



Update

Sept. 8, 2010



New notices and disclosures due under health care reform

Employers with group health plans must provide a host of new government reports and employee notices under the Patient Protection and Affordable Care Act (PPACA), as amended. While some requirements are straightforward, others await regulatory guidance, which may include model notices or forms. This *Update* highlights the health care reform law's new or expanded notices, reports and other disclosures.

What notices and reports does PPACA require?

The table on page 2 lists PPACA's new or expanded disclosures by known effective date. As the table shows, many requirements apply to all insured and self-insured health plans; others depend on a plan's grandfathered status (see the July 21 *Update*); and a few cover all employers or any employer offering or contributing to health coverage. Some debate remains about the effective dates for at least two new disclosures (see page 3 sidebar).

Employers with ERISA plans should note that even when a reform does not result in a new disclosure, benefit changes to conform to PPACA may trigger existing legal duties to distribute updated summary plan descriptions or summaries of material modifications. While regulators have issued model notices for some health care reforms, employers may want to revise the models or craft their own. Many notices for the coming plan year can be provided with open-enrollment materials.

What's required for the coming plan year?

For plan years starting on or after Sept. 23, 2010 (Jan. 1, 2011, for calendar-year plans), all group health plans must meet these notice requirements:

- **Extended dependent coverage and enrollment notice.** Plans that offer dependent coverage must provide a one-time notice informing employees that their children's coverage can continue until age 26 and offering a 30-day period to enroll eligible children who lost or were denied coverage because the plan had a lower age limit. Regulators have issued a model notice that employers may use (see the May 19 *Update*).

PPACA reporting and disclosure provisions	
Plan years starting on or after Sept. 23, 2010	
Dependent coverage extension and enrollment notice	All group health plans
Lifetime limits elimination and enrollment notice	All group health plans
30-day advance notice of coverage rescission	All group health plans
Grandfathered status disclosure	Grandfathered group health plans
Provider choice notice	All group health plans, unless grandfathered
Notices of adverse benefit determination, final internal adverse benefit determination and final external review decision	All group health plans, unless grandfathered
Disclosure of plan data	All group health plans, unless grandfathered
Quality-of-care report and employee notice	All group health plans, unless grandfathered
Tax years starting on or after Jan. 1, 2011 (first report due in 2012)	
Form W-2 health coverage reporting	All employers offering group health plans and/or contributing to health savings accounts (HSAs) or health reimbursement arrangements (HRAs)
Beginning Jan. 1, 2012	
Expanded Form 1099-MISC reporting	Any business paying more than \$600 to a property or service provider in calendar year
By March 23, 2012	
Summary of benefits	All group health plans
By March 1, 2013	
Health insurance exchange notice	All employers, regardless of health plan offering
Starting in 2014	
Employer report of health coverage offerings	Employers with more than 50 full-time equivalent (FTE) employees; certain other employers offering group health plan coverage
Employer report of individual health coverage	Employers offering self-funded group health coverage; insurers providing insured coverage
Starting in 2018	
Notice of high-cost coverage subject to excise tax	Employers and others liable for excise tax
Effective date uncertain	
Material modification notice	All group health plans
Auto-enrollment notice	All employers subject to the Fair Labor Standards Act (FLSA) that have more than 200 full-time employees and offer a group health plan

- **Lifetime limits elimination and enrollment notice.** Under PPACA, plans must eliminate lifetime dollar limits on essential health benefits (see the Aug. 11 *Update*). Eligible individuals who had lost coverage on reaching a plan's lifetime dollar limit must receive a written notice stating that the limit no longer applies and offering a one-time, 30-day special enrollment opportunity. A [model notice](#) is available for this purpose.

Notices with uncertain effective dates

Where PPACA omits a specific effective date, exactly when plans must provide certain notices is unclear.

Advance notice of material modification. Group health plans must give enrollees at least 60 days' advance notice of material modifications, unless the latest benefits summary covers the changes. Some believe this duty took effect with the law's enactment and currently applies to all plans. However, because the notice is tied to the new benefits summary, others believe this provision applies later.

Auto-enrollment notice. FLSA-covered employers that have more than 200 full-time employees and sponsor group health plans must automatically enroll employees and provide them auto-enrollment notices with an opt-out opportunity. Uncertainty remains about the effective date.

- **Advance notice of rescission.** Plans cannot retroactively cancel or terminate an individual's coverage, except in cases of deliberate fraud and similar situations. Plans that rescind coverage under the narrow grounds allowed must give affected individuals at least 30 days' advance notice.

Grandfathered status disclosure. Other disclosures depend on whether a plan has grandfathered status. If so, all benefit materials must clearly state that the sponsor believes the plan has grandfathered status and is exempt from certain health care reforms. Regulators have issued model language for this disclosure.

Nongrandfathered plan notices. If a group health plan does not have grandfathered status, additional notice requirements may apply for plan years starting on or after Sept. 23, 2010:

- **Provider choice notice.** PPACA requires certain network plans to offer enhanced provider choice and direct access to OB/GYN services. Affected plans can use model language for the mandatory notices informing enrollees about these new rights.
- **Claim appeals notice.** Enrollees whose claims are denied must receive notices about a plan's procedures for internal appeals and external reviews of these decisions. Model notices are available for initial and final internal adverse benefit determinations and for final external review decisions.
- **Plan data disclosure.** PPACA requires plans to provide certain government agencies and the public with information related to enrollment and disenrollment; claims payments, denials, processing and appeals; cost sharing; financial information; and covered individuals' rights. Regulators must develop "plain language" standards for this disclosure, but guidance is not yet available.
- **Quality-of-care report and notice.** Plans must annually file a report and provide enrollees a notice describing quality-of-care initiatives, including wellness programs; health-improvement activities; and efforts to prevent hospital readmissions, improve patient safety or reduce medical errors. The due date for the first reports and notices is uncertain.

What other notices or reports will apply in later years?

Form W-2 health coverage reporting. For tax years starting on and after Jan. 1, 2011, employers must report the value of each employee's health coverage on Form W-2, the annual wage and tax statement, although the amount will remain tax-free. The W-2s due in early 2012 will be the first to report coverage costs for the prior calendar year. More guidance is expected on this requirement.



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*This **Update** represents our current understanding of an evolving health care reform landscape, subject to change in the event of further guidance and regulations. It is for information only and does not constitute legal advice; consult with legal and tax advisers before applying this information to your situation.*

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Form 1099-MISC reporting. Starting in 2012, businesses must report to the IRS on Form 1099-MISC, Miscellaneous Income, any payment of \$600 or more to a corporation for goods and services and send a copy to the vendor. Payments to nonprofits and tax-exempt governmental entities remain excluded. Proposed legislation would repeal or scale back this expanded reporting duty, but prospects for action are uncertain.

Benefits summary. By March 23, 2012, group health plan sponsors and insurers must provide a benefits summary during annual open enrollment and when someone first becomes eligible for coverage. This summary will cover information similar to a summary plan description but use a standardized, four-page format to be prescribed by regulators.

Health insurance exchange notice. Before the expected start of health insurance exchanges in 2014, all employers will have to provide employees a notice explaining the coverage available from the exchanges and the tax credits and free-choice vouchers to offset costs for certain employees. More guidance is expected.

Employer report of health coverage offerings. Starting in 2014, any employer (or an insurer on an employer's behalf) that has more than 50 full-time employees or requires employees to pay more than 8% of wages for coverage must file an annual report with the IRS describing the health coverage(s) offered. By Jan. 31 of the year after an annual report is filed, employees covered in the report must receive a notice with details reported on their coverage.

Employer report of individual health coverage. Starting in 2014, employers with self-funded health plans must report to the IRS about their plans and covered participants. Covered individuals must receive notices with information about their own benefits reported in the IRS filing. For insured coverage, the insurer is responsible for the IRS report and individual notices.

Notice of high-cost coverage. Starting in 2018, any employer sponsoring "high-cost coverage" triggering PPACA's 40% excise tax must notify the IRS and the health insurer (for insured coverage) or plan administrator (for self-insured coverage) and provide information on each party's associated tax liabilities.