues, they may also look at investment practices, trustee expenses and specific items like insurance rebate issues.

Many EBSA offices have also conducted reviews of insured single employer plans based on data in the 5500 Schedule A to determine if they were handled properly.

The witness testified they oftentimes do not use the 5500 to make a decision to open up an investigation. They find that people will come in and complain when they have not been getting benefits paid, and that initiates our reviews. They select plans for review sometimes because of the nature of their investment holdings, for instance, to make sure that they are prudently being operated. They also take a look at with whom the plan is dealing, particularly in the insurance world, to make sure they don't have prohibited transactions arise.

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Summary of testimony, Scott Albert, Division of Reporting Compliance, US Department of Labor, Washington DC

Mr. Albert testified that the responsibility of the Division of Reporting Compliance is simply to do what they can to affect the ERISA database to make sure the required data required exists and that it is timely, complete and accurate. There are various programs to make sure that this mission is achieved. The ERISA database is built primarily on the information that comes off of the Form 5500.

Mr. Albert further testified that the mission of the Division of Accounting Services is to make sure that audits are performed in accordance with generally accepted auditing standards and the financial statements are prepared in accordance with the applicable requirements.

The witness testified that there were 105 cases of welfare benefit plans that have filed late for this past year. The total plans that participated in the Delinquent Filer Voluntary Compliance Program were a bit over 25,000, 38 percent of which or roughly 9,600 of welfare benefit plans. A lot of the administrators don't know they have a welfare benefit plan filing requirement, particularly when they cross that 100th participant threshold or milestone. Funded plans file late due to complications in the audit. There are complications in the audit because the auditor has difficulty in getting information, doing some test work, coming up with questions that have to be answered.

Mr. Albert said that one big difficulty in filings that plan administrators complain about is getting the Schedule information from the insurance companies. A lot of insurers will generate a Schedule A or at least the information to be included on it for policies that cover 100 lives or more but not for policies with fewer than 100 lives. Some of these welfare benefit plans are a conglomerate of different types of coverages or multiple policies. They're not getting information on all of the policies contained within that plan. If they have multiple policies, life, dental, disability, and health, in the XYZ employee benefit plan and they want to prepare and consolidate the filing for the whole thing, they sometimes have trouble getting Schedule A information from the insurance company because the insurance company simply says, "We don't do that for policies that have fewer than 100 lives."

The health and welfare filings appear to be simple and oftentimes have just a 5500 and a Schedule A. If they're funded, there aren't a lot of assets or there are assets, but they are not all that complicated. The multi-employer plans are more complicated.

A lot of the focus in the division has been on pension plans, only because with the new EFAST system, they have been enhancing the targeting practice and the way they casework to take advantage of all of the technology that is available.

Most of the plan administrators that participate in the DFVC program are viewing each contract as a separate plan, rather than considering them all as one plan. The advantage that some of them have argued, at least with the DFVC program or any filing to reduce filing costs is if the plan is unfunded, fully insured, you won't kick off an audit requirement on all the components. If you consolidate it, it's all one filing, instead of ten different filings. Providing that there is no plan document that says this is one huge plan, they can disaggregate.

Mr. Albert testified that his division just makes sure whatever should be there is there. If there is supposed to be a statement or a footnote on post-retirement, post-employment benefits, then it had better be there. And the accountant's opinion had better be written correctly.

If there is anything that suggests there is a problem with a plan, the division would make a referral to the Office of Enforcement. And with the welfare plans, there hadn't been all that many to have an audit.
The division scans the footnotes of the financial statements for anything that suggests there is a problem in the plan operationally that may or may not be reflected in the 5500.

The chief accountant has often spoken at conferences about the value of looking at claim payments and that there could be an opportunity for fraud because there are a lot of people and providers involved.

Of the 88,000 plans that file, 11 percent reported having assets. Approximately 90 percent of the health and welfare plans are not audited because they don't have assets. There could be abuses in plans that don’t file Form 5500s or have audits such as cafeteria flex arrangements with employee contributions.

Summary of Testimony of Janice M. Wegesin, JMW Consulting Inc., Palatine, IL

Janice Wegesin is President of JMW Consulting, Inc. in Palatine, Illinois. Her firm specializes in compliance work associated with qualified retirement plans and welfare benefit arrangements. She is author of the Form 5500 Preparer's Manual and is a member of the American Society of Pension Actuaries. Ms. Wegesin presented the views and experiences of ASPA members.

Ms. Wegesin listed a number of problems that an employer faces. Sometimes, employers do not know whether a given benefit program constitutes an ERISA plan, nor do they know enough to ask that question. As a result, Form 5500 filings are not prepared when needed.

She gave examples from her professional experience. She stated that the documents for the medical, dental, and life plans may consist solely of the employee booklet issued by the insurance carrier. For some benefits, the only document may be the information presented in the employee handbook.

She stated that many tax form preparers do not have the skills necessary to properly advise the plan sponsor about welfare plan reporting, so merely continue to prepare only those Form 5500 filings that the sponsor has historically filed. They follow the “SALY” (same as last year) principle. No thought is given to changing circumstances and benefit structures and the impact on Form 5500 reporting.

She has found that an employer whose business begins to expand doesn't realize that there is a Form 5500 filing requirement. Ms Wegesin did emphasize that it is rare that employers are purposely avoiding filing Form 5500 for their welfare plans.

Ms. Wegesin described that bundled products offered by a single insurance carrier 10 years ago required only a single Form 5500 filing. If the employer subsequently added other benefits through a

separate carrier, the employer may have just expanded the reporting on the Form 5500 for the new benefit. If all H&W benefits were unbundled in the past and are now offered by multiple separate insurance carriers and perhaps operate on different policy years, separate plans filings are required.

In preparing for this hearing, ASPA members were surveyed, who are routinely involved in Form 5500 preparation for welfare plans. It was unanimously agreed that these types of filings should be eliminated if, in fact, it is shown that none of the data being collected is being analyzed for any purpose.

She stated that the insured welfare plan often presents data collection problems. For example, one employer has a welfare plan that covers more than 41,000 employees nationwide. The plan is a combination of insured and unfunded and attempted to collect approximately 160 Schedules A from the various insurance carriers but could only account for 147 Schedules A.

Ms. Wegesin spoke on the difficulties in securing Schedule A and noted that DOL is aware of the problem from many discussions with ASPA that there is no apparent enforcement of this rule. ASPA has been told by members that Schedule A is not being sent to them automatically, that it takes multiple calls and follow-up with the vendors to receive this information. And often, participant counts or other data are missing or Schedule A information is forwarded to the broker involved in the sale of the insurance.

When discussing costs, the ASPA survey shows preparer costs for Form 5500 filings in those first two categories of unfunded or insured and unfunded generally start at $500. Higher fees will be charged depending upon the complexity of the arrangement and the number of Schedules A required to be filed. The cost also depends on whether it is the responsibility of the employer or the preparer to collect Schedule A data.

Large plans requiring an audit have costs ranging from $8,000 to $50,000. One accounting firm noted that their fees for health and welfare plans are three to four times that of 401(k) plans and that fees have increased dramatically the past several years. Additional costs result from the time attributable to employees of the plan sponsor who are involved in compiling data or working through the issues during the audit and the consulting costs that are associated with developing actuarial benefit obligation information.

She has seen that some accountants inappropriately produce a report for the trust, rather than the plan, or do not reflect activity that may have occurred outside of the trust. Many of the health plans under audit have activity that does not flow through the tax-exempt trust, and a significant portion of audit time is spent determining that activity and in most cases auditing it.

Ms. Wegesin reports that she frequently sees companies use the VEBA trust as a conduit for payments and collection of premiums, triggering an audit requirement even though they maintain very little or no assets in the trust. In these situations, she stated that the audit does not provide any value in protecting participant contributions or benefits.

Audits of medical plans necessitate auditor access to protected health information, such as support for

paid claims. Outside service providers require the auditor and the plan sponsor to sign confidentiality agreements. In order to comply with HIPAA provisions, plan sponsors also require the auditor to sign a business associates agreement. Several different accounting firms reported that it often takes months for the attorneys of the service provider, auditor, and plan sponsor to agree on the wording of these agreements.

She observes that outside service providers change frequently resulting in the protocol established in one year not necessarily applying in the following year. In addition, there is high turnover in staff at many of the outside service providers, which adds time for the auditors and the plan sponsor.

Many health and welfare plans have obligations associated with them, such as the incurred but not reported (IBNR) claims or post-retirement benefit or post-employment benefits. The financial accounting for these obligations is required under SOP 01-2, but it is not consistent with the Form 5500 reporting.

ASPA states that the utility of the audited financial statements is limited. Unlike audited financial statements for defined contribution or defined benefit pension plans, which provide important information on investment returns or funding levels for benefits, decisions of health benefit elections involve information that is not included in the statements, such as benefit coverages, deductibles, preexisting condition limitations, et cetera. Neither participants nor plan sponsors particularly care about the investment returns in the welfare plan context.

This litany of issues illustrates a variety of factors that should be considered by the working group. One ASPA recommendation is to consider a lesser reporting requirement and auditor scrutiny to welfare plans that are funded but which really have no assets than to plans that maintain substantial assets and push the funding limits under the Internal Revenue Code.

ASPA members have noted that sponsors of self-insured plans generally assume compliance with the regulations without any mechanism in place for monitoring application of the employee contributions to paid claims. In short, employers assume the plan is not funded for reporting purposes and that no audit is required.

The ASPA survey also netted multiple comments about the confusion surrounding Form 5500 reporting for cafeteria plans. In notice 2002-24, IRS formally suspended the filing of Schedule F for fringe benefit plans, including cafeteria plans, educational assistance plans, and adoption assistance plans. However, welfare features of cafeteria plans must still continue to be reported on Form 5500. Many people who read the notice understood it to say that Form 5500 filings for cafeteria plans were eliminated. Several years have now passed, and employers and practitioners are starting to realize they may have read the notice too broadly and are faced with a gap in Form 5500 filings.

To make more efficient use of data time and other resources, ASPA requests the following should be considered. The Form 5500 is primarily designed to collect information about the activity of retirement plans. If specific data is needed for analysis by the DOL, perhaps the creation of a Schedule W that specifically captures welfare plan data would be more appropriate than filing a square peg, the welfare plan, in a round hole, a retirement plan-oriented filing.

Data currently provided on multiple Schedules A could be condensed to a few lines of summary data on "Schedule W". And more pertinent questions could be included, such as whether the coverage is in force and premiums are current or if the application of employee contributions meets the requirements of the plan asset regulations.

Further, the Summary Annual Report (SAR) format should be reexamined in light of participant concerns and consideration given to providing more useful data to participants in both welfare benefit and retirement plans.

Since welfare plans are more volatile in terms of plan design, Ms. Wegesin stated that it is important to communicate meaningful information about the state of the welfare plan to the participants, rather than a recitation of global facts and figures that cannot be translated into significant information for the individual.

Regarding the DOL interest in seeking ways to promote electronic filing of Form 5500, ASPA made recommendations on September 20th, 2002 submitted comments in response to the RFC on the proposal dubbed EFAST-2. Part of the RFC presented the possibility of billing capabilities for EFAST to accept Schedule A directly from carriers. It is highly doubtful the direct filing of Schedule A is in any way feasible. E-filing, however, is more attractive if simplified and consolidated information streamlines the collection of data, shrinks the number of filings required, and reduces the preparation time.

Ms. Wegesin concluded by noting that it is important to collect the data about welfare plans that enables the DOL to meet its obligation to protect plan participants. It is also important to consider the differences between the information needs and concerns of welfare plan participants and retirement plan participants and to address those differences by providing them with truly meaningful information.

Summary of Witness Testimony – September 22, 2004

Summary of Testimony of Judy Bauserman, Mercer Human Resource Consulting

Judy Bauserman is a senior consultant heading up the healthcare and group benefits team at Mercer, human resource consultant in Washington. They have about 35 legal professionals who assist Mercer's consultants and clients and meet their health and welfare group benefit retirement and other human resource objectives within the legal parameters. Mercer Consulting has more than 4500 employees, serving about 5,000 employers and other organizations

Ms. Bauserman's comments focused on three broad areas: the mismatch between the important features of health and welfare plans and the more pension-focused information that is requested on the Form 5500; the administrative challenges in gathering from insurers the data needed to be reported on the Schedule A; and the value of the financial information and the auditors report that it's required to be reported and included in the report for funded health and welfare plans.

Ms. Bauserman recommended that the DOL should consider creating a separate schedule for the Form 5500 focused solely on health and welfare plans, revising the Schedule A filing procedure considerably, and eliminating or limiting the financial audit and financial information reporting for a large number of health and welfare plans.

The main challenge for health and welfare plans preparing the 5500 is that the form has historically been focused primarily on pension plans, and the instructions are focused on pension plan information, and it's difficult for health and welfare plan sponsors to figure out what information the Department is really seeking. For instance, for the participant count the instructions to the form go into great detail about the kind of information that pension plans need to report. But with respect to health and welfare plans they instruct the user to go look at the regulations, whereas, there are about five paragraphs of description for pension plans.

In addition, there are pieces of information that are requested on the Schedule H, which must be filed only for funded health and welfare plans, and, as a result, only funded plans respond. But some of this information could be useful for unfunded health and welfare plans. One example is a question on the Schedule H that asks whether the employer, if the employer failed to transmit participant contributions on a timely basis.

And, similarly, the Schedule H asks about plan mergers, and that information could be relevant to unfunded health and welfare plans. Employers often consolidate several types of benefit programs under a single ERISA plan, and they have historically had multiple separate ERISA plans and merged them together. The department might like to know that. They stopped filing for the plans that get merged in, and the Department only learns that if there was a funded arrangement as part of the mix.

Ms. Bauserman recommended that one way to resolve this might be to move some of those questions off of the Schedule H onto the main 5500. Another way might be to just create a separate schedule that would be focused solely on health and welfare plans where the instructions might be a little bit more elaborate with regard to the information requested and make it easier for the plan sponsors and plan administrators to actually report the information.

Ms. Bauserman further testified that another challenge for many health and welfare plans is getting the information that they need from their insurance carriers to report the required information on the Schedule A. The reporting requirement necessitates attaching a Schedule A for each insurer that provides coverage under the plan, and many plans have numerous insurers, and there are some clients that have in excess of a hundred Schedule A's that must be attached to their Form 5500.

ERISA requires the insurers to provide the plan administrator with the information required to be reported on the Schedule A and to certify its accuracy within 120 days of the close of the plan year. It also requires the plan administrators to attach the insurer's statement to the Form 5500. However, the process doesn't really track what the statute seems to require. The Schedule A does not include a place for the insurer to attest to the accuracy of the information on the form and, in fact, the insurers typically don't actually complete a form Schedule A and send it to their clients. Instead, they send the information that they think the employer needs to report and using their own format, sometimes including information that's not

needed on the Schedule A but perhaps was in the pre-1999 version and sometimes not reporting the information that is needed. Some insurers do not meet the 120-day deadline and some, in fact, never report the information to their clients at all.

In addition, plan sponsors and administrators on the Form 5500 must attest to the accuracy of the form and all of the schedules that are attached. However, this is difficult if insurance companies don't report accurately.

Ms. Baurserman testified that one recommendation could be that if the insurer fails to provide the Schedule A on a timely basis, the plan sponsor could simply check that they have not attached it because they have not received it. But the DOL would be aware that the insurer did provide benefits under the plan, and if they wanted to pursue enforcement of the ERISA requirement, they would have the information to be able to do that. And the Schedule A could then include a place for the insurer to attest to the accuracy of the form and allow that responsibility to lie with the insurer, where ERISA seems to place it. Electronic filing of the schedule A could alleviate some of the issues.

She also testified that plan sponsors and administrators face considerable challenges in properly reporting financial information on a Schedule H and getting an auditor's report to be able to attach it on a timely basis. Many of these challenges result from the unique funding arrangements of health and welfare plans, and the Department of Labor recognized these unique arrangements when they created the non-enforcement policy providing relief from certain reporting requirements, as well as the trust requirement in technical releases 88-1 and 92-01. And if the relief that that non-enforcement policy applies were carried all the way through the reporting requirement to encompass also the financial reporting and audit requirements, the process would be simplified considerably and less costly for plan sponsors.

However, in some cases, plan sponsors create a trust to hold some of the funds associated with the plan for reasons completely unrelated to ERISA. There may be trust holding part of the assets of the plan and other assets related to the plan are not held in trust. Many auditors take the view that the entire plan, not just the benefits being paid out of the trust, must be audited. And so in these cases, the auditor is obligated to review not just the assets in the trust but also the benefits that are provided outside the trust if they are part of the same ERISA plan. And this broad scope of the audit makes the process more complicated than it might be, for example, in the pension arena, where assets that belong to the plan are all held in the trust, so all of the money flows to one place, and the records that the auditors have to review are generally easier to get at than when some of the money is in the trust and some if it is not.

The financial information, from her perspective, that participants receive from the Schedule A is of little value to them because, for welfare plans, the benefits provided generally are not dependent upon the sufficiency of assets in the trust. Instead, the benefits are defined by the terms of the plan, and the employer is responsible for providing those benefits under the terms of the plan, regardless of whether the trust exists or has sufficient assets to do so.

ERISA gives the Department of Labor the authority to exempt any welfare plan from all or part of the reporting and disclosure requirements in Title I. The agency could exercise this authority to state that the non-enforcement of the financial and audit reporting requirements contained in the non-enforcement policy would extend to apply to all plans that otherwise would be eligible to rely on the release, even if

they have, in fact, established a trust to hold some or all of the assets.

Alternatively, the Department of Labor could narrow the financial and audit reporting requirements to encompass only the components of the plan that are funded by the trust. This would reduce the time and expense associated with the broader scope audit that occurs now.

Mercer's fees for assisting clients to prepare these forms and the associated summary annual report vary considerably, depending upon the number of Schedule A's to be attached and whether the plan must report financial information and attach an auditor's report. An unfunded plan with very few Schedule A's, the cost can be less than a thousand dollars, whereas we have one employer that has 18 different plans, some of which have in excess of a hundred Schedule A's and a few of which have must report financial information and attach an auditor's report. The fees in that case are in excess of $100,000, so there's a very broad range of fees.

In terms of timeliness of audits, this is an area where plan sponsors have a lot of difficulty trying to get the auditor's report in time to file their Form 5500s. The audit process is quite difficult due to the broad range of information that must be reviewed, and so it's hard on everybody involved, both the plan sponsors and the auditors to gather all of the necessary information to get access to all of the information in order to complete the reports. And so this is often a reason employers have to file their forms late or are down to the last day and frantically trying to get all of the information in.

The HIPPA privacy rules have had an impact in the area of the plan audit. For the auditors to perform their tasks, they must review certain health information that is protected by the privacy rules in order to verify that the plan payments are being used in accordance with the plan. The auditor signs a business associate contract agreeing to protect the information but these contracts are difficult to negotiate and sometime claims processors are still unwilling to share protected health information with the auditors. The privacy rules have made it difficult for auditors to perform health and welfare audits.

Ms. Bauserman concluded that its not clear how the Department of Labor uses much of the information that's collected on the Form 5500 for health and welfare plans, and by revising the form to tailor it more to health and welfare plans, they could enable their plan sponsors to focus their very limited resources on providing benefits to participants and beneficiaries rather than on filling out extensive forms that do not necessarily lead to any information of value for the Department of Labor.

Summary of Testimony of Peter Kelly, Chief Employee Benefit Consultant, Blue Cross Blue Shield Association

Peter Kelly is the Chief Employee Benefits Counsel for Blue Cross Blue Shield Association. Peter has recently gone in-house after 30 years in private practice, and he's currently chair of the ABA Committee on Employee Benefits.

Mr. Kelly testified that the Form 5500 is a process that takes an awfully lot of activity on the part of many different people over a relatively lengthy period of time. And where there are impediments in that process, each impediment, since it appears to be a sequential process, is going to both slow down the process and make it more expensive.

Mr. Kelly further testified reporting standards are a serious and important part of ERISA. ERISA is designed to ensure that there's some oversight, some opportunity for plan participants and the independent auditors who are their representatives in financial matters to have reliable and timely information about the financial affairs of the plan. It's a serious obligation.

That obligation has a subset that runs directly to the insurer. There is, in Section 103, direct obligation on insurers to provide certain information.

Mr. Kelly testified that there was a disconnect between what has evolved in the compensation practices for brokers and agents and what's required by Schedule A. A single Schedule A can get quite difficult. If you go through the interpretations that have come from the Department and you read carefully through the rules and instructions, it's pretty clear that each and every agent or fee recipient from the insurer has to be individually listed.

You get into all kinds of problems in terms of the fee arrangements and the compensation arrangements that are made with brokers and agents in a modern context where they don't relate to a particular employer plan. They may relate to a group or a line of business, they may not relate to a group or line of business. The service they may provide may cross many lines, and it creates a problem in allocating to individual plans.

What essentially happens at that very earliest stage of this process, where you need quick turnaround of 120 days, an insurer has to aggregate all these different service arrangements that arguably fall within this bucket they have to report on Schedule A, and they have to aggregate them all and then somehow disaggregate them all among the different accounts. The slicing and dicing problem becomes extremely difficult.

Mr. Kelly suggested that where there is a clear and direct connection to the particular plan, what Schedule A now requires should be done, which is an individual, single listing of that broker or agent. But there should be a way where it's possible within the 120 days to come up with a group listing with some kind of a bottom-line allocation to the plan, as opposed to an item-by-item, line-by-line slicing and dicing of the various services.

There may be contracted service providers who are not providing original placement brokerage or retention brokerage. They're not doing brokerage at all. They're doing something that, traditionally, the insurer has done with its own employees, or they're doing some special purpose support to the insurers activities that really is kind of a core insuring function that one always thinks of as something that's provided for the premium, in return for the premium. And they don't quite fit under the general agent category. In some states, that category really isn't even used in the health context at all. So that exception doesn't apply in some states because you don't have a general agent for health coverage. It's for other property and casualty.

Mr. Kelly said that getting the stakeholders in the room in a negotiated rulemaking for a re-design of the 5500 makes a lot of sense. Similar examples include the reportable events negotiating rulemaking over at the PBGC was a classic example of reporting that benefited from this; the MEWA rulemaking; the qualified child support order rulemaking that took place here within the Department are examples where

that worked. This may be a good example where negotiated rulemaking can see if there's someway to be true to the statutory requirement of disclosure, to be transparent.

Mr. Kelly concluded that reporting is an important part of ERISA, and we should preserve that. But we should do it in a way where we don't frustrate each other or make it difficult for one another.

Summary of Testimony of Jeffrey Capwell, McGuire Woods LLP

Jeffrey is a partner with the law firm of McGuire Woods and leads the employee benefits practice for the firm's Charlotte, North Carolina, office.

Mr. Capwell testified that he noticed a number of recurring difficulties which sponsors and plan administrators face in understanding and meeting their reporting responsibilities. These difficulties arise from the current structure of the Department of Labor's annual reporting requirements for welfare plans and from certain specific information requirements contained on Form 5500 and its related schedules.

Mr. Capwell said that the issues with respect to plan reporting fall into two general categories. The first category relates to the general structure of the department's reporting regime for welfare plans as set forth in Subparts C, D, and E, of the department's rules and regulations for reporting and disclosure under ERISA. These issues concern the extent and scope of the reporting obligations imposed on plans by those regulations. The second category of issues are those created by the specific requirements of the form itself. The specific requirements of the form and the manner in which the form is structured present certain difficulties and burdens for plan sponsors and administrators that, in my opinion, should be considered and addressed.

First, problems with the annual reporting requirements. The first category here is annual reporting for uninsured non-contributory welfare plans. Many plan sponsors and administrators are unaware that annual reporting may be required for an uninsured and non-contributory welfare plan

Confusion about filing and concerns with its usefulness is also caused by the fact that there is very little information relating to such plans, and because the information that is provided on the form typically does not change from year to year. Finally, the Internal Revenue Service's decision in 2002 to abandon reporting for fringe benefit plans has lulled some sponsors and plan administrators into an erroneous belief that uninsured non-contributory arrangements are exempt from all annual reporting requirements.

The second issue is one concerning combined plan filings. A common question among sponsors and administrators is whether multiple welfare plans can be reported on a single annual report. Prior to 2002, many advisors counseled clients that all of the welfare plans that provided substantive benefits under an Internal Revenue Code Section 125 cafeteria plan could be reported on a single report because the plans had a common relationship. They were all funded, and related to, and could provide benefits under that plan, and because information covering a cafeteria plan was otherwise required to be provided on the form, specifically Schedule F as then in use. This approach provided little comfort, however, with respect to plans for which there was no common relationship. Although there was anecdotal evidence that the department would allow multiple welfare plans to be reported on a single report, there's apparently no

official statement of this position in any published guidance, and many advisors question whether such an approach is permissible. As a result, many sponsors have taken steps to create a plan document for the sole purpose of unifying the reporting of their welfare plans. These plans, which are typically referred to "wrap" plan documents, are generally nothing more than a shell document which incorporates by reference the plan documents for the plans that provide the substantive welfare benefits. While wrap documents may serve the purpose of combining plan documents into a single place and thus facilitate plan administration, they are for practical purposes merely a device to facilitate a single Form 5500 filing. Employers who do not have sophisticated advisors are generally unaware of this plan-drafting technique and file separate reports for each one of their welfare plans. This process generally takes longer than the preparation of a single report, and can lead to more errors and omissions in the preparation process.

Completing Schedule A continues to be one of the most nettlesome issues in annual reporting for welfare plans. Despite the official estimate that the schedule should take approximately two hours to complete for a small plan and eight hours to complete for a large plan, plan administrators may spend significantly greater amounts of time in attempting to obtain the information necessary to complete the form. The problem lies in the fact that the information requested on the form is not readily available to the plan administrator, but must be requested from insurance carriers and then transcribed onto the schedule. Although some carriers are diligent about providing this information to their customers, others are slow, and a smaller number are uncooperative. Information that is received is sometimes incomplete, thus requiring successive attempts to follow up with carriers for the missing information. In addition, the plan sponsor or plan administrator sometimes may inadvertently transcribe erroneous information from the carrier onto the schedule. Finally, the instructions to the form provide no guidance to plan administrators of what they should do if they are unable to obtain from a carrier all the information requested on the form with respect to a policy. Instead, the instructions indicate that any refusal by a carrier to provide information should be noted. There are many circumstances in which all of the information cannot be provided because of a reason other than a refusal by a carrier to provide such information, such as the delivery of only partial information, or the inability to locate persons with a carrier who are capable of responding to inquiries regarding Schedule A.

A second issue on Schedule A deals with a confusion over covered contracts. Administrators and sponsors of self-insured health benefit plans are frequently confused about whether information relating to a stop-loss policy should be reported on the form. Although the instructions on the form attempt to clarify the issue by noting that only those stop-loss policies which are assets of the plan must be reported -- that's specifically in the instructions for Line 7 of Schedule A -- plan sponsors and administrators routinely misunderstand this rule and provide information about such policies where none is technically required under the schedule.

A third item, Form 5500 itself, the questions regarding covered participants. Sponsors and administrators of welfare plans are frequently confused by the instructions for completing the questions regarding number of participants. See Page 16 of the 2003 instructions. The instructions to the form, which reflect a general bias toward reporting of pension benefit plan information, provide little guidance on how these questions should be answered for welfare plans. For example, Line 7(c) of the form regarding retired or separated participants entitled to future benefits seems to have little relevance to a welfare plan, and frequently generates confusion and questions from those who complete the form.

In addition, Mr. Capwell noted the following list of recommendations for the Working Group to consider.

- Consider expanding the filing exemption for uninsured non-contributory welfare plans.
- Consider whether the exemption for small plans should be limited to plans with less than 100 participants
- Consider providing formal guidance on reporting multiple welfare plans on a single Form 5500. The department should indicate when and under what circumstances multiple welfare plans can be filed on a single report. Specifically, the department should consider formalizing its position on this issue in guidance that would generally be available to plan sponsors and administrators. For example, it may be appropriate for such guidance to be added in some fashion to the instructions to Form 5500.
- Consider requiring direct reporting by carriers of information requested on Schedule A
- Consider revising the following questions on the Form 5500 itself:
  - Clarify questions and instructions relating to "stop-loss policies"
  - Clarify questions and instructions relating to "number of participants" questions on Form 5500 as they relate to health and welfare plans. This is Line 6 and 7 specifically of the main 5500 form.

**Summary of Testimony of Phyllis Borzi, Research Professor
School of Public Health and Health Services, George Washington University Medical Center**

Phyllis Borzi is a Research Professor in the Department of Health Policy in the School of Public Health and Health Services at the George Washington University Medical Center. She is also an attorney with O'Donoghue & O'Donoghue, LLP, in Washington, DC. However, Ms. Borzi addressed the Working Group as an individual with extensive experience with ERISA and its reporting and disclosure requirements and with group health plans and health care issues, and as a health care consumer.

Consistent with other witnesses, Ms. Borzi testified that the current Form 5500 requirements for health and welfare plans are useless and provide no useful information to plan participants, plan sponsors, consultants, advisors, or the Department of Labor, even though studies show employees view group health care as the most important benefit an employer can offer its employees. However, in contrast to other witnesses, Ms. Borzi recommended that the Form 5500 reporting requirements for health and welfare plans not be reduced or eliminated, but rather that the Working Group take a closer look at what information might be valuable and would make the Form 5500 useful.

Ms. Borzi stated that, as long as employer-sponsored health plans comprise the network through which a majority of people get their health care coverage, it is important to plan sponsors, workers and retirees and their families, policymakers, the Department and other federal agencies, and academics and researchers to have important information about these plans, including:

- number and types of plans offered;
- plan structure (including benefit design features such as covered benefits, co-insurance, cost sharing features);

- who is responsible for paying claims (*i.e.*, is the plan fully insured, self-insured, or both, and with or without stop loss or other reinsurance);
- financing methods; and
- solvency protections.

This information would assist the Department with its responsibility to make sure that benefits promised are actually provided. This information would also be useful to participants in understanding what their plan benefits are and whether they are going to receive the benefits that have been promised. This information is not currently on the Form 5500 and portions of it are not currently required to be disclosed in the plan's summary plan description.

Ms. Borzi made three specific recommendations. First, all health and welfare plans should be required to annually file at least a simple report with the Department providing basic information about:

- the plan sponsor (*e.g.*, industry, location);
- employee information (*e.g.*, number of full-time employees and part-time employees);
- participant information (*e.g.*, number of active participants and retiree participants);
- benefit information (*e.g.*, the types of benefits provided); and
- funding method for each benefit (*e.g.*, fully insured and name of insurer, self-insured and with or without stop loss or other reinsurance, assets held in a trust, or any combination of these).

Because of regulatory exemptions, Form 5500 is currently only required to be filed by welfare plans with more than 100 participants. As a result, the Department does not even know how many of these plans exist. An annual filing requirement for all plans will assist the Department in understanding the universe of plans and enable policymakers to evaluate legislative and regulatory proposals using actual plan data.

In addition, Ms. Borzi testified that an annual filing by all welfare plans will assist the Department in its enforcement activities. Specifically, Ms. Borzi stated that she has observed a disconnect in the marketplace between the ERISA-compliant insured products employers think they are buying and the insurance product the insurance carriers are selling. The most obvious shortfalls are in the areas of summary plan descriptions and fiduciary responsibility.

The brochures, booklets, and certificates provided by insurance carriers rarely include all of the information required by the Labor Regulations to meet the requirements for summary plan descriptions, including the statement of ERISA rights. However, employers are not aware of this deficiency. Similarly, insurance carriers generally only accept fiduciary responsibility for making claims decisions. The employer retains all other fiduciary responsibility and plan administrator responsibilities, even if the employer is unaware of this. The Department cannot effectively assist these employers with complying with the applicable ERISA requirements because the Department doesn't know these plans exist in the absence of an annual reporting requirement.

Ms. Borzi's second recommendation is to redesign the Form 5500 used by welfare plans to focus the information on the plan sponsor and the plan itself. The revised Form 5500 should require the plan sponsor to disclose:

- the benefit choices available to participants;
- the participants to whom benefits are offered;
- the plan's eligibility requirements;
- whether the same options offered to all employees;
- the specific options available to different groups of employees;
- the number of employees in each type of plan; and
- the types of covered benefits offered (perhaps in a checklist form).

Additional questions regarding the funding of benefits should also be included, some of which are already on the existing Form 5500.

Finally, Ms. Borzi's third recommendation is for the Department to establish a regular procedure or working group that monitors the reporting and disclosure requirements imposed on ERISA plans by other federal agencies and coordinate those requirements wherever possible. For example, an employer who wants to apply for the subsidy available under the Medicare Part D prescription drug benefit must submit an annual certification describing the employer's retiree prescription drug benefit. Schedule B of Form 5500 could be revised to provide a uniform reporting requirement that discloses plan benefit information for participants and satisfies the Medicare Part D certification requirement.

Ms. Borzi noted that the biggest challenge to revising Form 5500 is balancing the need to collect information that is user-friendly to participants and other end users with the burdens imposed on plan sponsors in filling out form. Ms. Borzi suggested that separate schedules for the Form 5500 could be designed that would be required to completed by a plan's various third-party service providers, including administrators and insurers, instead of by the plan sponsor. Both plan sponsors and service providers would incur start-up costs associated with reporting on a revised Form 5500.

If all welfare benefit plans are required to file a revised Form 5500 on an annual basis, the Department could compile more comprehensive and accurate data on these plans. Currently the only available data on these plans is based on information only gathered by researchers from entities that provide it on a voluntary basis. Employers may be interested in cumulative or summary information that the Department could compile from revised Form 5500, to gain a better understanding of the benefit marketplace. To that end, Ms. Borzi suggested that information compiled by the Department from the revised Forms 5500 should be made available to the public.

Summary of Testimony of John J. Canary, Office of Regulations and Interpretations, Division of Coverage, Reporting and Disclosure, EBSA, U.S. Department of Labor

The Employee Benefits Security Administration is responsible for advisory opinions, developing regulations, and provides other guidance on coverage reporting and disclosure under ERISA.

The Division of Coverage, Reporting and Disclosure is responsible for interpretive and regulatory matters relating to coverage, 5500 reporting, disclosure, suspension of benefits, claims procedures, multiple

employer welfare arrangements, COBRA, and other provisions in Parts 1, 2, 5, and 6 of Title I of ERISA.

Under Part 1 of Title I of ERISA, administrators of pension and welfare benefit plans subject to Title I are required to file reports annually concerning among other things their financial condition, investments in operations of the employee benefit plan. ERISA Section 101 sets forth the general reporting requirement. Section 103, which I'll talk about in a little bit more detail, contains the content requirements for the annual report, and Section 104 describes the timing and manner of filing requirements.

Section 103 of ERISA lists the following. As required contents of an annual report of a welfare plan. The section speaks both to pension and welfare plans, and these provisions are the ones that really address the required contents of an annual report for a welfare plan. First, there has to be financial statements and supplemental schedules. The financial statements include the asset and liabilities, income and expenses, and related financial information. The supplemental schedules focus on particular subjects like party in interest transactions, loans, fixed income obligations, and leases in default or determined to be uncollectible, and reportable transactions, which reportable generally is based on the amount or percentage of plan assets involved in a transaction or series of transactions. Right now that threshold is at about five percent.

The second part is a report and opinion of an independent qualified public accountant. The accountant's report requirements are really governed by GAAS, Generally Accepted Auditing Standards, and GAAP, Generally Accepted Accounting Principles. The statute specifically requires that the opinion include notes that focus on the description of the plan, major changes to the plan, material leased and other commitments, contingent liabilities, tax status of the arrangements, and other matters. The third is information on the number of employees covered by the plan, the name and address of plan fiduciaries, information on service providers who received compensation from the plan during the reporting year, and explanation of any reason for the change in appointment of trustees, administrators, accountants, insurance carriers and certain other listed service providers, information regarding insurance contract used to provide plan benefits, including information on fees and other commissions associated with those insurance contracts. And then a catch-all item, which is other financial and actuarial information the department may find necessary or appropriate.

In addition to setting forth the content requirements, the statute also provides the Department of Labor with authority to issue regulations exempting welfare plans from some or all of the annual reporting requirements, as well as creating simplified methods of reporting for small plans.

In the case of welfare plans, that authority is in Section 104(a)(3) of ERISA, which authorizes the department to issue regulations establishing exemptions and simplified reporting. Those exemptions and simplified reporting requirements require that they make a finding that the otherwise applicable statutory reporting requirement is inappropriate as applied to welfare benefit plans. Section 505 of ERISA also gives the department general authority to issue regulations necessary and appropriate to carry out ERISA's provisions.

The department has exercised the authority in the statute to grant exemptions from the annual reporting requirements for various classes of welfare plans. Those exemptions are codified in the Code of Federal Regulations at Title XXIX starting at Sections 2520.104-2, and following

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Health and Welfare Form 5500 Requirements
Working Group Report

The Form 5500 was developed by the Department of Labor as a mechanism whereby plans could satisfy their annual reporting requirements, meeting the conditions of the exemptions. The form is developed jointly with the IRS and the PBGC. The objective was to simplify the annual reporting process by allowing one form to be used by plan administrators to meet their annual reporting obligations under Title I of ERISA for the DOL, under Title IV of ERISA for the PBGC, and under the Internal Revenue Code for the IRS.

The Form 5500 series has thus become a primary source of information concerning the operation, funding, assets, and investments of pension plans, as well as a source of information for other employee benefit plans in the welfare plan area with a significant group of that population being either exempt from the annual reporting requirement, or being eligible for limited exemptions from the audit and financial reporting requirements.

The form is also a compliance and research tool for the department. It's a source of information and data used by other federal agencies, Congress, and the private sector in assessing employee benefit plan issues and trends. The current form, which is largely unchanged since the 1999 plan year form, includes a basic document which they refer to as the Form 5500 itself, and 12 schedules focused on particular subjects or filing requirements.

Changes to the Form 5500 or our reporting regulations generally require that they engage in what is called a rulemaking. The provisions of the Administrative Procedure Act, the APA, are the central provisions governing federal agency rulemaking. Congress has enacted other specific administrative law statutes with mandated rulemaking and other procedures that supplement the APA's procedures. The Department of Labor has its own internal clearance procedures that are used to manage the agency's regulatory agenda. These various procedural and rulemaking requirements are designed to improve the quality of agency decision-making and to further policy goals set forth in the federal statutes. One of the overarching themes of those various statutes is getting public input and public comments on agency-proposed rules and rulemakings as a way of making sure that they have considered impacts on the regulated community as they are making decisions on implementing and modifying regulations.

There typically is a catalyst or some reason to start the process of considering a change to the Form 5500. That can take a variety of different forms. In some cases it's a statutory requirement that they are required to either change the form itself or are required to collect information. And the 5500 is then considered as a vehicle to meet that statutory requirement. Other things can be reports and recommendations from groups like the ERISA Advisory Council, the General Accounting Office, or other sources that may recommend changes or modifications to the Form 5500. EBSA also does its own annual review of the Form 5500 as part of the process where they republish the form and the instructions every year. They do get public input throughout the course of the year with people either asking questions about the form, or suggesting areas where they can improve the instructions. And those are taken into account as part of this annual process of reevaluating the form. So those would be examples of catalysts. And there could be a variety of others.

After something, an initiating event where they are now in the process of considering a change to the 5500 or our regs, the second step is obviously our development internally of the proposed change and deciding

on the form of rulemaking that will be used. The normal rulemaking approach is through what's called a Notice of Proposed Rulemaking.

So the third step would be to go through our approval process at the department level, and also through the Office of Management and Budget

After they go through the process of submitting and getting clearance from the department and OMB, the fourth step would be publishing the proposed change in the Federal Register for public comment. After they publish and solicit public comments, the next step is then to evaluate and review the public data, comments, and arguments that are submitted in response to that solicitation and go through the clearance process.

The next step would then be to publish that change in the Federal Register as a final rule or a final change to the Form 5500. As part of that process, they have to be sensitive to the disruption to plans and various service providers involved in data collection and preparation of the form.

The process to change the Form 5500 can take anywhere from 12 to 24 months depending on the nature of the changes. There may be circumstances where the department goes through a more expedited process like Interim Final Rulemaking. .

If they are changing an element of the form which is really a three-agency or two-agency form, the other agencies may have to go through their own administrative process to make that change.

Another element which is very important is the E-FAST processing system. It's a computerized system where a private contractor is the agent of the agencies that receives and processes the form. When the department consider changes to the form, they have to consider that processing system and make sure that whatever changes they would adopt to the form, that computerized processing system then is modified if necessary and is really ready and able to deal with those form changes when they start to be filed by the public. E-FAST needs adequate time to adjust to changes.

The department does an annual review of the form for both welfare and pension plans. The last two major revisions to the Form 5500 occurred in 1999. That was a multi-year exercise that the agencies went through that culminated in those publications in late 1999 and early 2000 of the final form changes and the final reg changes. Prior to that, the 1988 forms were the major revision of the forms that occurred, and again there was a multi-year process in advance of those form changes being finalized in 1988.

The objective of the health and welfare Form 5500 has multiple purposes that it's designed to serve as described in Title I of ERISA. One is information collection, where that information is collected for enforcement purposes, research purposes, and public disclosure purposes. The Form 5500 as an annual report also serves a discipline in terms of plan management where as part of the statute the plan administrators and other parties involved then are required at least annually to prepare this report and do the work that would be necessary to prepare the report, which imposes sort of an annual discipline to manage the plan, keep the plan's data, and be able to put that into an annual report. Plans that are subject to the audit requirement are also part of that discipline that the annual report serves. The audit requirement serves as a way of trying to make sure that the data that is filed with us on the form is reliable

such that the agencies that use the data for enforcement, disclosure, or research purposes can put some faith in the fact that the data that they have there is data they can rely upon as being accurate.

Health and welfare plan exemptions were originally created to the extent that the information collection wasn't relevant. The status focused on plan assets and financial transactions. For example, an unfunded or insured program is not going to have plan assets with an investment pool. The statute seems to focus on plan assets, financial transactions.

There was some thinking that went into the burden associated with filing the information for small employers versus large employers, and that the relative burden on the larger plan of making that filing is probably much smaller. And the value of having a report that at least identifies the plan as being in existence, and gives us some basic information was seen as worthwhile as compared to the relative burden on what would be a not small business filing a Form 5500 where you may expect that once you reach that size, they are going to have other sorts of filing obligations, and this is really not going to be terribly burdensome.

The department used negotiated rulemaking as part of our MEWA regulation dealing with the definition of what would be a plan maintained pursuant to collective bargaining for purposes of certain preemptory provisions in the statute. There are some issues in negotiated rulemaking whether a particular subject matter is appropriate for negotiated rulemaking.
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After 1988, the DOL would periodically look at the issue of is the 100 life standard the appropriate one. But I don't think there's been a move at this point to shift away from that.

Summary of Testimony of Alice Wunderlich, AICPA

Ms. Alice Wunderlich is a member of the Employee Benefit Plans Expert Panel at the American Institute of Certified Public Accountants and is Deloitte & Touche's national employee benefit plan industry professional practice director, serving as the firm's national accounting and auditing technical resource for employee benefit plans.

She stated that central to the accounting profession's mission is to help ensure meaningful financial reporting to protect ERISA plan participants, the investing public, and other financial statement users. In doing so, she considers that it is important to consider the financial information needs of the various users of the plan financial statements, and also to evaluate the effort and the cost to the plans in preparing the financial statements. The benefits to financial statement users should outweigh the administration burden of the plan financial reporting.

She distinguished between two types of health and welfare plans under Title I of ERISA: defined benefit and defined contribution. An example of a defined benefit health and welfare plan is a medical plan where the benefit to be provided is defined as certain medical procedures or care as covered by the plan. A defined contribution plan is one where the contribution amount for funding an individual participant account is defined, and the benefits are limited to the available funds in that participant's account.

She stated that there is no requirement for health and welfare plans to be funded, nor establish a trust. A company may choose to pay health benefits on a pay-as-you-go basis directly from the general assets of the corporation in which case the plan is considered to be unfunded

Speaking briefly about multi-employer plans, she stated that funded multi-employer plans, sometimes referred to as union plans, exist where more than one employer is required to contribute to the plan pursuant to one or more collective bargaining agreements. In multi-employer plans, the plan financial statements indicate the plan's ability to provide benefits to participants. Payments of current and future benefits depend on the amount of the plan's net assets and obligation. As such, Ms. Wunderlich believes that the financial statements of multi-employer plans provide values to users of those financial statements.

She described how, often, both participants and the corporate sponsors contribute to the plan. Set dollar amounts are withheld from the participant's paycheck for employee/dependent coverage. This withholding plus the sponsor contributions are used to purchase insurance coverage or otherwise to pay benefits and to fund any shortfall.

She stated that the plan's financial statements may not necessarily be an indication of the future probability of a participant's getting benefits because the corporate funds the plan shortfall. The plan's financial statements may well show a deficit funding position when in fact it is a financially healthy plan. Since the ultimate obligation to pay benefits rests with the corporate plan sponsor, it's the financial health of the plan sponsor, not the funded status of the plan itself that determines the likelihood of participants receiving benefits they were promised. The financial statements, while reflecting plan assets and liabilities in contributions made by the plan sponsor and employees, may not be fully meaningful in assessing whether the plan has the ability to pay current and future benefits.

She mentioned that for some single employer health and welfare plans, several different plans are used to provide different benefits to employees. While each plan has its own separate ERISA reporting requirement, at least those that are funded, employees may view their health and welfare benefits as all part of the same package, even though they may in fact be participating in many different health and welfare plans.

In contrast, she stated that this disaggregating arrangement is rare for a 401(k) plan or a pension plan, where typically an employee would participate in only one 401(k) plan, or only one pension plan.

She stated that there is a disconnect between those financial statements and the Form 5500 reporting. Many health and welfare plans have obligations, such as incurred but not reported claims (IBNR), post retirement benefits, and post employment benefits, that are required by GAAP to be reported on the audited financial statements but are not reported on the 5500. Consequently, there are often numerous and substantial dollar differences between the amounts reported on the 5500 submitted to the department and the audited financial statements that accompany the Form 5500. The auditor frequently spends significant time auditing this GAAP obligation information that is neither reported to the department on the Form 5500 nor in most cases funded by the plan sponsor through the trust at the reporting date.

As a recommendation, she stated that the DOL may wish to consider whether this additional GAAP information would be useful on the Form 5500, or for other department reporting purposes.

She observed that the information in the financial statements is not available from a single source because all of the plan's activity does not flow through the trust, nor are all of the plan's transactions accumulated in a single place such as a general ledger. The plan's financial statements are typically prepared once a year, only for ERISA reporting purposes, and to her knowledge are not routinely used for other purposes.

Because the financial statements are complex and there is generally a lack of readily available information, and the preparation requires significant accounting knowledge, the auditor is often relied on to prepare the financial statements. Even when the plan sponsor drafts the statements, in many cases the auditor spends a lot of time helping him in that process.

Regarding costs, Ms. Wunderlich explained that plan sponsors incur two types of cost in relation to the audit of their health and welfare plans: internal costs and then the fees that they pay to their external auditors. Internal costs, including time spent gathering and organizing information needed to prepare the financial statements and time associated with the administration of an audit can be quite high. Fees have dramatically increased over the past several years because of changes in the health care system delivery and payment systems, and the impact of HIPAA. Factors affecting the audit fee include the size of the plan, the number of participants, the types of benefits offered in the plan, the number of outside service providers, quality of plan record-keeper, and the plan sponsor's ability to prepare the financial statements.

The HIPAA regulations have significantly affected the audit of health and welfare plan financial statements in several ways. In most audits of health and welfare medical plans, it's necessary for the auditor to access protected health information, such as information regarding claim payments. A significant amount of administrative time, as much as 30 percent of the total audit hours incurred, can be spent obtaining legal documentation that permits access to health care claim data.

AICPA encourages the EBSA to evaluate whether the current financial reporting and audit requirements for single employer defined benefit health and welfare plans cost effectively meets the needs of the department participant protection and the needs of other potential users of plan financial statements.

AICPA also encourages consideration to be given to alternative types of independent audit assurances that could provide for more cost effective protection to plan participants and provide the department with the information that it needs.

Regarding VEBA trusts, Ms. Wunderlich stated that the existence of a VEBA trust triggers audits for H&W plans. So a VEBA trust may be structured as having many different plans that are providing different benefits (medical benefits, dental benefits, long-term disability, short-term disability, vacation) in some way using this VEBA trust, but most of the payments are coming directly from the corporate sponsor. The use of that VEBA in any way, even for one day, putting any money into it

triggers an audit requirement for each of those six plans.

Ms. Wunderlich stated that she often suggests to clients that they evaluate what they're using a VEBA trust for, suggesting that they make it inactive if appropriate. She's found that clients many times are very reluctant to close down those trusts because of the effort it takes to establish trusts. And if administrators of the plans don't have a very good understanding of why the VEBA exists, it prevents many of the clients from discontinuing use of those trusts and incurring an audit requirement.

She stated that there is always a struggle with the definition of "plan." She believes that it's unclear if there is a plan document, exactly what benefits it covers, and what benefits are covered by another plan. Sometimes if it's been misinterpreted, it causes the auditor to have to restate prior year financial statements, which is a costly thing to do.

She stated that it would seem to make a lot of sense for the DOL to take a fresh look and understand what is meaningful to the participants in the plans and the other stakeholders in the process, and develop a reporting based on that information. And if any of that information -- they believe that it requires some sort of verification, then design some directed procedures at verifying the information that they believe is important. She agreed with other witnesses in recommending a full revamp or reevaluation of all of the information in the 5500 and the audited financial statements as to whether they are useful to participants and they help protect their benefits and rights.

Bibliography for Health and Welfare Form 5500 Requirements Working Group Report– 2004

August 3, 2004 Meeting of the Working Group at Dept. of Labor

- Agenda
- Working Group Statement of Description and Goals, List of Witness Questions
- Official Transcript
- Statement by Janice M. Wegesin, JMW Consulting Inc., Palatine, IL

September 22, 2004 Meeting of the Working Group at Dept. of Labor

- Agenda
- Official Transcript
- Statement by Judy Bauserman, Mercer Human Resource Consulting
- Statement by Peter Kelly, Chief Employee Benefit Consultant, Blue Cross Blue Shield Association
- Statement by Jeffrey Capwell, McGuire Woods LLP
- Statement by Phyllis Borzi, Research Professor, School of Public Health and Health Services, George Washington University Medical Center
- Statement by Alice A. Wunderlich, AICPA and Audit Director, Deloitte & Touche LLP,

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October 29, 2004 Conference Call of the Working Group

- Official Transcript

November 9, 2004 Meeting of the Working Group at Dept. of Labor

- Agenda
- Official Transcript

November 10, 2004 Presentation by the Working Group at Dept. of Labor

- PowerPoint Slides
- Official Transcript

(Transcripts for the Council's full meetings and working group sessions are available at a cost through the Department of Labor's contracted court reporting service, which is Neal R. Gross and Co., Inc. 1323 Rhode Island Avenue, NW, Washington, DC 20005-3701 at 202.234.4433 or www.nealgross.com)