CLARKE & COMPANY
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HEALTH CARE REFORM: Legislative Brief

Reporting Requirements for Employers and Health Plans

The Affordable Care Act (ACA) created a number of federal reporting requirements for employers and health plans. The additional reporting is intended to promote transparency with respect to health plan coverage and costs. It will also provide the government with information to administer other ACA mandates, such as the large employer shared responsibility penalty and the individual mandate.

ACA reporting requirements for employers and health plans

- Form W-2 reporting
- Large employer health coverage reporting (Code § 6056)
- Reporting of health coverage by health insurance issuers and sponsors of self-insured plans (Code § 6055)
- Transparency in coverage reporting and cost-sharing disclosures
- Quality of care reporting

It is expected that federal agencies will issue more guidance on the new reporting requirements in the future. The Department of the Treasury recently announced that it is considering ways to simplify the new reporting requirements consistent with ACA, particularly the reporting required under Internal Revenue Code (Code) sections 6055 and 6056, and that it expects to issue more guidance later this summer.

Clarke & Company Benefits, LLC will continue to monitor health care reform developments and will provide updated information when it becomes available.

FORM W-2 REPORTING – CURRENTLY EFFECTIVE

ACA requires employers to report the aggregate cost of employer-sponsored group health plan coverage on their employees' Forms W-2. The purpose of the Form W-2 reporting requirement is to provide information to employees regarding how much their health coverage costs.

In general, all employers that provide "applicable employer-sponsored coverage" must comply with the Form W-2 reporting requirement. Applicable employer-sponsored coverage is, with respect to an employee, coverage under any group health plan made available to the employee by the employer which is excludable from the employee's gross income under Code section 106.

The Form W-2 reporting requirement is **optional for small employers for 2012 and 2013**. Small employers will continue to be exempt from the reporting requirement for later years, unless and until the IRS issues further guidance. An employer is considered a small employer if it had to file **fewer than 250 Forms W-2** for the prior calendar year.

Large employers (those that file 250 or more Forms W-2) were required to comply with the reporting requirement beginning in 2012 for the Forms W-2 that were due by the end of January 2013.

LARGE EMPLOYER HEALTH COVERAGE REPORTING (CODE § 6056) – DELAYED UNTIL 2015

Large employers subject to ACA's shared responsibility provisions must file a return with the IRS that reports the terms and conditions of the health care coverage provided to the employer's full-time employees for the calendar year. Related statements must also be provided to employees.

On Sept. 5, 2013, the Internal Revenue Service (IRS) issued **proposed regulations** on these information reporting requirements. The regulations are proposed to be effective for calendar years beginning on or after **Jan. 1, 2015**. This date reflects the one-year delay provided in IRS Notice 2013-45. However, the IRS is encouraging voluntary compliance for 2014.

An employer qualifies as a large employer under the shared responsibility provisions if it employed on average at least **50 full-time employees**, including full-time equivalents, on business days during the preceding calendar year.

The IRS will use the information that employers report to verify employer-sponsored coverage and administer the shared responsibility provisions for large employers. The shared responsibility provisions impose penalties on large employers that do not offer affordable, minimum value coverage to their full-time employees and dependents. **The ACA's employer penalties were set to take effect on Jan. 1, 2014, but they have been delayed until 2015.**

The large employer's return must include the following information:

- The employer's name and employer identification number (EIN);
- The date the return is filed;
- A certification of whether the employer offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan;
- The number of full-time employees for each month during the calendar year;
- The name, address and taxpayer identification number (TIN) of each full-time employee employed by the employer during the calendar year and the months (if any) during which the employee and any dependents were covered under the eligible employer-sponsored plan during the calendar year; and
- Any other information required by the IRS.

Most employer-sponsored health plans will qualify as minimum essential coverage. The ACA broadly defines "minimum essential coverage" to include both insured and self-insured group health plans, as well as plans with grandfathered status under the ACA. However, minimum essential coverage does not include specialized coverage, such as coverage only for vision care or dental care, workers' compensation, disability policies or coverage only for a specific disease or condition.

In addition, large employers that offer the opportunity to enroll in minimum essential coverage must report:

- The duration of any waiting period with respect to the coverage;
- The months during the calendar year when coverage under the plan was available;
- The monthly premium for the lowest-cost option in each enrollment category under the plan; and
- The employer's share of the total allowed costs of benefits provided under the plan.

The section 6056 information returns must be filed with the IRS annually, no later than February 28 (March 31 if filed electronically) of the year after the calendar year to which the return relates. Due to the one-year transition relief, the first section 6056 returns required to be filed are for the 2015 calendar year and must be filed no later than March 1, 2016 (Feb. 28, 2016, being a Sunday), or March 31, 2016, if filed electronically.

Large employers must also provide each full-time employee with a written statement that includes the information relating to that employee (and dependents) that is required to be reported on the IRS

return. The statement must be provided to full-time employees by **January 31** following the calendar year for which the information was required to be reported to the IRS. Extensions of this deadline may be available in certain circumstances. The first section 6056 employee statements (meaning the statements for 2015) must be furnished no later than Feb. 1, 2016 (Jan. 31, 2016, being a Sunday).

The proposed rules contain include provisions that reduce duplicative reporting and otherwise simplify reporting. The IRS has requested comments on a number of provisions. Comments can be submitted for a period of 60 days after the proposal is published in the Federal Register. A hearing on the proposed rules for section 6056 reporting will be held on Nov. 18, 2013.

REPORTING OF HEALTH COVERAGE FOR ISSUERS AND SELF-INSURED PLANS (CODE § 6055) – DELAYED UNTIL 2015

ACA requires every health insurance issuer, sponsor of a self-insured health plan, government agency that administers government-sponsored health insurance programs and any other entity that provides minimum essential coverage to file an annual return with the IRS reporting information for each individual who is provided with this coverage. Related statements must also be provided to individuals.

On Sept. 5, 2013, the IRS released **proposed rules** on the section 6055 reporting requirements. These rules are proposed to apply beginning in 2015, with the first returns due in 2016 for coverage provided in 2015. In 2014, employers are encouraged to voluntarily comply with the reporting requirements; however, compliance is completely optional for 2014 and no penalties will be assessed for failing to comply.

For employers with insured group health plans, it is anticipated that future IRS regulations will make the health Health insurance issuers are responsible for section 6055 reporting for all insured coverage except:

- Coverage under certain government-sponsored programs (such as Medicaid and Medicare) that provide coverage through a health insurance issuer; and
- Coverage under QHPs through the individual market Exchange.

To avoid collecting duplicate or unnecessary information, the proposed rules provide that issuers are not required to submit section 6055 information returns for coverage under a QHP through an individual market Exchange. The Exchange will provide the necessary information to the IRS and the individual. However, issuers must report on QHPs in the small group market enrolled in through the Small Business Health Options Program (SHOP), because the Exchanges will not be reporting information on these plans.

The IRS will use the information from the returns to implement the ACA's individual mandate (that is, the requirement that individuals obtain acceptable health insurance coverage for themselves and their family members or pay a penalty). **The ACA's individual mandate goes into effect in 2014.**

The return must include the following information:

- The name, address and TIN of the primary insured and each other individual covered under the policy or plan;
- The dates each individual was covered under the policy or plan during the calendar year;
- If the coverage is health insurance coverage, whether the coverage is a qualified health plan (QHP) offered through an Exchange;
- If the coverage is a QHP offered through an Exchange, the amount of any advance payment of the premium tax credit or of any cost-sharing reduction for each covered individual; and
- Any other information required by the IRS.

In addition, if health insurance coverage is through an employer's group health plan, the return must contain the following information:

- The name, address and EIN of the employer maintaining the plan;
- The portion of the premium (if any) to be paid by the employer; and
- Any other information the IRS may require to administer the ACA's small employer health care tax credit.

Reporting entities must file the section 6055 information return with the IRS by **February 28** (or March 31, if filed electronically) of the year following the calendar year in which they provided MEC.

The entity required to file the IRS return must also furnish a written statement to each individual listed on the return. The statement must be provided by **January 31** following the calendar year for which the information was required to be reported to the IRS.

The IRS has requested comments on a number of provisions. Comments can be submitted for a period of 60 days after the proposal is published in the Federal Register. A hearing on the proposed rules will be held on Nov. 19, 2013.

Combined Reporting

For large employers with self-insured health plans that are subject to both section 6055 and section 6056 reporting, **separate reporting is required** under the proposed rules. However, the proposed rules include provisions that reduce duplicative reporting and otherwise simplify reporting. For example, substitute forms and statements to individuals are permitted, which may allow self-insured health plans to furnish a single substitute statement to covered individuals for both sections 6055 and 6056.

In addition, the proposed rules provide that the IRS is considering permitting applicable large employers with self-insured plans that provide mandatory, minimum value coverage to employees and offer that coverage to spouses and dependents, all with no employee contribution, to forgo providing section 6056 statements to those covered employees. Because the section 6055 return would provide the individual taxpayers with information to accurately file income tax returns, and would provide the IRS the necessary information, the IRS is considering whether, for those employees, the employer could file and furnish only the return required under section 6055 and include a code on the employees' Forms W-2.

TRANSPARENCY IN COVERAGE REPORTING AND COST-SHARING DISCLOSURES – DELAYED UNTIL AT LEAST 2015

ACA requires health insurance issuers seeking certification of a health plan as a QHP under an Exchange to disclose certain information to the Exchange, Department of Health and Human Services (HHS) and state insurance commissioner. QHP issuers must also make this information available to the public. The information subject to reporting includes, for example, claims payment policies and practices, data on enrollment and disenrollment, data on the number of claims denied, data on rating practices and information on cost-sharing and payments for any out-of-network coverage.

Also, a health plan seeking QHP certification must provide certain cost-sharing disclosures (including deductibles, copayments and coinsurance) to participants upon request. At a minimum, this information must be made available through an Internet website and by other means for individuals without Internet access.

ACA's transparency in coverage reporting and cost-sharing disclosure requirements also apply to non-grandfathered group health plans and health insurance issuers offering group or individual coverage outside of an Exchange. The reporting requirements are identical to those for QHPs, except plans and issuers outside of the Exchange are not required to report information to an Exchange.

Because QHP insurers will not have certain required data until the first year of operation, this reporting requirement will go into effect after a QHP has been certified for one benefit year. This

reporting requirement will become applicable to other group health plans and insurers no sooner than when the QHP reporting requirement becomes effective.

It is expected that HHS will issue more guidance on this reporting requirement, including how it applies to health plans and issuers offering coverage outside of an Exchange.

QUALITY OF CARE REPORTING – EFFECTIVE DATE TO BE DETERMINED

ACA requires group health plans and health insurance issuers to submit an annual report to HHS regarding plan benefits and provider "reimbursement structures" that may affect the quality of care in certain ways. Grandfathered plans are not subject to ACA's "quality of care" reporting requirement.

In general, the report must address whether the plan or coverage:

- Improves health outcomes through activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives (including the medical homes model);
- Implements activities to prevent hospital readmissions using a comprehensive discharge program and post-discharge reinforcement;
- Implements activities to improve patient safety and reduce medical errors through best clinical practices, evidence-based medicine and health information technology; and
- Implements wellness and health promotion activities.

The annual quality of care reports will be available to the public through an Internet website. This report must also be provided to enrollees under the plan or coverage during each open enrollment period.

ACA does not include a compliance deadline for the quality of care reporting requirement. ACA required HHS to issue guidance on this reporting requirement by March 23, 2012 (that is, two years after ACA's enactment date). However, HHS has not yet issued this guidance. When this guidance is issued, it will likely specify a compliance deadline for plans and issuers.