



Benefit Trends

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Health Care Reform – Special Edition

Health Care Reform: New Reporting and Disclosure Rules

LEGISLATIVE BRIEF

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For more than thirty five years, federal law has required employers to follow reporting and disclosure rules applicable to employee benefit plans pursuant to the Employee Retirement Income Security Act (ERISA) and its regulations. Since ERISA does not apply to public agencies and churches, these organizations had no legal duty under federal law to provide “summary plan descriptions” to plan participants. Most state laws, on the other hand, require insurers to provide certificates of coverage to employers including churches and public agencies for distribution to employees.

Now comes Health Care Reform (HCR): In 2012 for example, insurers and plan sponsors of self-funded group health plans must provide a benefit summary (Uniform Summary of Benefits) to all participants prior to enrollment, subject to a four page maximum, 12 point type minimum font size. The purpose of this Memorandum is to discuss this new Uniform Summary and its requirements as well as other HCR disclosure and reporting requirements which lie ahead for plan sponsors. It’s important to note, that to date, we have no proposed rulemaking for guidance.

Effective Dates for the Uniform Summary

Section 2715(a) of the Public Health Service Act (PHSA), in conjunction with the Patient Protection and Affordable Care Act (PPACA) provision 10101(b), require insurers and self-funded health plan plan sponsors to provide these new summaries, regardless of whether the plans are grandfathered, within 24 months of the date of Health Care Reform’s enactment. Other disclosures will apply in 2012 and 2014.

Guidance to Come

Although HCR law lays out the basic requirements for the Uniform Summary as well as the other reporting and disclosure rules, the law also requires both the Department of Labor (DOL) (with respect to ERISA modifications) and the Department of Health and Human Services (HHS) to produce standards for developing the four page summary as well as the reporting requirements for group health plans’ annual reporting on “Quality of Care.” The Internal Revenue Service

(IRS) will provide guidance on its new reporting requirement disclosing information about employees who are covered by the minimum essential benefits coverage, employer contributions, length of waiting periods, etc. The IRS reporting requirement is applicable to employers with 50 or more employees and is effective on January 1, 2014.

Discussion

1. **The Uniform Summary.** In addition to the requirement that the content of this notice must be at a minimum 12 point font size, the content must also describe “in a culturally and linguistically appropriate manner” the health benefits available under the plan. We can only assume the new 25% translation rule will apply here. The summary must contain a uniform set of definitions, medical terms, etc. It also must include plan limitations and exclusions, cost sharing requirements (e.g. co-pays, coinsurance deductibles, etc.), and a contact number if a participant has questions. The summary must incorporate illustrations of common benefit scenarios, text on renewability and COBRA rights, and must specify whether the plan meets the minimum essential benefit requirements, and the statutory minimum cost sharing requirements.

This new Uniform Summary applies to all plans: grandfathered and non-grandfathered, ERISA, non-ERISA, insured, and self-funded. The Uniform Summary is in addition to the summary plan description requirements applicable to ERISA plans. The law also specifically acknowledges the ability of states to create even more stringent disclosure rules.

2. **Notice of Plan Changes.** In addition to the Uniform Summary, HCR law will also require that insurers and self-funded plan sponsors must send out notice of a plan change 60 days prior to the effective date of the change. This rule takes effect as of the first plan year beginning after March 23, 2012. You can find the law at PPACA Section 1001(5) and PHSA Section 2715(c)(4).
3. **Qualify of Care Annual Report.** HCR requires insurers and self-funded health plans to provide an annual report to plan participants and to HHS specifying whether the plan has met the following criteria:
 - Improved health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of Section 3602 of PPACA, for treatment or services under the plan or coverage;
 - Implemented activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;
 - Implemented activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and,
 - Implemented wellness and health promotion activities.

The report must be made available to eligible employees at the time of open enrollment. HHS must also make the reports available on the HCR web portal. HHS has two years from date of enactment to develop the quality of care reporting requirements and publish regulations. HCR also has given HHS the right to develop and impose penalties for noncompliance. It is worth noting that this quality of care annual reporting

rule does not apply to grandfathered plans. You can find the law at PPACA Section 1001(5) and PHSA Section 2717(b).

4. **2014: Compliance Disclosure to the IRS.** As we all know by now, HCR will require all employers with 50 or more employees to provide health care coverage providing minimum essential benefits to eligible employees on an affordable basis beginning in 2014. HCR will require that these employers, including non federal government employers, file an annual report certifying their compliance. The report will also necessitate the following disclosures:
- In the case of an applicable large employer, the length of any waiting period with respect to such coverage;
 - The months during the calendar year for which coverage was available;
 - The monthly premium for the lowest cost option in each of the enrollment categories under the plan;
 - The employer's share of the total allowed costs of benefits provided under the plan; and,
 - In the case of an offering employer, the option for which the employer pays the largest portion of the cost of the plan and the portion of the cost paid by the employer in each of the enrollment categories under that option (Section 6056(b)(2)(C), as added by PPACA).

The required return must also state the number of full-time employees for each month during the calendar year, the name, address, and taxpayer identification number of each full-time employee during the calendar year, and the months, if any, during which such employee and any dependents were covered under a health benefits plan (Section 6056(b)(2), as added by PPACA).

This report currently would be independent of the Form 5500 filing (applicable to ERISA plans only). The IRS penalties currently in place for failure to file information returns will also apply to this new filing requirement. It will apply to plan years beginning after December 31, 2013. You can find the law at PPACA Section 1514(d).

5. **Other Disclosures.** As you know, HCR requires employers to report the value of coverage on W-2s effective for tax years beginning on January 1, 2011, for informational purposes only. Employers must also provide notices in 2013 to all employees regarding the new insurance Exchanges which will be operational in 2014. Additionally, the regulatory agencies will require a variety of targeted notices, some of which, the agencies have provided model notices.

This Memorandum includes only disclosures and reporting requirements applicable to employer/plan sponsors. HCR contains additional reporting and disclosures applicable to insurers, providers, and even certain manufacturers.

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