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How Much is Too Much? Employer-Sponsored Plan Notice and Reporting Requirements Under PPACA, 47 J. Marshall L. Rev 855 (2014)

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HOW MUCH IS TOO MUCH? EMPLOYER-SPONSORED PLAN NOTICE AND REPORTING REQUIREMENTS UNDER PPACA

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An initial pass through the dense Patient Protection and Affordable Care Act (“PPACA” or “ACA”)² and its ever-increasing volume of governing regulations³ reveals at least one thing: we are

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² Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010) (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (2010) (HCERA). The version of PPACA consolidating the amendments made by title X of PPACA and the HCERA, as prepared by the House Office of the Legislative Counsel (HOLC) for the use of its attorneys and its clients, spans a remarkable 907 pages.

³ While we have not seen an official computation of the length of ACA

all glad that the days of carbon paper copies are gone! Employer notice and reporting obligations are strewn throughout this law. These notice requirements are layered on top of a myriad of existing notice and disclosure requirements applicable to group health plans, and in many respects require duplicative or overlapping disclosures.⁴ To date, no regulatory efforts have been devoted to coordinating these disparate notice requirements.

Congress and the administration's enforcing agencies' apparent thinking has been that more information is always better, and PPACA is no exception. The notice and reporting requirements imposed on employers with respect to their employees and the enforcing agencies are prevalent (or, perhaps more accurately, overwhelming). The purpose of this article is to consider the point at which employers are being asked to provide too much information in too many formats that really provides no added value. Stated another way – when does the law of diminishing returns⁵ prevail such that the expenditure of time associated with creating and sending notices is not a valuable exercise – but one that not only fails to increase, but perhaps even reduces the ability to understand and process information? This article also advocates for adoption of a methodology that is consistent with this administration's stated goals of using the “best, most innovative, and least burdensome tools for achieving regulatory ends” that take into account “benefits and costs”⁶ and that streamline PPACA's reporting requirements to achieve the goals of Congress and the enforcing agencies without imposing unnecessary financial and administrative burdens on employers – and paralyzing (or mind-numbing) employees.

To set the stage, we will summarize the types of notices

regulations, popular press reports that, as of July 2012, at least 13,000 pages of regulations had already been drafted by the implementing agencies and that, as of October 2013, the ACA final regulations were comprised of 11,588,500 words. See Grant, *So What Exactly Do We Get For Our New Tax?*, FORBES.COM, available at www.forbes.com/sites/richardgrant/2012/07/15/so-what-exactly-do-we-get-for-our-new-tax (last visited Jan. 31, 2014); Star, *CSNNEWS.COM, 11,588,500 Words: Obamacare Regs 30x as Long as Law*, available at www.csnnews.com/news/article/penny-starr/11588500-words-obamacare-regs-30x-log-law (last visited Feb. 5, 2014).

⁴ For example, the ACA-required “Summary of Benefits and Coverage” requires disclosure of information which must be disclosed to the summary plan description mandated by ERISA. 77 Fed. Reg. 18,310, 18,328 (Mar. 27, 2012).

⁵ Encyclopedia Britannica describes the “law of diminishing returns” as the “economic law stating that if one input in the production of a commodity is increased while all other inputs are held fixed, a point will eventually be reached at which additions of the input yield progressively smaller, or diminishing, increases in output.” See Editors of the Encyclopedia Britannica, “diminishing returns” *Britannica Online*, www.britannica.com/EBchecked/topic/163723/diminishing-returns (last visited Jan. 29, 2014).

⁶ Exec. Order 13563, 3 C.F.R. § 13563 (2011), available at www.gpo.gov/fdsys/pkg/CFR-2012-title3-vol1/pdf/CFR-2012-title3-vol1-eo13563.pdf.

implemented with PPACA, which include:

- A. Grandfathered Plan Notice
- B. Notice of Coverage of Children Up to Age 26
- C. Notice of Patient Protections
- D. Notice of Lifetime Limit Elimination
- E. Notice of Rescission⁷
- F. Notice of Early Retiree Reinsurance Program Participation
- G. Notice to Employees of Coverage Options (also known as the “Marketplace Notice” or “Exchange Notice”)
- H. Automatic Enrollment Notice
- I. Summary of Benefits & Coverage (“SBC”)
- J. Notice of Material Modifications
- K. W-2 Cost of Coverage Reporting
- L. Information Reporting under Code Sections 6055 and 6056

We will then outline the anticipated time and costs associated with drafting, completing, and distributing these notices and reports. We will contrast this information with the anticipated value these additional notices will provide to the intended recipients. Finally, we will detail a proposal for consolidation or elimination of certain notice requirements to reduce the burden on employers without decreasing the provision of relevant/helpful information for employees or hindering the ability of the enforcing agencies to ensure compliance with the substantive aspects of the law.

I. PPACA’S LITANY OF NOTICE AND REPORTING REQUIREMENTS

PPACA added many new specific participant notice and disclosure requirements applicable for health plans, insurers, and employers. PPACA also imposed new obligations for employers who

⁷ Note that additional market reform provisions outlined in PPACA do not contain specific notice requirements, but will trigger (or already have triggered) the need for sponsors to update the governing summary plan descriptions (“SPDs”) or prepare summary of material modifications (“SMMs”), and to distribute the same to participants and beneficiaries, in accordance with 29 U.S.C. § 1022. For example, updated SPDs or new SMMs need to describe, as applicable, the discontinuation of any now-prohibited annual limits (under PHSA § 2711), procedures related to enhanced internal and external claims and appeals processes (under PHSA § 2719), information on any annual cost-sharing imposed under the plan (under PHSA § 2707(b)), changes in waiting periods that were in excess of 90 days (under PHSA § 2708), removal of any preexisting condition exclusions (under PHSA § 2704), or changes in cost-sharing limitations under certain preventive services (under PHSA § 2713). These requirements are beyond the scope of the notice requirements discussed in this article, but should not be overlooked as yet another employer notice requirement existing under ERISA.

sponsor health insurance plans to report certain information to the government. Our focus in this article is those notice and reporting requirements impacting employers who sponsor (or, under the law will be required to either sponsor, contribute to, or, alternatively, pay excises taxes with respect to⁸) group health plans for their full-time employees.

The portion of PPACA that implicates notice and reporting obligations of employer-sponsored group health plans modifies not only the Employee Retirement Income Security Act of 1974, as amended (“ERISA”)⁹ and the Internal Revenue Code of 1986, as amended (“Code”), but also the Fair Labor Standards Act (“FLSA”)¹⁰ and the Public Health Service Act (“PHSA”).¹¹ Given the breadth and variety of laws implicated by PPACA, the Internal Revenue Service (“IRS”), Department of the Treasury (“Treasury”), the Employee Benefits Security Administration (“EBSA”) of the Department of Labor (“DOL”), Centers for Medicare & Medicaid Services (“CMS”), and the Department of Health and Human Services (“HHS”), all have certain jurisdiction and responsibility over implementing and enforcing certain aspects of the PPACA as well as promulgating the governing regulations and other interpretive guidance.¹² For simplicity (and since it is largely irrelevant for our purposes in this article), we shall refer collectively to these enforcing agencies as the “Departments” throughout this article.¹³

A. Grandfathered Plan Notice

Section 1251 of the ACA, as modified by section 10103 of the ACA and section 2301 of the HCERA, specifies that certain plans or coverage¹⁴ existing as of March 23, 2010 (the date PPACA was enacted), that satisfy certain conditions are treated as “grandfathered plans” and are, therefore, excepted from certain

⁸ 26 U.S.C. § 4980H.

⁹ Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered Sections of 5 U.S.C., 18 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.).

¹⁰ Fair Labor Standards Act of 1938, 29 U.S.C. § 201 et seq.

¹¹ Public Health Service Act, 42 U.S.C. § 201 et seq.

¹² See, e.g., PHS Act section 2715A, which also is incorporated into section 715(a)(1) of ERISA, and section 9815(a)(1) of the Code. Accordingly, HHS, the DOL, and Treasury have concurrent jurisdiction over the implementation of PHS Act section 2715A.

¹³ However, for accuracy’s sake, we note that not all of the distinct agencies are involved with (or have jurisdiction over) each separate notice and reporting obligation discussed herein.

¹⁴ PPACA, Pub. L. No. 111-148, § 1251(e) (2010).

provisions of the law.¹⁵ The interim final regulations¹⁶ (on which plans may rely until final regulations are issued)¹⁷ require that, in order to maintain status as a grandfathered health plan, a plan must, among other things, include in “any plan materials”¹⁸ provided to participants or beneficiaries describing the benefits provided under the plan or health insurance coverage, a statement that the plan “believes” that it constitutes a grandfathered health plan within the meaning of section 1251 of the ACA and contact information for questions and complaints.¹⁹

The interim final regulations contain model language that may be included in plan documents (such as SPDs) to satisfy the grandfathered plan disclosure requirement.²⁰ The Departments

¹⁵ The PPACA provisions applicable to grandfathered plans are summarized by the DOL here: www.dol.gov/ebsa/pdf/grandfatherregtable.pdf (last visited Feb. 2, 2014); and in the Preamble to Grandfathered Health Plan Regulations, 75 Fed. Reg. 34,542 (June 17, 2010).

¹⁶ 26 C.F.R. § 54.9815–1251T; 29 C.F.R. § 2590.715–1251; 45 C.F.R. § 147.140.

¹⁷ The interim final rules may be relied upon until final rules are published. 75 Fed. Reg. at 34,537.

¹⁸ This ambiguous language caused concern about whether a grandfathered health plan sponsor needed to provide the disclosure statement every time it sends out a communication related to the plan. The Departments (somewhat) clarified this issue in FAQs About the Affordable Care Act Implementation Part IV, Q/A-1, *available at* <http://www.dol.gov/ebsa/faqs/faq-aca4.html> (last visited Jan. 16, 2014), stating that a plan sponsor will comply with this requirement if it distributes a grandfathered plan statement whenever it distributes an SBC to participants and beneficiaries. The Departments provided the following example of when disclosure would be required: “many plans distribute summary plan descriptions upon initial eligibility to receive benefits under the plan or coverage, during an open enrollment period, or upon other opportunities to enroll in, renew, or change coverage.” Despite this implicit “safe harbor” the Departments further “encouraged” plan sponsors to identify other communications in which disclosure of grandfathered status would be appropriate and helpful to participants and beneficiaries. *Id.*

¹⁹ 26 C.F.R. § 54.9815–1251T(a)(2); 29 C.F.R. § 2590.715–1251(a)(2); 45 C.F.R. § 147.140(a)(2).

²⁰ The Model language is set forth in 26 C.F.R. § 54.9815–1251T(a)(2)(ii), 29 C.F.R. § 2590.715–1251(a)(2)(ii), and 45 C.F.R. § 147.140(a)(2)(ii), and provides as follows:

This [group health plan or health insurance issuer] believes this [plan or coverage] is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

estimate that 2.2 million ERISA-covered group health plans will be subject to this disclosure requirement and those 2.2 million plans will be required to notify an estimated 56.3 million participants/policy holders of their plans' grandfathered health plan status.²¹

B. Notice of Coverage of Children Up to Age 26

PHSA section 2714, as added by PPACA,²² mandates that to the extent a group health plan or insurer provides dependent coverage for children, then it must make such coverage available until a child turns age 26. The mandate became effective for plan years beginning on or after September 23, 2010 (i.e., January 1, 2011, for calendar-year plans).²³

The interim final regulations issued by the Departments in May of 2010 require that a plan give eligible adult children an opportunity to enroll that continues for at least 30 days as well as written notice of that opportunity to enroll.²⁴ This enrollment opportunity (including the written notice) was required to be provided by the first plan year beginning on or after September 23, 2010. The Departments estimated that approximately 105 million individual notices will be distributed to satisfy this requirement.²⁵

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.]

²¹ The Departments' estimate of the number of ERISA-covered health plans was obtained from the 2008 Medical Expenditure Panel Survey's Insurance component. 75 Fed. Reg. at 34,555. This data reveals that there are 72,000 "large ERISA-covered health plans" (i.e., those with at least 100 participants) and 2.8 million small group health plans (i.e., those with 3-99 participants), with an estimated 97 million participants and beneficiaries in large group plans and 40.9 million participants and beneficiaries in small group plans. *Id.* at 34,550.

²² Parallel provisions for changes made to the PHSA were incorporated by reference in the Code (Code § 9815, as added by PPACA § 1563(f)) (formerly PPACA § 1562(f)) and in ERISA (ERISA § 715, as added by PPACA § 1563(e)) (formerly PPACA § 1562(e)).

²³ 26 C.F.R. § 54.9815-2714(a)(2); 29 C.F.R. § 2590.715-2714; 45 C.F.R. § 147.120.

²⁴ 26 C.F.R. § 54.9815-2714(e)(2); 29 C.F.R. § 2590.715-2714(e)(2); 45 C.F.R. § 147.120(e)(2).

²⁵ 75 Fed. Reg. 27,130 (May 13, 2010).

Note that this notice is in addition to and separate from the need to prepare and distribute a new SPD or summary of material modification (“SMM”)²⁶ alerting participants and beneficiaries to this change in plan design (discussed more fully below).

C. Notice of Patient Protections

Section 2719A of the PHSA,²⁷ as added by the ACA, requires that plans and issuers provide participants the right to choose a primary care provider /pediatrician (for plans that require or allow such designations) and also to obtain obstetrical or gynecological care without a referral. The implementing regulations²⁸ add a notice requirement with respect to these available choices.²⁹ Under the regulations, this notice must be provided whenever the plan or issuer provides a participant with an SPD or other similar description of benefits under the plan or health insurance coverage.³⁰ This notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010. Model language to satisfy this requirement was provided in the interim final regulations.³¹

D. Notice of Lifetime Limit Elimination

Effective for plan years beginning on or after September 23, 2010, section 2711 of the PHSA³² restricts group health plans and insurers from imposing any lifetime limit on the dollar amount of

²⁶ 29 U.S.C. § 1022.

²⁷ 42 U.S.C. § 300gg-19a(d).

²⁸ 26 C.F.R. § 54.9815-2719AT; 29 C.F.R. § 2590.715-2719A; 45 C.F.R. § 147.138.

²⁹ The Departments indicate that this notice obligation was added, despite the statute not calling for it, simply because it “is important that individuals enrolled in a plan or health insurance coverage know of their rights.” 75 Fed. Reg. at 37,194.

³⁰ *Id.*

³¹ 26 C.F.R. § 54.9815-2719AT(a)(4)(iii); 29 C.F.R. § 2590.715-2719A(a)(4)(iii); 45 C.F.R. § 147.138(a)(4)(iii). The Model language provides as follows:

[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].

Id.

³² 42 U.S.C. § 300gg-1.1

essential health benefits for any individual. The implementing regulations³³ require that anyone who exhausted a lifetime limit on the dollar value of all benefits under a group health plan or insurance coverage before the prohibition became effective and who is otherwise eligible under the plan or coverage is entitled to a one-time special enrollment right to re-enroll as of the first day of the first plan year on or after September 23, 2010.³⁴ These individuals must be provided a written notice (no later than the first day of the first plan year beginning on or after September 23, 2010) informing them of the elimination of the lifetime limit and of their opportunity to enroll as of the first day of the first plan year beginning on or after September 23, 2010.³⁵

E. Notice of Rescission

PHSA section 2712³⁶ is another market reform provision added by the ACA that prohibits a plan or issuer from rescinding coverage under the plan, policy, certificate, or contract of insurance except in the case of fraud or intentional misrepresentation of a material fact and following the provision of notice. The interim final regulations provide that a group health plan or a health insurance issuer offering group health insurance coverage must provide at least 30 calendar days before such a rescission.³⁷

F. Notice of Early Retiree Reinsurance Program Participation

While the statute establishing the Early Retiree Reinsurance Program (“ERRP”)³⁸ is silent on any participant notice obligations, and the interim final regulations³⁹ are similarly quiet on the issue, HHS, as the enforcing agency over this program,⁴⁰ issued guidance on the ERRP website indicating that plan sponsors must send a form notice to plan participants regarding the sponsor’s participation in the ERRP.⁴¹ The notice is intended to inform plan

³³ 26 C.F.R. § 54.9815–2711T; 29 C.F.R. § 2590.715–2711; 45 C.F.R. § 147.126.

³⁴ 26 C.F.R. § 54.9815–2711T(e); 29 C.F.R. § 2590.715–2711(e); 45 C.F.R. § 147.126(e).

³⁵ *Id.*

³⁶ 42 U.S.C. § 300gg-12.

³⁷ 26 C.F.R. § 54.9815–2712T.

³⁸ P.L. 111-148: Law Sec. 1102.

³⁹ 75 Fed. Reg. 24,450 (May 5, 2010).

⁴⁰ Generally, EERP is a \$5 billion program designed to provide “reimbursement to participating employment-based plans for a portion of the cost of health benefits for early retirees and their spouses, surviving spouses and dependents.” *Id.*

⁴¹ HHS, *Instructions for Delivering Required Form Notice to Plan Participants of Sponsors Participating in Early Retiree Reinsurance Program, and Form Notice*, available at http://errp.gov/download/Notice_to_Plan_

participants that they may experience changes in the terms and conditions of their plan participation since the plan is participating in the ERRP and that the plan may, therefore, use the ERRP reimbursements to reduce premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs.⁴² According to HHS, the text of form notice may not be changed in any way (regardless of whether it is delivered separately or with other materials).⁴³

G. Marketplace (or Exchange) Notice

Section 18B of the FLSA,⁴⁴ as added by section 1512 of the ACA,⁴⁵ generally provides that employers subject to the FLSA⁴⁶ must provide employees written notice of the following:

The existence of the ACA “Marketplace” (referred to in ACA as the “Exchange”) including a description of the services provided by the Marketplace, and the manner in which the employee may contact the Marketplace to request assistance;

If the employer plan’s share of the total allowed costs of benefits provided under the plan is less than 60 percent of such

Participants.pdf (last visited Feb. 10, 2014). The authority to require distribution of this notice is unclear; in addition, the model notice does not display a currently valid OMB control number. However, since the EERP program has sunset by operation of law, we don’t belabor this issue. P.L. 111-148: Law Sec. 1102(a)(1).

⁴² HHS, *Early Retiree Reinsurance Program Common Questions*, Miscellaneous, Answer ID: 500-2, available at www.errp.gov/faq_misc.shtml (last visited Jan. 5, 2014).

⁴³ *Id.* at Answer ID: 500-8.

⁴⁴ 29 U.S.C. § 218B.

⁴⁵ 42 U.S.C. § 18B, as added and amended by P.L. 111-148, Sec. 1512, Title I, Subtitle F, Part II, Sec. 10108(i)(2), Title X; April 15, 2011, P.L. 112-10, Sec. 1858(c) Title VIII.

⁴⁶ 29 U.S.C. section 203(s) provides that the FLSA applies to [e]nterprise engaged in commerce or in the production of goods for commerce” means an enterprise that: has employees engaged in commerce or in the production of goods for commerce, or that has employees handling, selling, or otherwise working on goods or materials that have been moved in or produced for commerce by any person; and is an enterprise whose annual gross volume of sales made or business done is not less than \$500,000 (exclusive of excise taxes at the retail level that are separately stated); is engaged in the operation of a hospital, an institution primarily engaged in the care of the sick, the aged, or the mentally ill or defective who reside on the premises of such institution, a school for mentally or physically handicapped or gifted children, a preschool, elementary or secondary school, or an institution of higher education (regardless of whether or not such hospital, institution, or school is public or private or operated for profit or not for profit); or an activity of a public agency.

The DOL’s Wage and Hour Division provides an interactive internet compliance assistance tool designed to assist employer in determining whether the FLSA applies to them. See www.dol.gov/elaws/esa/flsa/scope/screen24.asp (last visited Jan. 29, 2014).

costs (i.e., the plan does not provide “minimum value”), that the employee may be eligible for a premium tax credit under section 36B of the Code if the employee purchases a qualified health plan through the Marketplace; and

If the employee purchases a qualified health plan through the Marketplace, the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer, and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

This notice requirement applies both to employers providing group health coverage and those not offering coverage.⁴⁷ In addition, employers must provide a notice of coverage options to each employee, regardless of plan enrollment status or of part-time or full-time status.⁴⁸ Employers are not required to provide a separate notice to dependents or other individuals who are not employees.⁴⁹

On January 24, 2013, the DOL issued guidance delaying the effective date on the initial notice (originally set by statute to be March 1, 2013) to coordinate with the HHS’s educational efforts and the IRS’s guidance on minimum value (see B.2. above). Following additional guidance, this notice was to be provided by employers to their then-current employees, by October 1, 2013, and, for 2014, to new employees hired after October 1, 2013, within 14 days of their start date.⁵⁰ The Departments clarified⁵¹ that the Marketplace notice must be provided in writing in a “manner calculated to be understood by the average employee” via either first-class mail or electronically, provided the requirements of the DOL’s electronic disclosure safe harbor⁵² are met.

H. Automatic Enrollment Notice

Section 18A of the FLSA,⁵³ as added by section 1511 of PPACA, generally provides that an employer (1) with more than 200 full-time employees, and (2) that offers employees enrollment

⁴⁷ The DOL provided two separate models available at www.dol.gov/ebsa/pdf/FLSAwithplans.pdf (“New Health Insurance Market Options”) and www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf (“Your Health Coverage, Form No. 1210-0149”) (last visited Jan. 20, 2014).

⁴⁸ EBSA Technical Release No. 2013-02, United States Department of Labor, at III (May 8, 2013) *available at* www.dol.gov/esba/newsroom/tr13-02.html.

⁴⁹ *Id.*

⁵⁰ *Id.* at I. The DOL also modified its Model COBRA election notice “to help make qualified beneficiaries aware of other coverage options available in the Marketplace.” *Id.*; *see also* COBRA Continuation Coverage, United States Department of Labor, *available at* www.dol.gov/esba/cobra.html (last visited Mar. 11, 2014) (providing the revised Model COBRA election notice).

⁵¹ EBSA Technical Release, *supra* note 38.

⁵² 29 C.F.R. § 2520.104b-1(c).

⁵³ 29 U.S.C. § 218A.

in one or more health benefits plans, is required to automatically enroll new full-time employees in one of the plans offered (subject to any waiting period authorized by law) and to continue the enrollment of current employees in a health benefits plan offered through the employer. Along with this automatic enrollment program, employees must be provided “adequate notice and the opportunity” to opt out of the coverage in which they were automatically enrolled.⁵⁴

Since the statute is silent on an effective date for this provision (but expressly calls for implementing regulations to be promulgated), the Departments have delayed application of this rule pending issuance of regulations.⁵⁵ Despite the fact that the DOL sponsored a public forum nearly three years before the writing of this article (on April 8, 2011) which was designed to gather information and assist it in developing proposed regulations on compliance with this automatic enrollment provisions,⁵⁶ no such regulatory guidance has been issued. These regulations are expected in 2014.⁵⁷

I. Summary of Benefits and Coverage

PHSA Section 2715⁵⁸ generally requires all group health plans and health insurance issuers offering group health insurance coverage to provide applicants, enrollees, and policyholders or certificate holders with an accurate summary of benefits and coverage (“SBC”).⁵⁹ This four-page⁶⁰ SBC is subject to strict regulation concerning content and format (called

⁵⁴ *Id.*

⁵⁵ IRS Notice 2012-17 (Mar. 5, 2012), available at www.irs.gov/irb/2012-10_IRB/ar10.html; see also *HHS Bulletin: Frequently-Asked-Questions from Employers Regarding Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods*, Department of Labor Technical Release No. 2012-01 (Feb. 9, 2012), available at www.dol.gov/ebsa/newsroom/tr12-01.html (stating, “[i]n view of the need for coordinated guidance and a smooth implementation process, including an applicability date that gives employers sufficient time to comply, the Department of Labor has concluded that its automatic enrollment guidance will not be ready to take effect by 2014”).

⁵⁶ EBSA News Release, *US Labor Department to hold public forum on automatic enrollment in large employer health plans* (Mar. 14, 2011), available at www.dol.gov/ebsa/newsroom/2011/ebsa031411.html (last visited Feb. 6, 2014).

⁵⁷ DOL Technical Release No. 2012-01, *supra* note 55.

⁵⁸ 42 U.S.C. § 300gg-15.

⁵⁹ As recognized in the “Executive Summary” to the final SBC regulations (set forth in 77 Fed. Reg. 8668 (Feb. 14, 2012)), ACA provides detailed information about the SBC requirements, but is “not self-implementing, contains ambiguities, and specifically requires the Departments to develop standards, consult with the National Association of Insurance Commissioners, and issue regulations.”

⁶⁰ Double-sided yielding a total of eight pages.

“appearance” in the regulations),⁶¹ and must be provided to participants and beneficiaries prior to enrollment or re-enrollment. Thus, at open enrollment, an SBC must be provided for each benefit package offered for which the participant or beneficiary is eligible (e.g., one for an available PPO and one for an available HDHP). Upon renewal, only the summary for the benefit package in which the participant is enrolled needs to be furnished no later than 30 days prior to the first day of the new plan year, unless the participant or beneficiary requests a summary for another benefit package. The SBC must also be furnished to special enrollees⁶² within 90 days after enrollment pursuant to a special enrollment right and upon request. The instructions for completing the SBC are 15 pages long.⁶³

Attempting to avoid this burdensome undertaking, many commenters contended that large group health plans and/or self-insured group health plans should be exempt from the SBC distribution requirement since “such plans already provide a wealth of useful information, including a summary plan description and open season materials that accurately describe the plan and any coverage options.”⁶⁴ However, the Departments rebuffed these comments, citing a lack of statutory authority for such an exemption. The Departments further noted that the SBC’s “uniform format and appearance requirements” would be beneficial in allowing individuals to compare coverage options across different types of plans and insurance coverage.⁶⁵

J. Advance Notice of Material Modifications

PPACA’s SBC requirement includes a second component mandating that a plan sponsor provide 60 days advance notice to participants before the effective date of any “material modifications”⁶⁶ to its plan.⁶⁷ Such notice must be given only

⁶¹ 26 C.F.R. § 54.9815-2715(a)(2)-(3); 29 C.F.R. § 2590.715-2715(a)(2)-(3).

⁶² As defined in 26 C.F.R. section 54.9801-6; 29 C.F.R. section 2590.701-6; and 45 C.F.R. section 146.117.

⁶³ *What This Plan Covers and What It Costs: Instruction Guide for Group Coverage*, DOL.GOV, available at www.dol.gov/ebsa/pdf/SBCInstructionsGroup.pdf.

⁶⁴ Summary of Benefits and Coverage and Uniform Glossary, 77 Fed. Reg. 8670 (Feb. 14, 2012).

⁶⁵ *Id.*

⁶⁶ For this purpose, the PHSA incorporates the definition set forth in Section 102 of the Employee Retirement Income Security Act of 1974. The Preamble to the SBC regulations further clarifies that a material modification can be either an “enhancement of covered benefits or services or other more generous plan” term or “a material reduction in covered services or benefits, as defined in 29 C.F.R. section 2520.104b-3(d)(3) of the Department of Labor regulations.” 77 Fed. Reg. at 8677.

⁶⁷ 42 U.S.C. § 300gg-15(d)(4).

where the material modification(s) would affect the information required to be included in the SBC. The final regulations provide that advance notice may be either in the form of an updated SBC or a separate document describing the material modification(s).⁶⁸ Provision of a compliant notice of material modification for PHSa section 2715(d)(4) purposes will also satisfy the SMM requirements under Part 1 of ERISA for ERISA-covered plans.⁶⁹

K. W-2 Cost of Coverage Reporting

Code section 6051(a)(14) was added by section 9002 of PPACA and requires that employers⁷⁰ must report the “aggregate cost”⁷¹ of “applicable employer-sponsored coverage”⁷² on an employee’s Form W-2. Although the text of PPACA provided that the requirement would be effective beginning with the 2011 tax year,⁷³ the IRS made compliance optional in 2011.⁷⁴ Thus, the W-2 reporting requirement was first mandated for the 2012 tax year (meaning that the value of employer-provided coverage was required to first be reported on the W-2s issued by January 31, 2013, for the 2012 tax year). Employers subject to this requirement must calculate and report the applicable cost of employer-sponsored coverage⁷⁵ on each employee’s Form W-2 (in Box 12 using new Code “DD”).⁷⁶ The cost of employer-sponsored health coverage is displayed for the recipient employee’s “information only”⁷⁷ and, as stated by the IRS, is intended to “provide employees useful and comparable consumer information on the cost of their health care coverage.”⁷⁸ However, the IRS specifically requested comments on how future

⁶⁸ 77 Fed. Reg. at 8677.

⁶⁹ *Id.*

⁷⁰ Pending future guidance, this rule only applies to employers that were required to file at least 250 W-2s in the preceding year. IRS Notice 2012-9, 2012-4 I.R.B. 315, Q/A-3 (superseding Notice 2011-28). For this purpose, an employer need not be “aggregated” with any other employer. *Id.* The following plans are also currently exempt from reporting: multi-employer plans; HRAs; stand-alone dental and vision plans; self-insured plans of employers not subject to COBRA continuation coverage or similar requirements; and employee assistance programs, on-site medical clinics, or wellness programs for which the employer does not charge a premium under COBRA continuation coverage or similar requirements. *Id.*

⁷¹ Determined under rules similar to the rules of 26 U.S.C. § 4980B(f)(4).

⁷² As defined in 26 U.S.C. § 4980I(d)(1).

⁷³ PPACA, Pub. L. No. 111-148, § 9002(b).

⁷⁴ IRS Notice 2010-69, 2010-44 IRB 576 (Oct. 12, 2010).

⁷⁵ As determined in accordance with IRS Notice 2012-9, Q&A-6.

⁷⁶ Form W-2 Wage and Tax Statement (as visited February 6, 2014); Instructions for Forms W-2 and W-3 (as visited February 6, 2014).

⁷⁷ *Id.*

⁷⁸ IRS, Employer-Provided Health Coverage Informational Reporting Requirements: Questions and Answers, Q/A-1, available at www.irs.gov/uac/Employer-Provided-Health-Coverage-Informational-Reporting-Requirements-Questions-and-Answers (last visited February 6, 2014).

guidance could reduce the burden of compliance with the reporting requirements while still meeting those objectives.⁷⁹

L. Information Reporting under Code Sections 6055 and 6056

New Code sections 6055 and 6056, added by sections 1502(a) and 1514(a) of PPACA, respectively, require certain information reporting for insurers, sponsors of self-insured plans, and other entities that provide “minimum essential coverage” and additional “applicable large employer”⁸⁰ information reporting. These reports are designed for employers to report to the IRS whether they offer their full-time employees and their employees’ dependents the opportunity to enroll in “minimum essential coverage”⁸¹ under an eligible employer-sponsored plan and to provide certain other related information. Reporting employers must also provide a related written statement to their full-time employees. These reports are to be used, at least in part, by the IRS to enforce the requirements of the employer mandate and assess excise taxes. The first reports were to have pertained to the 2014 coverage period (coverage provided at any time during the 2014 calendar year) and were required to be filed in 2015;⁸² however, mandatory compliance was delayed a year.⁸³

Since applicable large employers may also be self-insured, they could be subject to reporting under Code sections 6051, 6055, and 6056. The IRS indicated a desire throughout its proposed regulations 6055 and 6056 to streamline information reporting under these two sections. In line with this intention and comments received in response to those proposed regulations, the IRS made some headway in adopting certain simplified methods for IRC 6056 reporting, such as using codes on Form W-2 to report whether full-time employees, spouses, and their dependents had been offered coverage.⁸⁴ Additionally, the IRS will allow employers sponsoring self-insured group health plans to fulfill their employee statement requirements by using a single substitute statement.⁸⁵ At the time the final regulations were issued in March of 2014, the IRS

⁷⁹ IRS Notice 2011-28, 2011-16 IRB 656 (Mar. 28, 2012).

⁸⁰ For this purpose, those employers subject to this information reporting requirement are those subject to the employer mandate in IRC § 4980H. 26 C.F.R. § 301.6056-1.

⁸¹ As defined in 26 U.S.C. § 5000A(f).

⁸² IRS Notice 2012-32, 2012-20 IRB 910 (Apr. 26, 2010); IRS Notice 2012-33, 2012-20 IRB 912 (Apr. 26, 2012).

⁸³ IRS Notice 2013-45, 2013-31 I.R.B. 116, Q/A-1 (providing transition relief that IRC §§ 6055 and 6056 reporting will be optional for 2014 and “encouraging” voluntary Code § 6055 reporting for coverage in 2014).

⁸⁴ 79 Fed. Reg. 13,237 (Mar. 10, 2014).

⁸⁵ *Id.* at 13,224 and 13,233.

indicated that the forms to be used by plan issuers and sponsors in complying with these final regulations will, supposedly, “be made available in draft form in the near future.”⁸⁶ No such forms have been issued to date.

II. THE TIME AND COST BURDEN ESTIMATES BY THE DEPARTMENTS

Regulation	Time Estimates	Cost Estimates
Grandfathered Plan Notices	<i>Plan Disclosure</i> ⁸⁷	
	Clerical Per Plan: 5 minutes to incorporate the required language into the plan documents	Clerical Rate: ⁸⁸ \$26.14/hour HR Professional Rate: \$89.12/hour
	HR Professional Per Plan: 10 minutes to review the modified language	Printing Costs: \$873,000 ⁸⁹
	Total Expenditure for All Plans: 538,000 hours	Total Expenditure for All Plans: \$39.6 million (for 2011); this figure does not include any allocation of costs to either (1) reviewing or retaining the language in the governing plan documents or (2) removing such language, since they estimated such costs to be <i>de minimis</i> . ⁹⁰

⁸⁶ *Id.* at 13,235.

⁸⁷ Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34,538, 34,555 (June 17, 2010), available at <http://www.gpo.gov/fdsys/pkg/FR-2010-06-17/pdf/2010-14488.pdf>. “These estimates are based on the assumption that 2.2 million ERISA-covered plans will need to notify an estimated 56.3 million policy holders of their plans’ grandfathered health plan status.” *Id.*

⁸⁸ Hourly wage estimates used by the Departments in the applicable regulations discussed throughout this article are based on data from the DOL’s Bureau of Labor Statistics Occupational Employment Survey (May 2008) and the Bureau of Labor Statistics Employment Cost Index (June 2009).

⁸⁹ *Id.* The Departments assume this notice will comprise one-half of a page at five cents per page (38% delivered electronically yielding the following calculation: (\$0.05 per page*1/2 pages per notice*34.9 million notices*0.62). *Id.*

⁹⁰ 75 Fed. Reg. 34554 (June 17, 2010).

<i>Record Keeping Requirement</i> ⁹¹	
Legal Professional: 5 minutes to determine the relevant plan documents that must be retained. Clerical Staff: 10 minutes to organize and file the required documents to ensure that they are accessible to participants, beneficiaries, and Federal and State governmental agency officials Total Expenditure for All Plans: 538,000 hours	Legal Professional Rate: \$119.03/hour Clerical Staff Rate: \$26.14/hour Total Expenditure for All Plans: \$30.7 million
<p>Notes: No distribution costs are taken into account since the Departments note this notice can be included in SPD distribution.</p> <p>In unexplainable math, the Departments estimate that the total cost estimate associated with compliance with the grandfathered plan rules will be \$291,000.⁹²</p> <p>The plan disclosure and the record keeping requirement are information</p>	

⁹¹ *Id.* The record-keeping requirement is expected to be a one-time cost, with any future costs being *de minimis. Id.*

⁹² During the 60-day period following the issuance of the final interim grandfathered plan regulations, the Departments (in accordance with 44 U.S.C. section 3507(d)) submitted a copy of the regulations to OMB for review of the information collections, given the imposition of the reporting and record retention requirements. The Departments and OMB noted that they were particularly interested in comments that:

Evaluate whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

Evaluate the accuracy of the agency's estimate of the burden of the collection of information, including the validity of the methodology and assumptions used;

Enhance the quality, utility, and clarity of the information to be collected; and

Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, for example, by permitting electronic submission of responses.

75 Fed. Reg. at 34,554-55.

collection requests (“ICR”) that are subject to the Paperwork Reduction Act (“PRA”) of 1995.⁹³ There is no requirement to comply with an ICR, unless the ICR has a valid OMB control number.⁹⁴

These figures do not include the time and cost estimates attributable to governmental plans of 26,000 hours with equivalent costs of \$1.5 million.⁹⁵

Regulation	Time Estimates	Cost Estimates
Notice of Coverage Up to Age 26	Legal Professional: 30 minutes to prepare the enrollment notices. ⁹⁶ Clerical Staff: 1 minute per paper notice to distribute ⁹⁷ Total Expenditure for All Plans: 1.1 million hours	Legal Professional Labor Rate: \$119/hour Clerical Staff Labor Rate: \$26/hour Printing ⁹⁸ Costs: Not specifically noted in regulations; generally noted to be one-half of a page, five cents per page (38% delivered electronically) ⁹⁹ Total Expenditure for All Plans: Roughly \$21.5 million for preparation and \$2.5 million for distribution
<p>Notes:</p> <p>The estimates are based on the assumption that service providers will prepare the notices, even though plans could prepare their own notices.¹⁰⁰ Notices may also be sent with other plan documents (<i>e.g.</i>, open enrollment documents) to eliminate postage costs.¹⁰¹</p> <p>Again, in math that does not reflect the other estimates, the Departments note an estimated cost burden of approximately \$2.01 million.</p>		

⁹³ *Id.* The PRA can be found at 44 U.S.C. § 3506(c)(2)(A).

⁹⁴ 75 Fed. Reg. at 34,555.

⁹⁵ *Id.* at 34556.

⁹⁶ 75 Fed. Reg. 27,122, 27,132 (May 13, 2010).

⁹⁷ *Id.*

⁹⁸ Printing includes materials wherever referenced throughout this document.

⁹⁹ *Id.* Noting that 79,573,000 participants covered by the approximately 2.8 million ERISA plans will receive the notice.

¹⁰⁰ *Id.* n.21.

¹⁰¹ *Id.*

Regulation	Time Estimates	Cost Estimates
Notice of Patient Protections	Clerical Staff Rate: 5 minutes to incorporate the required language into the plan document HR Professional: 10 minutes to review the modified language Total Expenditure for All Plans: 85,000 hours to prepare notice	Clerical Staff Rate: \$26.14/hour HR Professional Rate: \$89.12/hour Printing Costs: \$124,000 (one-half of a page, five cents per page (38% delivered electronically)) ¹⁰² Total Expenditure for All Plans: \$5.8 million for preparation, plus printing The Departments estimate that the total cost to plans and insurance issuers to prepare and distribute the disclosure is \$6.1 million in 2011. ¹⁰³
<p>Notes:</p> <p>The Departments estimate that 339,000 ERISA-covered plans will need to notify an estimated 8.0 million policyholders of their plans' policy in regards to designating a primary care physician and for obstetrical or gynecological visits.</p> <p>In arriving at their estimates, the Departments assume that 22 percent of group health plans will not have grandfathered health plan status in 2011.</p> <p>Plans that relinquish their grandfathered plan status in years following 2011 will become subject to this notice requirement and incur a cost to prepare and distribute the notice in the year they relinquish such status.¹⁰⁴</p>		

¹⁰² 75 Fed. Reg. at 37,219 (\$0.05 per page*1/2 pages per notice*8.0 million notices*0.62).

¹⁰³ *Id.* at 37214.

¹⁰⁴ *Id.* The Departments estimate a total hour burden associated with this requirement as follows: 62,000 hours in 2012, and 50,000 in 2013, resulting in an estimated cost burden of \$90,000 and \$73,000, respectively, for 2012 and 2013.

Regulation	Time Estimates	Cost Estimates
Notice of Lifetime Limit Elimination	<p>Legal Professional: 30 minutes to draft notice¹⁰⁵</p> <p>Clerical Staff: 5 minutes to incorporate the specific information into the notice and mail the estimated 13,000 notices¹⁰⁶</p> <p>Total Expected Expenditure for All Plans: 200 hours of legal for notice preparation¹⁰⁷ and 1,100 hours of notice preparation clerical time¹⁰⁸</p>	<p>Legal Professional Labor Rate: \$119/hour</p> <p>Clerical Staff Labor Rate: \$26/hour</p> <p>Printing and Mailing Costs: \$6,500¹⁰⁹</p> <p>Total Expenditure for All Plans: \$48,000 for preparation, plus printing and mailing costs¹¹⁰</p>
Notes:		
Postage at 44 cents per notice is included in this cost estimate. ¹¹¹		

¹⁰⁵ 75 Fed. Reg. 37,218.

¹⁰⁶ *Id.*

¹⁰⁷ This estimate is arrived at by the Departments since they assume that the notice for all plans (including self-insured plans that are administered by insurers) will be prepared by the estimated 630 health insurers operating in the U.S. and, therefore, do not allocate any time to plan-level legal review.

¹⁰⁸ *Id.*

¹⁰⁹ *Id.* Noting that 79,573,000 participants covered by the approximately 2.8 million ERISA plans will receive the notice.

¹¹⁰ *Id.*

¹¹¹ Effective January 26, 2014, postage increased to 49 cents per 1 oz. letter; however, for purposes of this article we will continue to apply the 44 cent figure utilized in the majority of the Departments' ACA guidance. USPS Postal News, *U.S. Postal Service Announces New Prices for 2014*, (Sept. 25, 2013) available at www.doa.nc.gov/msc/documents/USPSPriceIncreasepr13_077.pdf (last visited Feb. 9, 2014).

Regulation	Time Estimates	Cost Estimates
Notice of Rescission	Legal Professional: 15 minutes to draft notice ¹¹² Clerical Staff: 1 minute to distribute ¹¹³ Total Expected Expenditure for All Plans: 50 hours ¹¹⁴	Legal Professional Labor Rate: \$119/hour ¹¹⁵ Clerical Staff Labor Rate: \$26/hour ¹¹⁶ Printing and Mailing Costs: \$800 ¹¹⁷ Total Expected Expenditure for All Plans: \$3,700 for preparation, plus printing and mailing
<p>Notes:</p> <p>Since the Departments did not have a data source on the number of group plans whose policy is rescinded, they made an assumption that 100 group health plan policies are rescinded in a year.</p> <p>The Departments estimate that there is an average of 16 participants in small, insured plans, which they contend are the plans impacted by rescission.</p> <p>Postage at 44 cents per notice is included in this cost estimate.</p>		

¹¹² 75 Fed. Reg. 37,218.

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ *Id.* This estimate is based on an average document size of one page, \$.05 cents per page material and printing costs, and \$.44 cent postage costs.

Regulation	Time Estimates	Cost Estimates
Notice of ERRP Participation	Not specified in applicable guidance	No cost estimates provided
<p>Notes: The Departments initial estimates reflected that approximately 4,500 sponsors would apply to participate ERRP (3,000 privates and 1,500 State and local governments).¹¹⁸</p> <p>If we assume, however, 1 minute of clerical time at \$26/hour and an average document size of one page, \$.05 cents per page material and printing costs, and \$.44 cent postage costs, for the 4,500 plan sponsors anticipated to apply for ERRP participation, this would yield a <i>de minimis</i> amount of \$1,950 in preparation costs and \$2,205 in printing and distribution costs.</p>		

Regulation	Time Estimates	Cost Estimates
Marketplace (Exchange) Notice ¹¹⁹	No time estimates provided; however, the Departments estimate that each individual response will take less than 15 seconds, since an employer may send a copy of the same notice to each affected employee. ¹²⁰	No cost estimates provided
<p>Notes: Using the 2008 data¹²¹ above and rough estimates of 138 million participants, application of the clerical rate (at \$26.14/hr) would yield a cost burden of roughly \$1.5 million in preparation costs</p> <p>Since the model notice is three pages long, if we apply costs of \$.05 cents per page material and printing costs, and \$.44 cent postage costs (with 38% electronic delivery), the printing and distribution costs would be nearly \$50.5 million.</p>		

¹¹⁸ 75 Fed. Reg. 24,465 (May 5, 2010).

¹¹⁹ The Department of Labor has issued temporary guidelines to employers about providing marketplace coverage options notices to employees, but does not provide any time or cost estimates for compliance. Dep't of Labor, Technical Release 2013-02 (May 8, 2013), *available at* www.dol.gov/ebsa/pdf/tr13-02.pdf.

¹²⁰ EBSA Technical Release 2013-02.

¹²¹ Medical Expenditure Panel Survey's Insurance Component approved in 75 Fed. Reg. 34555.

Regulation	Time Estimates	Cost Estimates
Notice of Automatic Enrollment	N/A	N/A
Notes: The DOL has yet to issue regulations; there are no time or cost estimates available at this time.		

Regulation	Time Estimates	Cost Estimates
Summary of Benefits & Coverage	1.9 million hours for 2012 and 2013 ¹²²	The Departments estimate third-party administrators and issuers will have “one-time and maintenance costs of approximately \$90 million in 2012, and \$55 million in maintenance costs in 2013.” See Appendix A. ¹²³
Notes: The hour and cost burdens for the SBC are allocated among the SBC requirements, the coverage example requirements, and the glossary requests.		

Regulation	Time Estimates	Cost Estimates
Notice of Material Modifications to the SBC	N/A	N/A
Notes: The SBC regulations do not provide time or cost estimates for a NMM to the SBC because the Departments expect a very small percentage of plans to issue a modification “in the middle of a plan year.” ¹²⁴		

¹²² 77 Fed. Reg. at 8683, see Appendix A for more detail.

¹²³ Summary of Benefits and Coverage and Uniform Glossary, 77 Fed. Reg. 8668, 8683 (Feb. 14, 2012), available at <http://webapps.dol.gov/federalregister/PdfDisplay.aspx?DocId=25818>. This regulation provides detailed tables (that have been recreated in APPENDIX A) to calculate estimated time and cost burdens. See *id.* at 8684-87.

¹²⁴ *Id.* at 8685 n.60.

Regulation	Time Estimates	Cost Estimates
Form W-2 Cost of Coverage Reporting	N/A	N/A
Notes: The IRS has proposed rules to streamline the process and incorporate the W-2 reporting with Section 6056. ¹²⁵ There are no time or cost estimates available at this time.		

Regulation	Time Estimates	Cost Estimates
Information Reporting under Code Sections 6055 and 6056	N/A	N/A
Notes: Applicable large (generally 50 or more employees) employers may voluntarily report in 2014, and there is no penalty. The regulation becomes effective in 2015. ¹²⁶ The IRS is expected to issue reporting rules, and has requested comments on how to implement the reporting rules. ¹²⁷		

A quick perusal of the Departments' estimates reveals that they are conservative to the point of being laughable. For example, the suggestion that it takes only five minutes of clerical time to (1) determine where to incorporate legally required notices in a complex medical plan document and then (2) incorporate the language appropriately, exhibits either a critical failure to understand the world outside the beltway or a complete lack of intellectual honesty. Even if these highly conservative estimates are taken at face value, as summarized above, the cost estimates for PPACA participant notice requirements, known as of the date of this article, exceed \$200 **million**.¹²⁸ This figure does not include ongoing costs nor does it taken into account any of the unknown costs – including automatic enrollment, W-2, and Code Section

¹²⁵ Information Reporting by Applicable Large Employers on Health Insurance Coverage Offered Under Employer-Sponsored Plans, 78 Fed. Reg. 54,996, 55,003 (Sep. 9, 2013) (to be codified at 26 C.F.R. pt. 301), *available at* <http://www.gpo.gov/fdsys/pkg/FR-2013-09-09/pdf/2013-21791.pdf>; *see also* Information Reporting of Minimum Essential Coverage, 78 Fed. Reg. 54,986, 54,991 (Sep. 9, 2013), *available at* <http://www.gpo.gov/fdsys/pkg/FR-2013-09-09/pdf/2013-21783.pdf> (suggesting that section 6055 is incorporated with Form W-2 for reporting purposes).

¹²⁶ I.R.S. Notice 2013-45, 2013-31 I.R.B. 86, 116, *available at* <http://www.irs.gov/pub/irs-irbs/irb13-31.pdf>.

¹²⁷ Request for Comments on Reporting by Applicable Large Employers on Health Insurance Coverage Under Employer-Sponsored Plans, I.R.S. Notice 2012-33, *available at* <http://www.irs.gov/pub/irs-drop/n-12-33.pdf>.

¹²⁸ The authors believe, based on actual experience assisting employers with ACA notice requirements, that the actual cost burden is a substantial multiple of this amount.

6055 and 6056 information reporting requirements. The question is now ripe: are participants (and the government) receiving an equivalent value from this huge time and cost burden being imposed on the industry? While not a simple question to answer, we, the authors, believe that there is room for consolidation and streamlining these notice and reporting requirements in order to reduce the burden and increase the value to participants.

A November 2005 “Report Of The Working Group On Communications To Retirement Plan Participants” produced by the Advisory Council on Employee Welfare and Pension Benefit Plans, includes helpful guidance on the value of participant communications.¹²⁹ The group was tasked with considering how to best provide meaningful information to plan participants and to assess the current retirement plan disclosure obligations.¹³⁰ In this report, the Working Group affirmed that “plan participants can feel overwhelmed by the amount of information they receive” about their plans.¹³¹ One witness who testified before the Working Group stated the required disclosures “are not effective participant communications and should be limited to as few as possible” and noted the compliance with complex disclosure requirements is burdensome and discourages plan adoption.¹³²

III. GOVERNING LAW AND CORRESPONDING PROPOSAL

A. Burden Imposed Inconsistent with Administrative Objectives

The complex myriad of ACA notices set forth above is prodigious. While, as discussed above, some notice requirements were statutorily-mandated, others were added by the enforcing agencies (either in regulations or in some other less formal type of guidance). Compliance with these notice requirements is in

¹²⁹ United States Department of Labor, *Advisory Council Report: Report of the Working Group on Communications to Retirement Plan Participants*, (Nov. 2005), available at http://www.dol.gov/ebsa/publications/AC_1105b_report.html (last visited Feb. 9, 2014).

¹³⁰ While we are clearly dealing with different types of benefit plans, this information is largely transferable given that the information is being provided to the same universe of recipients.

¹³¹ Notably, this Working Group also considered whether any required disclosures be combined to ease the administrative burden on plans “without causing confusion for participants or beneficiaries.” *Id.* This concept is actually considered in our proposal below.

¹³² See *id.* (citing testimony of David Wray, President of the Profit Sharing / 401(k) Council of America (PSCA), a national non-profit association of companies that sponsor profit sharing and 401(k) plans covering over four million employees).

tension with Executive Order 13563,¹³³ signed by President Barack Obama on January 18, 2011, which mandates that enforcing agencies assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). This Executive Order further requires that each agency “periodically review its existing significant regulations to determine whether any such regulations should be modified, streamlined, expanded, or repealed so as to make the agency’s regulatory program more effective or less burdensome in achieving the regulatory objectives.”¹³⁴ As detailed by the Office of Management and Budget (“OMB”)’s Office of Information and Regulatory Affairs (“OIRA”), Executive Order 13563 “endorses, and quotes, a number of provisions of [Executive Order 12866] that specifically emphasize the importance of considering costs.”¹³⁵

In early 2013 (when the promulgation and finalization of PPACA regulations were in full swing), Cass Sunstein, Administrator of the OMB’s OIRA, sent a memorandum to all Chief Information Offices in the government regarding “Minimizing Paperwork and Reporting Burdens.”¹³⁶ In that memo, Mr. Sunstein recited that the PRA “expresses the national commitment to minimizing paperwork burdens and improving the quality of information collected while ensuring the greatest possible benefit to the public.” He further recognized that the paperwork burden on the public has grown over the past decade.¹³⁷ Based on these statistics (and applicable law), Mr. Sunstein mandated that the CIO’s of certain agencies, including Labor and HHS, respond to this call for action.

This call to action came on the heels of Sunstein’s open invitation to the public to assist the government in complying with

¹³³ See Exec. Order 13563, 3 C.F.R. § 13563 (2011), *available at* <http://www.gpo.gov/fdsys/pkg/CFR-2012-title3-vol1/pdf/CFR-2012-title3-vol1-eo13563.pdf> (last visited Feb. 9, 2014) (supplementing and reaffirming the principles and structures governing contemporary regulatory review that were first established in Executive Order 12866).

¹³⁴ *Id.* at section 6(b).

¹³⁵ Office of Information and Regulatory Affairs, *Frequently Asked Questions*, *available at* <http://www.reginfo.gov/public/jsp/Utilities/faq.jsp> (last visited Feb. 10, 2014).

¹³⁶ Cass R. Sunstein, Memorandum for Chief Information Officers, Administrator Office of Information and Regulatory Affairs (Feb. 23, 2012), *available at* http://www.whitehouse.gov/sites/default/files/omb/inforeg/icb/2012_icb_datacall_0.pdf.

¹³⁷ One example in his memorandum noted that, in FY 2010, the public spent an estimated 8.8 billion hours responding to Federal information collections, which represents a 19% net increase (of 1.4 billion burden hours) from the corresponding number in FY 2000. *Id.*

Executive Order 13563 and opine: “How can we continue to streamline, simplify, and improve rules and regulations? Which rules should be eliminated, streamlined, or made more effective? How can we reduce reporting and paperwork burdens? What are the best ways to cut regulatory costs?”¹³⁸

The Departments (and the OMB) have unequivocally paid lip service to minimizing burdens on employers sponsoring plans. To that end, the OMB has noted on multiple occasions that the administration is particularly interested in comments that: “[1] Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; [2] Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; [3] Enhance the quality, utility, and clarity of the information to be collected; and [4] Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.”¹³⁹

We applaud efforts of the Departments to act and regulate in a manner consistent with these stated goals, for example in the context of the W-2, Code Section 6055 and 6056 when the Departments are carefully collecting information and taking time considering how to best implement ACA's requirements without being duplicative and overly-burdensome. However, additional efforts are appropriate (and, indeed, necessary to comply with the President's 2011 order) to further minimize the burdens imposed by PPACA.

B. Proposal

To ensure, among other things, that the reporting burden (including both the time and financial resources expended) imposed on employers attempting to comply with the ACA is minimized in a manner called for by the President, further streamlining, consolidation, and government assistance is appropriate. While the market reforms of PPACA (including the notices set forth in I.B through F) are largely “water under the bridge” given the time periods in which such notices were required, there remain ample places for improvement in ongoing

¹³⁸ Advise the Advisor: Streamlining, Improving, and Simplifying Rules and Regulations, Office of Management and Budget, <http://www.whitehouse.gov/blog/2012/07/18/advise-advisor-streamlining-improving-and-simplifying-rules-and-regulations> (last visited Feb. 2, 2014).

¹³⁹ See, e.g., 78 Fed. Reg. 70961-62 (Nov. 27, 2013).

administration of PPACA's requirements.

As an initial matter, to remediate any unbearable burden, the Departments should limit notice requirements to those absolutely deemed necessary, including when called for by statute. Thus, notices like the ERRP notice that stem exclusively from non-statutory and non-regulatory means should be eliminated.¹⁴⁰ The government should also continue to issue model language wherever possible. Beyond model language, we believe that it would be appropriate to consolidate all annual disclosures into a single document.

The single document we envision would be set forth in a government-prescribed format, and adoption and distribution of the same would result in full compliance with all applicable group health notice requirements. The template document could, for example, be structured like a retirement plan using a "Volume Submitter" document, and have a menu format from which a plan sponsor should select and include all provisions that apply to the adopting plan. All irrelevant or inapplicable menu items not selected would be deleted and not included in the form of document provided to participants and beneficiaries so as to avoid confusion about the inclusion of such language.

The government-approved health plan enrollment package could be comprised of the following sections:

Section 1. Notice to Employees of Coverage Options – Using DOL-approved model.

Section 2. Automatic Enrollment Notice – Does the plan include an automatic enrollment feature [Y / N]; if the plan checks yes, then the opt-out provisions apply and are included.

Section 3. Grandfathered Plan – Is the plan intended to be Grandfathered [Y / N]; if the plan checks yes, the Model Notice applies and is included.

Section 4. SBC – Using the Departments' template.¹⁴¹

Section 5. Summary Annual Report Information – Is the plan subject to the SAR reporting requirements? [Y / N]; if the plan checks yes, a fill in the blank SAR Notice is completed and included.

Section 6. Notice of Patient Protections – Using DOL-

¹⁴⁰ Not only are such requirements unduly burdensome, but they are arguably violative of administrative rulemaking laws. Administrative Procedure Act (APA) § 6, 5 U.S.C. § 555. However, that topic is beyond the scope of this article.

¹⁴¹ Additional information providing detailed coverage information could be attached to this model document (*e.g.*, in a certificate of coverage issued by the insurer or third-party administrator); however, inclusion of that information is cumbersome and could be confusing, particularly to the extent it is duplicative of the information contained in the SBC. Thus, we recommend that, alternatively, such a detailed document (or portion of a document) only be provided on request when such detailed information is relevant to a particular participant or beneficiary.

approved model language. The plan includes language pertaining to selection of primary care physicians solely to the extent such designation are applicable in the plan design.

Section 7. Cost of Coverage Reporting – Generally, we believe that, in lieu of the W-2 reporting, the plan sponsor should be able to provide cost of coverage information, updated annually, based on coverage level and type of benefit, at least until such information is needed by the government¹⁴² (e.g., in administration of the excise tax under 26 U.S.C section 4980I).¹⁴³

Section 8. SPD General Requirements¹⁴⁴ – including specific subsections with model language which details, among other things:

A blank for identification of the formal name of the plan (and, if different, the name by which the plan is commonly known);

A blank for the name and address of the employer whose employees are covered by the plan;

A blank for the employer identification number assigned to the plan sponsor by the IRS;

A blank for the three-digit plan number assigned by the plan sponsor;

Options for a description of the type of plan (e.g., whether it is a group health plan and / or any other type of plan);

Options for a description of the type of administration of the plan (e.g., contract administration, insurer administration, or sponsor administration);

Blanks for insertion of the name, business address, and business telephone number of the “plan administrator” (as defined in ERISA section 3(16));

Blanks for insertion of the name of the person designated as agent for service of legal process and the address at which process may be served on such person (including a statement that service of legal process may be made upon a plan trustee (if any) or the plan administrator);

Blanks for the name, title, and address of the principal place of business of each trustee of the plan (if the plan has a trust);

Is the plan maintained pursuant to one or more collective bargaining agreements [Y / N]; if the plan checks yes, reference to a statement referring to the collective bargaining agreement and directing the plan sponsor to complete information on how to obtain a copy of that agreement (i.e., a plan is maintained pursuant to a collective bargaining agreement if such agreement controls any duties, rights, or benefits under the plan, even though

¹⁴² At the very least, information reporting of the amount of coverage should be limited to one document—the W-2, and not duplicated in another form, such as the reporting required under Code Sections 6055 and / or 6056.

¹⁴³ Commonly referred to as the “Cadillac plan” tax, which becomes effective in 2018.

¹⁴⁴ ERISA, § 102(b); DOL Reg. § 2520.102-3(j).

such agreement has been superseded in part for other purposes);

A blank to insert the date of the end of the plan year;

Eligibility provisions, in a manner that complies with the adult dependent rules of PHSa section 2714 and waiting period rules of PHSa section 2708;

A general description of coverage of preventive services with no cost-sharing to comply with PHSa section 2707(b) (including a place to reference to a website that lists the preventive services covered under the plan);

Claims and appeals provisions to comply with PHSa section 2719;

The ERISA model statement of rights;

COBRA, HIPAA, and other health-mandate information (for group health plans);

The Women's Health and Cancer Rights Act ("WHCRA") notice, Children's Health Insurance Program ("CHIP") Notice, Newborn and Mothers' Health Protection Act notice, and Medicare Part D Notice; and

A statement regarding assistance for non-English speaking employee populations.

Use of the model language should be permissive, not mandatory, to allow flexibility to deal with certain administrative considerations or plan design features. Use of the model language, and completion of the same in a good faith manner consistent with all relevant guidance, should afford the plan sponsor with a "safe harbor" for documentary compliance purposes.

This package of information should be made available to employees upon hire, and annually, solely to the extent necessary to reflect any changes. For example, annual changes may only apply to Sections 3, 4, 5, 7 and 8 in the list above. In that case, only those sections would need to be modified and redistributed. In addition, to comply with the NMM requirement, a revised Section 4 could be disseminated to reflect any changes to the SBC.

As recommended by the 2005 DOL Working Group, we would mandate that this package of information be required to "introduce itself" to plan participants through an introductory statement. The introductory statement would briefly summarize why the participant is receiving the disclosure, including a general description of the plan information included in the disclosure; and emphasize that the participant should read the disclosure carefully and retain it for future reference. Sample language such as the following may be appropriate:

This package contains all legally-required information about your health benefits, including your opportunity to obtain coverage with your employer or on the government Marketplace. This package details your rights, obligations and costs with respect to coverage under your employer-sponsored plan. You should read this information very carefully and retain this document for future

reference.

Again, use of this sort of model language adopted by the Departments should be permissive, not mandatory.

Finally, with respect to Code sections 6055 and 6056, the Departments should concede to public comment that consolidation of these forms (also with the Form W-2 requirements) would be beneficial to avoid redundancies and certain entities (such as self-insured plans) from incurring duplicative costs. Time spent now consolidating and streamlining notice and disclosure requirements under ERISA, PPACA, and other laws in a manner consistent with our proposal will create a “win-win” for all parties involved, lessening the burden on plan sponsors and increasing the accessibility to and meaningfulness of information for participants and beneficiaries. This plan falls squarely within the President’s objectives – maximize net benefits with the least amount of burden.

APPENDIX A

TABLE 3—2012 HOUR BURDEN, EQUIVALENT COST, AND COST BURDEN—2012 DOLLARS

	Number of affected entities	Hour burden	Equivalent cost	Cost burden (non-labor)	Number of disclosures
SBC Requirements—Issuers	440	570,000	\$21,000,000	\$2,700,000	570,000
SBC Requirements—TPAs	750	760,000	30,000,000	3,600,000	60,000
Coverage Example Requirements—Issuers	440	193,000	10,500,000	1,400,000	193,000
Coverage Example Requirements—TPAs	750	330,000	17,900,000	1,800,000	330,000
Glossary Requests—Issuers	440	10,000	310,000	350,000	10,000
Glossary Requests—TPAs	750	12,000	380,000	460,000	12,000
Subtotal		1,900,000	80,000,000	10,000,000	1,900,000
Total 2012 Costs			90,000,000		

TABLE 4—2013 HOUR BURDEN, EQUIVALENT COST, AND COST BURDEN—2012 DOLLARS

	Number of affected entities	Hour burden	Equivalent cost	Cost burden (non-labor)	Number of disclosures
SBC Requirements—Issuers	440	430,000	\$14,000,000	\$2,700,000	41,000,000
SBC Requirements—TPAs	750	540,000	18,000,000	3,600,000	49,000,000
Coverage Example Requirements—Issuers	440	59,000	3,300,000	1,400,000	41,000,000
Coverage Example Requirements—TPAs	750	100,000	5,600,000	1,800,000	49,000,000
Notice of Material Modifications—Issuers	440	8,900	290,000	310,000	820,000
Notice of Material Modifications—TPAs	750	11,000	380,000	400,000	990,000
Glossary Requests—Issuers	440	20,000	630,000	710,000	1,100,000
Glossary Requests—TPAs	750	25,000	760,000	920,000	1,500,000
Subtotal		1,200,000	43,000,000	12,000,000	94,000,000
Total 2013 Costs			55,000,000		