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New Reporting and Disclosure Requirements

The recently enacted Affordable Care Act (ACA) imposes numerous new reporting and disclosure requirements on group health plans and health insurers.

Plan Sponsors

Plan sponsors must:

- Provide participants, at initial and annual enrollment, with a uniform summary of benefits that includes certain standard information and definitions. This summary is in addition to an ERISA-compliant Summary Plan Description (SPD) effective for plan years beginning on or after March 23, 2010, but the Department of Health and Human Services (DHHS) must issue regulations regarding the required information and standard definitions, so compliance will be delayed until these are issued. Nevertheless, summaries must be provided to participants no later than March 23, 2012.
- Provide notice of any material modifications to the group health plan at least 60 days prior to the date the change becomes effective (effective for plan years beginning on or after March 23, 2010).
- Report on an employee's Form W-2, the aggregate cost of health care provided to employee using a methodology similar to that used under COBRA, but excluding the cost of contributions to FSAs, HSAs, Archer MSAs, or the cost of long-term care (LTC), stand-alone dental and vision plans and other "excepted" benefits (effective for plan years beginning January 1, 2011 – *i.e.*, for Form W-2s to be issued in 2012 for 2011 wages).
- Provide "quality of care" reports to DHHS and participants about plan benefits that improve health outcomes. The DHHS has two years from March 23, 2010 to develop these quality reporting requirements for group health plans (effective for plan years beginning on or after March 23, 2012).
- Adopt a uniform set of operating rules and standards for the exchange of electronic information, with differing adoption and effective dates, depending on the nature of the transaction – (i) eligibility and claims status rules and standards to be adopted by July 1, 2011/effective by January 1, 2013; (ii) electronic funds transfer and payment/remittance rules and standards to be adopted by July 1, 2012/effective by January 1, 2014; (iii) health claims, enrollment, disenrollment, premium payments, referral certification and authorization rules and standards to be adopted by July 1, 2014/effective by January 1, 2016 -- and must report to DHHS certifying compliance with these standards within the same time frames.

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- Provide employees and new hires with information about the availability of the State Insurance Exchanges, and premium and cost-sharing subsidies (effective for plan years beginning on or after March 1, 2013).
- If it employs an average of at least 50 full-time employees during the preceding calendar year (*i.e.*, is a large employer for this purpose), or if it offers minimal essential coverage and pays any portion of the costs of that coverage and the employee's cost exceeds 8% of the employee's wages (*i.e.*, is an "offering employer" for this purpose), plan sponsors must provide to the Secretary of the Treasury the following information: (i) the employer's name and tax number, (ii) certification of whether it offers minimum essential coverage, (iii) the number of full-time employees for each month, (iv) the name address and taxpayer identification number of each full-time employee, (v) the length of any waiting period, (vi) the months during which coverage was offered, (vii) the premium cost of the lowest cost coverage option, (viii) the employer's share of the total plan cost, and (ix) for offering employers, the option for which the employer pays the largest portion of the cost. The employer must also make similar information available to each employee listed, as well as the name, address and phone number of the employee making the report to Treasury, before January 31 of the year following the calendar year for which the information return is filed (effective for plan years beginning on or after January 1, 2014).
- In order to enforce the individual coverage mandate, every entity that provides minimum essential coverage to an individual during a calendar year must file a return reporting such coverage and including the information that the Treasury Secretary may prescribe (effective for plan years beginning on or after January 1, 2014).

Insurers and State Insurance Exchanges

- Insurers maintaining qualified health plans on State Insurance Exchanges must report information to enrollees on claim payment policies, enrollment and disenrollment, number of claims denied, cost-sharing requirements, out-of-network policies and enrollee rights in plain language (effective once Exchanges are established after January 1, 2014).
- Insurers maintaining qualified health plans on State Insurance Exchanges for the small group market must file a return that includes such information as the Treasury Secretary may require for the administration of the new credit for employee health insurance expenses for small employers under new Internal Revenue Code Section 45R (effective once Exchanges are established after January 1, 2014).
- Insurers will be required to report to the Secretary of HHS the proportion of premium dollars spent on clinical services, activities that improve health care quality and other non-claim costs, including an explanation of the nature of such costs, but excluding federal and state taxes, licensing or regulatory fees. These costs constitute their "Medical Loss Ratio." The reports must be made for insured grandfathered plans. Insurers will also have to provide rebates to customers for the amount of the premium that is proportional to the amount of the

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Medical Loss Ratio that is less than 85% in the large group market and 80% in the individual and small group market (the reporting requirement is effective for plan years beginning on or after September 23, 2010, and the rebates must be provided no later than January 1, 2011).

- Insurers offering health coverage in the individual and group markets must also comply with the quality of care reporting requirements that the DHHS must develop by March 23, 2012.
- Exchanges must submit financial reports to the Secretary of the Treasury and comply with oversight investigations (effective once Exchanges are established after January 1, 2014).

Health Care Providers, Pharmacy Benefit Managers (PBM), Drug Manufacturers, Etc.

- Non-profit hospitals must undertake an annual community service assessment, maintain qualified financial assistance programs, limit charges to those eligible for assistance and avoid certain billing and collection policies. A hospital must disclose in its annual information report to the IRS how it is addressing the needs identified in its community health needs assessment, and if all identified needs are not being addressed, an explanation of why. Hospitals that fail to meet the community health needs requirements of the Internal Revenue Code face an excise tax of \$50,000 per year (the requirement to undertake assessments is effective for tax years beginning after March 23, 2010, but the excise tax applies for tax years beginning after March 23, 2012, though for failures occurring after March 23, 2010).
- Health plans (*i.e.*, health insurers) or any entity that provides Pharmacy Benefit Management (PBM) services on behalf of a health plan will have to report to the Secretary of HHS (i) the percentage of all prescriptions provided through retail pharmacies compared to mail order pharmacies, (ii) the percentage of prescriptions for which a generic drug was available and dispensed by pharmacy type, (iii) the aggregate amount and types of rebates, discounts or price concessions that are passed through to plan sponsors and the total number of prescriptions dispensed, (iv) the aggregate amount of the difference between the amount the health plan pays the PBM and the amount the PBM pays retail and mail order pharmacies and the total number of prescriptions dispensed. Failure to provide the information on a timely basis will subject the health plan or PBM to a penalty of up to \$10,000 per day, or up to \$100,000 per item, if false information is knowingly provided (effective as of March 23, 2010).
- Each U.S. hospital must establish, update and make public an annual list of the hospital's standard charges for items and services provided by the hospital (effective for plan years beginning on or after September 23, 2010).
- Any manufacturer of a covered drug, device, biological or medical supply that pays or provides something of value to a physician or teaching hospital must report to the Secretary of HHS in electronic format any information the Secretary deems appropriate, including (i) the name and address of the recipient, (ii) the amount paid, (iii) the dates on and the form

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in which the payments were made, and (iv) whether the payments were made in connection with marketing, education or research with respect to a specific drug, device, biological or medical supply. If a physician owns an interest in the manufacturer or group purchasing organization, additional information must be disclosed. There are a range of payments and items of value that need not be reported. By October 1, 2011, the Secretary of HHS must establish procedures for making this information available to the public through a Website. Failure to submit the required information in a timely manner will subject the manufacturer or group purchasing organization to a civil money penalty (CMP) of not less than \$1,000, but not more than \$10,000, for each payment or other transfer of value not reported, with a knowing failure being subject to a penalty of not less than \$10,000, but not more than \$100,000, for each unreported payment. For knowing failures, the overall penalty is capped at \$1 million (effective on March 31 2013, with reports being due on the 90th day of each calendar year thereafter).

- Owners of long term care facilities that receive at least \$10,000 in federal funding must annually notify each individual who is an owner, operator, employee, manager, agent or contractor that they are required to report any reasonable suspicion of a crime against any person who is a resident or is receiving care from the facility. If the suspected crime involved bodily injury, it must be reported immediately, but not later than 2 hours from the time the suspicion arose, and if the suspected crime does not involve bodily injury, it must be reported within 24 hours from the time the suspicion arose. Failure to timely report will subject the person to CMPs of not more than \$200,000 and the individuals may be excluded from receiving federal funds for up to two years (effective as of March 23, 2010).
- Manufacturers and authorized distributors of prescription drugs must report to the Secretary of HHS information about the quantity of drug samples distributed and to whom they were given (effective as of March 23, 2010).

All Payers

- In addition to current reporting obligations on Form 1099, all those who pay for services must provide a Form 1099 to all corporate service providers that receive payments totaling more than \$600 per year. The existing exemption from this information reporting requirement for payments to a corporation is repealed. The requirement to file a Form 1099 has been extended to amounts paid in consideration for property and other gross proceeds for both property and services. The amount of such gross proceeds is required to be shown on the information return (effective for payments made on or after January 1, 2012).

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Government Agency Reporting and Disclosure

- The Secretary of Labor, using data from Form 5500, is to prepare an aggregate annual report on self-funded group health plans (effective for plan years beginning on or after January 1, 2014).
- The IRS is permitted to disclose to the DHHS information on individual tax returns to facilitate eligibility determinations and to verify cost sharing reductions or premium tax credits for those seeking to be, or who are, enrolled in State Insurance Exchanges (effective for plan years beginning on or after January 1, 2014).

Action Steps

Employers must familiarize themselves with these new reporting and disclosure requirements, and will need to ensure that its accounting and administrative systems can capture all relevant data. It is not too early to develop a team and work plan to ensure that these requirements are met. Communications with employees about these new requirements may also be necessary in certain instances.

If you have any questions about these new reporting and disclosure requirements, or any changes imposed by the ACA, please contact any of the Honigman attorneys listed on this Alert.

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