

17475 Jovanna Drive—Suite 1B ■ Homewood, IL 60430 ■ (708) 799-7400 ■ Fax (708) 799-7747
Six Executive Drive—Suite One ■ Fairview Heights, IL 62208 ■ (618) 632-8539 ■ Fax (618) 628-0289

SPECIAL POINTS OF INTEREST:

- Electronic Filing of Form 5500 Again Postponed
- Medicare Part D Notification to Plan Participants
- Creditable Coverage Disclosure to CMS Website
- Women's Health and Cancer Rights Act Annual Notice
- Update PHI Access Form



Monthly Newsletter

Electronic Filing of Form 5500 Again Postponed

ELECTRONIC FILING OF FORM 5500 AGAIN POSTPONED, PLUS CHANGES TO FORM, SCHEDULES, INSTRUCTIONS, AND REGULATIONS FINALIZED

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[Annual Reporting and Disclosure, Revision of Annual Information Return/Reports, Final Rule, 29 CFR Part 2520, 72 Fed. Reg. 64709 (Nov.16, 2007); Notice of Adoption of Revisions to Annual Return/Report Forms, 72 Fed. Reg. 64731 (Nov. 16, 2007)]

For a copy of the final rule: <http://edocket.access.gpo.gov/2007/pdf/E7-21765.pdf>

For a copy of the notice: <http://edocket.access.gpo.gov/2007/pdf/07-5521.pdf>

The DOL, IRS, and PBGC have jointly issued final Form 5500 regulations and have adopted final revisions to the Form 5500 that will be applicable for 2009 and later plan year filings (although some of the form revisions apply on a transitional basis for the 2008 plan year). The agencies have retained most aspects of the prior proposed regulations and form revisions.

Effective Date of Mandatory Electronic Filing Postponed. Most importantly, the effective date for mandatory electronic filing of Form 5500 has been postponed again and will now be applicable for plan years beginning on or after January 1, 2009. Under this effective date, the vast majority of plan filers will have until at least July 2010 to make the changes necessary to allow electronic filing (since Form 5500 is generally due by the end of the seventh month following the end of the plan year). The design of the new electronic filing system--to be called EFAST2--is still being developed. Indeed, as indicated in the preamble to the new regulations, the DOL is still in the process of awarding a contract

to build the new system, which, as previously contemplated, will include a secure Internet-based filing method.

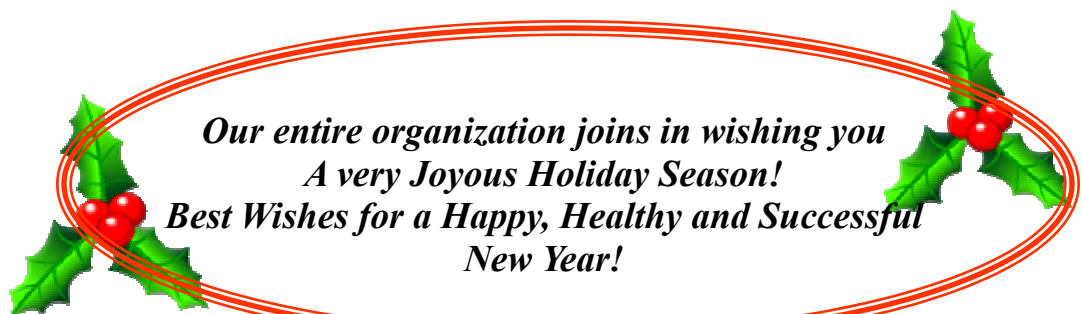
Schedule A--Reporting of Fees and Commissions Paid By Insurers. The DOL has retained the broad definition of fees and commissions required to be reported on Schedule A (as set out in Advisory Opinion 2005-02A). However, the new Schedule A will contain a special rule under which compensation paid by an insurer to third parties for recordkeeping, claims processing, and other similar types of administrative services will not be required to be reported as fees and commissions on Schedule A, provided that certain detailed conditions are satisfied. Also, the new Schedule A will exclude "occasional and insubstantial non-monetary compensation" paid by insurers to brokers and others (similar to the rule also added to Schedule C, discussed below). [EBIA Comment: As with the special rules for service provider compensation reported on Schedule C (discussed below), the detailed discussion of these new rules for Schedule A reporting should be required reading for insurance companies and plan administrators.]

Schedule C--Increased Reporting of Service Provider Compensation.

The final regulations and revised Form 5500 retain the prior focus on "transparency" regarding plan fees and expenses, reflecting the DOL's concern that plan officials have the information necessary to assess the reasonableness of the compensation paid to service providers. Many of the proposed revisions to Schedule C have therefore been retained. However, the DOL has made certain changes and clarifications to address comments about the administrative complexity of providing information regarding certain indirect service

Holiday Observance

Our offices will be closed on Monday and Tuesday, December 24 and 25, 2007 and Tuesday, January 1, 2008 this Holiday Season.



*Our entire organization joins in wishing you
A very Joyous Holiday Season!
Best Wishes for a Happy, Healthy and Successful
New Year!*

provider compensation (including "float" revenue, securities brokerage commissions, and revenue sharing among affiliates and other "bundled service providers"). For example, the new Schedule C will include an alternative disclosure option for certain "eligible indirect compensation," provided that the plan administrator receives separate disclosures regarding both the indirect compensation and the parties paying and receiving it. As another example, Schedule C will not require inclusion of compensation consisting of "ordinary business gifts" (like meals, entertainment, and other gratuities) that are occasional and insubstantial (e.g., less than \$50 in the case of a single gift from one source). Fee codes have also been added to the new Schedule C to better identify the various types of direct and indirect compensation required to be reported. [EBIA Comment: The notice contains a lengthy discussion of both the types of compensation reportable on the Schedule C and the new exceptions and special rules. This material is required reading for plans required to file Schedule C (and their service providers). In addition, according to the notice, the DOL is working on a regulation setting forth the standards applicable for the ERISA prohibited transaction exemption that permits a plan to make reasonable contractual arrangements with a party in interest for services; the new regulation is expected to eliminate uncertainty as to whether fees paid to plan service providers are reasonable.]

No Schedule C Required for Welfare Plans Relying on Technical Release 92-01. Notwithstanding the expanded scope of Schedule C reporting, the Instructions for Schedule C will be modified to make clear that large welfare plans (those with 100 or more covered participants at the beginning of the plan year), which are exempt from filing Schedule H and an accountant's opinion because they rely on the trust nonenforcement policy of Technical Release 92-01, are also exempt from filing Schedule C to report service provider compensation paid by or received from the plan. [EBIA Comment: The notice acknowledges that Technical Release 92-01 does not expressly address Schedule C reporting obligations. Given that omission, we have long cautioned that Schedule C might be required for certain large welfare plans that are otherwise exempt from the Schedule H and accountant's opinion requirements (i.e., in situations where participant contributions are used in whole or part to pay plan service providers). This is therefore a welcome clarification, but it should not be misunderstood. Even though ERISA plans that satisfy the conditions of Technical Release 92-01 are exempt from the Schedule H and accountant's opinion requirement (and under this new rule will also be exempt from the Schedule C requirement), participant contributions under such plans are still plan assets subject to ERISA's exclusive benefit rule and can be used only to pay plan benefits or reasonable administrative expenses.]

No Schedule C Required Where Plan Sponsor Pays Service Provider Compensation. One commenter asked for confirmation that amounts paid by a plan sponsor (and not reimbursed by the plan) are not reportable on Schedule C where the plan sponsor pays expenses of the plan. In response, the notice states that Schedule C is only required for amounts paid by or received "from the plan." [EBIA Comment: This is consistent with our longstanding interpretation that Schedule C is required only when compensation to service providers is paid from plan assets.]

Identification of Insurers and Service Providers That Fail to Supply Information. Schedules A and C will retain the requirement for plans to identify any insurer, fiduciary, or service provider that fails to provide requested information and the type of information not provided. However, the DOL expressed some sympathy for several commenters who complained that this requirement might unfairly single out insurers or service providers who were not responsible for providing required information. Among other things, the instructions for Schedule A will be revised to remind plan administrators that they have an obligation to take reasonable and prudent steps to obtain required Schedule A information and that they should contact the insurer about missing information.

Short Form 5500 for Certain Small Plans. The two-page Form 5500-SF is retained for certain small plans (generally, plans with fewer than 100 participants) with secure and easy-to-value investment portfolios.

Potentially eligible plans include certain small pension plans that qualify for the audit waiver and small welfare plans that do not otherwise qualify for a filing exemption. It should be noted that the Form 5500-SF will be used to satisfy the voluntary alternative reporting option imposed by the PPA (and applicable for 2007 plan years) for certain pension plans with fewer than 25 participants. Until Form 5500-SF becomes available (for 2009 plan years), such plans that meet enumerated eligibility requirements may choose to file a simplified Form 5500 (for reporting on 2007 and 2008 plan years).

EBIA Comment: The electronic filing requirement will now hit home in 2010, when the 2009 Form 5500s are due. Although plan administrators and advisors will want to begin planning for the changes, keep in mind that the DOL has indicated that reformatting changes may be made to the information copies of the Form 5500 attached to the notice. And, of course, it would not be surprising to see other substantive changes to the Form that is ultimately put in place for 2009 plan year filings.

Medicare Part D—Prescription Drug Coverage

As you may be aware, the Medicare Prescription Drug, Improvement & Modernization Act (MMA) implemented a voluntary prescription drug benefit (Part D) for Medicare eligible individuals beginning on January 1, 2006.

Two key components of this Medicare program, established by CMS, (Centers for Medicare and Medicaid) that impacts group health plans are:

- Part D Medicare eligible individuals must be *notified* by the group health plan whether or not the prescription drug coverage provided by the group health is or is not "creditable coverage". "Creditable Coverage" as defined by Medicare is coverage that is equal to or greater than the coverage being offered under the Medicare Part D program, and
- Annually, the group health plan must notify CMS of the Plan's Creditable/Non-Creditable Status.

Notification to Plan Participants

In an email distributed in October, 2007 to your Plan's primary contact, BAS advised that if we administer your primary medical plan and your prescription drug program (or if we have been provided with an analysis of your prescription drug plan) BAS would distribute the applicable Creditable or Non-Creditable Coverage Notice to all of your Plan Participants by first class mail. If you elected to have BAS distribute the Notice, they were mailed by November 15, 2007.

Annual Creditable Coverage Disclosure to CMS Website

PLEASE NOTE: In addition to the Creditable Coverage Notification requirement for Medicare eligibles, employers must disclose their Creditable Coverage status to CMS on an annual basis. The disclosure form **must be** completed online-**electronic filing is required.** The form and instructions for completion can be found at: www.cms.hhs.gov/apps/ccdisclosure/default.asp

The Disclosure Notice and policy guidance were posted on the Medicare website and require that the Disclosure Notice must be made to CMS on an annual basis and upon any change that affects whether the drug coverage is creditable. The initial Disclosure Notice had to be provided by March 31, 2006 for plan years that end in 2006. **For plan years that end in 2007 and beyond, disclosure of creditable coverage status must be provided within 60 days after the beginning date of the plan year for which the entity is providing the disclosure to CMS. (Example: plan year begins on April 1, 2007 – disclosure to CMS must be made by May 31, 2007.) Disclosure must also be made within 40 days after the termination of the prescription drug plan; and within 30 days after any change in the creditable coverage status of the prescription drug plan.**

CMS has released a Disclosure Notice form that requires information such as name of entity; Federal tax identification number; street address; type of coverage; number of options offered by the entity, creditable coverage status of option; period covered by the disclosure notice; number of Part D eligible individuals expected to be covered under the plan as well as the name, title and email of the Entity's authorized Individual.

A disclosure is required whether the entity's coverage is primary or secondary to Medicare. Entities that must comply with these provisions are listed in the regulation at 42 CFR Section 423.56(d) and are referenced on the creditable coverage homepage at <http://www.cms.hhs.gov/creditablecoverage/>. Those entities include group health plans, including those offered by employers; union/Taft-

Hartley plans; church, Federal, State and local government, and other group-sponsored plans. (Entities that contract with Medicare directly as a Part D plan or that contract with a Part D plan to provide qualified prescription drug coverage are exempt from the disclosure requirement.)

How to find this information: CMS has issued guidance on the form, manner and timing of providing the Disclosure Notice to CMS. This Disclosure to CMS guidance is posted on the Creditable Coverage web page at <http://www.cms.hhs.gov/creditablecoverage/>.

We encourage you to complete the Disclosure Notice at the CMS website as soon as possible and we recommend that you keep a copy for your records. If you have any questions or need assistance, please contact BAS' Pharmacy Department at www.benadmsys.com or 708-799-7400.

Women's Health and Cancer Rights Act Annual Notice

The "Women's Health and Cancer Rights Act", passed in 1998, requires health plans to provide Plan Participants with a written notice of the mastectomy provisions of the Act. An initial written notice of the coverage under the Act must be provided to Plan Participants upon enrollment an annually thereafter. Attached to this Newsletter is a sample notice that can be utilized for the initial, as well as the annual notification. This notification should, as on the case of other required notifications, be issued to Mr. & Mrs. in cases where new Plan Participants are married or active Plan Participants have their spouses covered by the Plan.

Update PHI Access Form

Our PHI Access Form was developed for your use in documenting those employees or classes of employees who will be given access to Protected Health Information (PHI).

Attached is a PHI Access Form for your use in providing us with the current names or classes of employees that are allowed to receive PHI from BAS. As changes occur in your staffing, we request that you submit a revised PHI Access Form. Please complete the form and return it within the next two weeks to the Compliance Manager at BAS' Homewood office at 17475 Jovanna Drive Suite 1B, Homewood, IL 60430 or email it to privacyassistance@benadmsys.com or fax it to 708-799-3256.

We further request that you provide BAS with a copy of the Business Associate Agreement you have with your broker and/or consultant if you haven't done so.