HealthAffairsBlog

Labor, IRS Propose New Health Plan Reporting Requirements; CMS Makes Its Case On Cost Sharing

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Most of the regulations and guidance analyzed in the "Following the ACA" *Health Affairs* Blog series are issued by the Centers for Medicare and Medicaid Services of the Department of Health and Human Services. HHS shares jurisdiction over the implementation of the ACA's insurance reforms, however, with the Employee Benefits Security Administration (EBSA) of the Department of Labor (DOL) and the Internal Revenue Service (IRS) of the Department of the Treasury. On July 11, EBSA posted a proposed rule on annual reporting and disclosure while EBSA, the IRS, and the Pension Benefit Guaranty Corporation (PBGC) posted an identical proposed revision of annual reporting forms and reports.

The proposed regulation relates to revisions to Form 5500, the Annual Return/Report of Employee Benefit Plans and Form 5500-SF, Short Form Annual Return/Report for Small Employee Benefit Plans. Pension and other employee benefit plans have long been required to file the form 5500, which focuses on the financial condition and operation of such plans. Form 5500 serves as an important disclosure document for plan participants and beneficiaries, but also serves as a critical enforcement, compliance, and research tool for EBSA, the IRS, and the PBGC; it also provides information for other federal agencies, Congress, and the private sector as well.

There are an estimated 2.3 million employee health plans covering, together with other health and pension plans, roughly 143 million private sector workers, retirees, and dependents. These numbers dwarf the numbers of plans and enrollees participating in the marketplace. Form 5500 is the primary source of information, funding, and investments of these plans.

The proposed revisions are intended to update the form 5500. They would also, however, extend basic reporting requirements to group health plans that are subject to the Employee Retirement Income Security Act (ERISA) and that have fewer than 100 members, most of which are currently exempt from reporting. Finally, they would establish a new Schedule J, which must be filed by all group health plans and which is intended to implement the transparency requirements of the Affordable Care Act (ACA). This post will focus on the proposed Schedule J and its requirements.

The Statutory Scheme

Section 2715A of the Public Health Services Act, as added by the ACA and applied to group health plans by section 715 of ERISA, requires non-grandfathered group health plans and health insurers offering non-grandfathered health plans to report to the DOL, HHS, Treasury, state insurance commissioners, and the public a host of information on health plan enrollment and claims, including:

(1) claims payment policies and practices;

(2) periodic financial disclosures;

(3) data on enrollment and disenrollment;

(4) data on the number of denied claims;

(5) data on rating practices;

(6) information on cost-sharing and payments with respect to any out-of-network coverage;

(7) information on enrollee and participation rights; and

(8) other information as determined by the Secretary.

In addition, section 2717 of the PHSA, also added by the ACA and applied to non-grandfathered group health plans by ERISA, requires reporting of various quality and outcome information. The information reported by plans will also assist the Secretary of Labor in making an annual report to Congress on self-insured health plans required by the ACA.

These ACA “transparency” provisions are very slowly and still only partially being implemented by HHS with respect to qualified health plans in the federal marketplace and in state marketplaces that use the federal platform. The regulations and forms proposed by the DOL would begin to implement these requirements with respect to group health plans as well.

The Proposed New Schedule J

The proposed rule and forms intend to collect data from, and provide it to, participants, beneficiaries, and regulators. The new Schedule J would collect information about benefits and plan design characteristics; funding; grandfathered plan status; medical loss ratio rebates and other rebates received by the plan; service provider information; information on any stop loss insurance; claims processing and payment information; wellness program

information; and other compliance information. DOL may require additional information in the future. See note 1

The new form 5500 and the Schedule J would apply to the approximately 800,000 ERISA plans with 100 or more participants that currently file the form 5500. Group health plans with fewer than 100 participants that are funded using a trust or that are completely or partially unfunded would generally have to file the same information as larger group plans, including the schedule J. Approximately 2.15 million fully insured plans with fewer than 100 participants will also be required to complete and file limited sections of the form 5500 and Schedule J. DOL will not be accessing data that are collected by the IRS for employer responsibility enforcement purposes; neither will it be using HHS data which are not collected at the plan level and thus are not suitable for ERISA purposes.

DOL is specifically seeking public comments on the proposed collection of information in light of the Supreme Court's decision in Gobeille v. Liberty Mutual Insurance Co. At first glance, it is hard to see that the information DOL proposes to collect under the Schedule J would be an adequate substitute for the all-payer claims database information that states were barred from collecting from ERISA plans under Gobeille.

Fully insured plans for plans with fewer than 100 participants would only be required to complete lines of Schedule J providing basic identifying information and basic participation, coverage, insurance company, and benefit information.

CMS Pushes Back On Cost Sharing Criticisms

A common criticism of Affordable Care Act marketplace coverage is that consumer cost sharing—that is deductibles, coinsurance, and copayments—is very high, indeed unaffordable for many enrollees. On July 12, the Centers for Medicare and Medicaid Services released a data brief pushing back against this assertion.

The brief contends that analyses that simply report average or median deductibles for various metal level plans in the marketplaces overlook two important qualifications. First, almost 60 percent of marketplace enrollees qualify for financial assistance that reduces their cost-sharing. One third of Healthcare.gov marketplace enrollees qualify for high cost-sharing assistance that reduces the median, enrollment-weighted deductible in 2016 to $0, and another 19 percent qualify for medium cost-sharing assistance that reduces the median, enrollment-weighted, 2016 deductible to $500.

Higher-income marketplace enrollees and enrollees in bronze plans, who do not qualify for premium tax credits, face higher deductibles. Twelve percent of enrollees purchase silver plans with no cost-sharing assistance (median 2016 deductible, $3000) and 21 percent buy bronze plans (median 2016 deductible $6,300).

(The cost-sharing reduction payments are, of course, the focus of the *House v. Burwell* litigation currently pending on appeal before the D.C. Circuit. If the House were to prevail in that litigation, the funding for the cost-sharing reductions, which make health care affordable for lower-income enrollees, would be threatened.)

Second, on average Healthcare.gov marketplace policies cover seven common health services before the deductible (in addition to preventive services) that are offered with no or with low cost sharing. These include, for example generic drugs, primary office visits, specialist visits, preferred brand drugs, and mental or behavioral health outpatient services. Only 19 percent of plans apply their deductible to all services other than preventive services. Focusing on deductibles, therefore, does not present an accurate picture of actual cost-sharing burdens.

The brief notes that the median individual deductible for Healthcare.gov coverage in 2016 is $850, lower than the $900 median for 2015. The brief summarizes an Urban Institute survey from 2015, which shows that by many measures marketplace plans perform similarly to employer-sponsored plans in providing access to care and financial protection. For example, 25.6 percent of marketplace enrollees had problems paying medical bills in the past 12 months compared to 24.5 percent for employer-sponsored plan enrollees; 21.2 percent of marketplace enrollees had out-of-pocket costs of $1,500 or more in the preceding 12 months, compared to 23.7 percent of employer sponsored plan enrollees.

The brief also notes census data that show that the total out-of-pocket cost for individual coverage fell by 25 percent from 2013 levels as the ACA market reforms went into effect in 2014.

Note 1.

In more detail, proposed Schedule J would collect information on group health plans subject to reporting requirements, including:

- The approximate number of participants and beneficiaries covered under the plan at the end of the plan year;
- the number of persons offered and receiving COBRA coverage under the plan;
- whether the plan offers coverage for employees, spouses, children, and/or retirees, and what type of group health benefits are offered under the plan, for example, medical/surgical, pharmacy or prescription drug, mental health/substance use disorder, wellness program, preventive care, vision, dental, or various other types of benefits;
- whether the health plan funding and benefit arrangement is insured and whether benefits are paid through a trust or from the general assets of the employer;
- whether there are participant and/or employer contributions;
- With respect to plans that use a prototype health insurance policy or arrangement, the relevant unique identifying information of the prototype/off-the-shelf policy or arrangement;
- whether one or more benefit package options are grandfathered;
- whether a plan is a high deductible health plan, a health flexible spending account, or a health reimbursement account;
- whether a plan received rebates, refunds, or reimbursements from a service provider, including medical loss ratio rebates, the amount of rebates, and how rebates were used;
- identifying information for service providers to the plan, such as a third party administrator/claims processors, including an insurer subject to an “administrative services only (ASO)” contract, mental health benefits manager, wellness program manager, substance use disorder benefits manager, pharmacy benefit manager/drug provider, or independent review organization;
- total premium payments made for any “stop loss” coverage, as well as information on the attachment points of coverage, individual claim limits, and/or the aggregate claim limits;
- for health plans not fully insured, information regarding employer and participant contributions, including employer contributions received, participant contributions received, employer contributions receivable, participant contributions receivable, other contributions received or receivable (including non-cash contributions) and the total of all contributions, as well as whether there was at any time during a reporting period a failure to timely transmit participant contributions to the plan;
- claims payment data, including how many post-service benefit claims were submitted during the plan year, how many benefit claims were approved during the plan year, how many benefit claims were denied during the plan year, how many benefit claim denials were appealed during the plan year, how many appealed claims were upheld as denials,

how many were payable after appeal, and whether any claims for benefits were not adjudicated within the required timeframes. Also information on how many pre-service claims were appealed during the plan year, and how many of those appeals were upheld during the plan year as denials and how many were approved during the plan year after appeal. (A pre-service claim is any claim for which approval is required before seeking medical care. A post-service claim is a claim for which advance approval is not required);
- whether the plan was unable to pay claims at any time during the plan year and, if so, the number of unpaid claims;
- the total dollar amount of claims paid during the plan year; and
- if the plan was insured, any delinquent payments to the insurance carrier within the time required by the insurer and whether any delinquencies resulted in a lapse

DOL is also considering collecting more information on denied claims, such as the dollar amount of claims denied, denial codes, and/or whether claims were for mental health and substance abuse disorder benefits or medical/surgical benefits. DOL recognizes, however, the need for a more uniform classification of denial codes and the need to establish a more uniform measure for "dollar amount." (Should it be based on a provider's fee, that plan's negotiated fee schedule, Medicare reimbursement rates, a state-published prevailing fees, or some other amount?)

The proposed Schedule J further contains a compliance section that would ask:

- whether all plan assets were held in trust or held by an insurance company qualified to do business in a State or under insurance contracts or policies issued by insurers consistent with federal regulations, except where plan assets are not held in trust in compliance with technical guidance;
- whether the plan's summary plan description (SPD), summaries of any material modifications (SMM), and summary of benefits and coverage (SBC) comply with applicable content requirements;
- whether coverage provided by the plan is in compliance with applicable federal laws and DOL regulations including the portability and nondiscrimination requirements of the Health Insurance Portability and Accountability Act, GINA's prohibitions against genetic information discrimination, mental health parity requirements, and protections of the Newborns' and Mothers' Health Protection Act of 1996, the Women's Health and Cancer Rights Act of 1998, Michelle's Law, and the Affordable Care Act

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