2025 Federal Reporting Requirements

Presented by Benefit Comply

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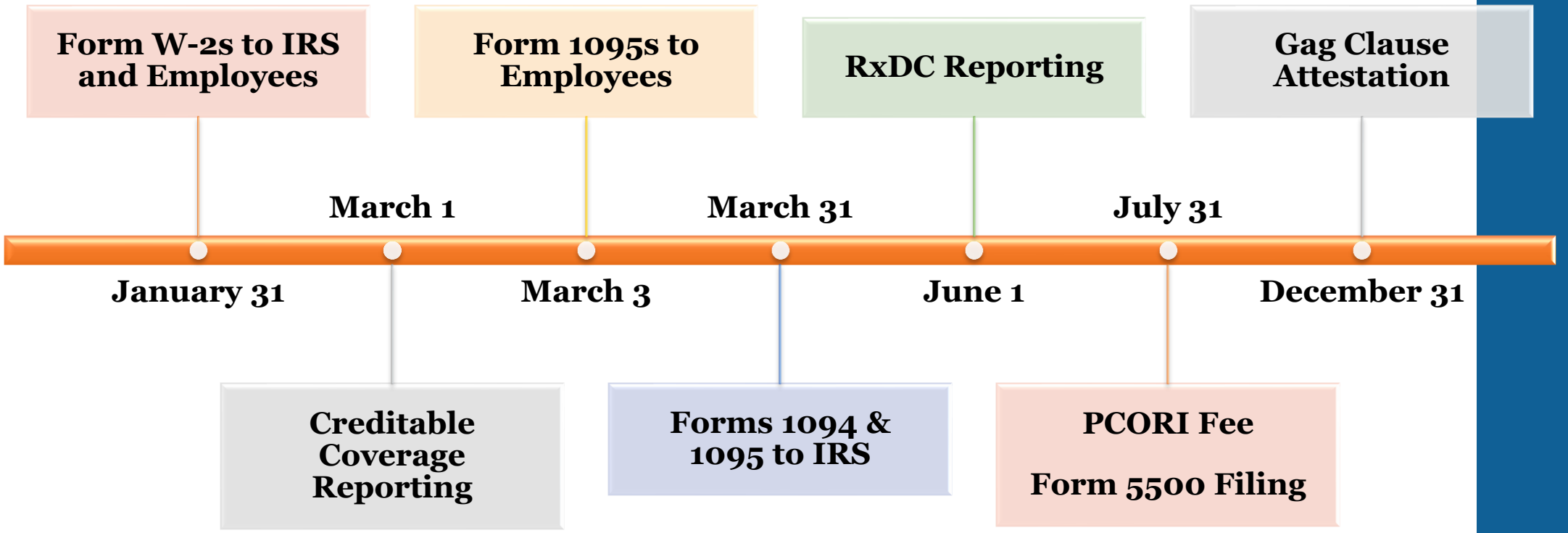
Agenda

- W-2 Cost of Coverage Reporting
- Creditable Coverage Status Reporting
- ACA Employer Reporting
- RxDC Reporting
- Form 5500 Reporting
- PCORI Fees
- Gag Clause Attestations
- MHPAEA Comparative Analyses

2025 Reporting Timeline

- Submission/Distribution deadlines for a calendar year plan in 2025:



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W-2 Cost of Coverage Reporting

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W-2 Cost of Coverage Reporting

- Applicability
  - Only required for employers who filed 250 or more Form W-2s in the previous year
  - Used solely for informational purposes
- Cost of Coverage
  - Entire plan cost (both employer and employee contributions)
  - Include cost of group health plans, but not HRAs or excepted benefits, not HSAs
- Reporting
  - Form W-2, Box 12, Code DD (HSA contributions reported in Box 12, Code W)

Creditable Coverage Status Reporting

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Rx Creditable Coverage

- Creditable Coverage =

Value of Group Health Plan Prescription Drug Coverage ≥ **Actuarial value of standard prescription drug coverage under Medicare Part D**

- How is Creditable Coverage Determined?
  - Carrier or TPA may provide creditable status; or
  - Employer must use simplified method or obtain actuarial determination

Rx Creditable Coverage – Why It Matters

- Once eligible for Medicare Part D, going 63 days or more without creditable Rx coverage may then result in late enrollment penalties
  - Individuals become eligible for Part D (Rx coverage) upon enrolling in Part A, Part B, or both
  - Individuals merely eligible for Medicare, but not yet enrolled in Part A or B are not eligible for Part D
- Upon a change in creditable coverage status, special enrollment is triggered for 2 months from loss of coverage or notification, whichever occurs later

Creditable Coverage Notice

- Notify eligible individuals of creditable status:
  - Upon initial eligibility;
  - Annually; and
  - Upon a change in creditable status

We recommend providing it during open enrollment each year (rather than each fall) to align with any change in creditable status

- Model notices available


MODEL INDIVIDUAL **CREDITABLE** COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011
OMB 0938-0990

Important Notice from [Insert Name of Entity] About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with [Insert Name of Entity] and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in the area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. [Insert Name of Entity] has determined that the prescription drug coverage offered by the [Insert Name of Plan] is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the [Insert Name of Plan]. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

MODEL INDIVIDUAL **NON-CREDITABLE** COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011
OMB 0938-0990

Important Notice From [Insert Name of Entity] About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with [Insert Name of Entity] and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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Creditable Coverage Reporting

- Report status to CMS:
  - Within 60 days of the start of each plan year;
  - Within 30 days of change in creditable status (if it changes mid-plan year); and
  - Within 30 days of termination of plan (if it terminates mid-plan year)

- Disclosure must be done online: https://www.cms.gov/medicare/employers-plan-sponsors/creditable-coverage/disclosure-form

ACA Employer Reporting

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ACA Employer Reporting

- Employers Subject to Reporting
  - Applicable large employers (50 or more FTEs)
  - Employers offering self-funded (or level-funded) group health plans

ALEs

1094-C and 1095-Cs

Required to report offer of coverage information for all employees who were full-time for at least one month

Self-Funded Plans

Small employers – 1094-B and 1095-Bs
ALEs – 1095-C Part III

Required to report coverage information for all individuals enrolled in the group medical plan

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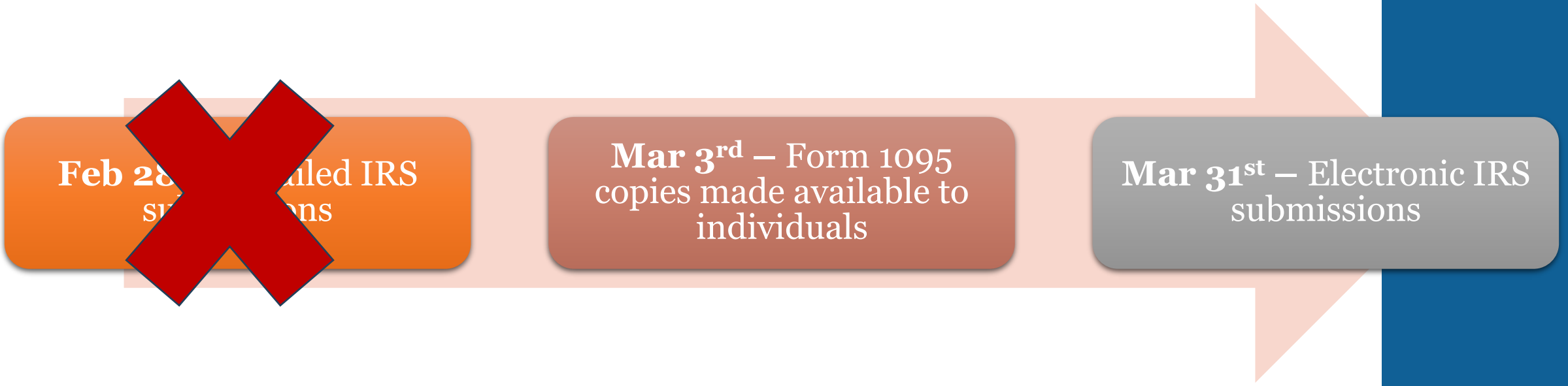
1094 / 1095 Reporting

- Federal 2025 Due Dates



Electronic Reporting Requirements

Employers filing 10 or more forms required to submit reporting electronically

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ACA Employer Reporting Changes

- ✓ Alternate method for distributing 1095s (post notice of availability)
- ✓ Further flexibility around obtaining electronic consent
- ✓ More flexibility to use date of birth versus SSN for covered spouses and dependents
- ✓ Increased Letter 226J enforcement protections
  - 90-day minimum response time must be given to employers
  - 6-year statute of limitations on enforcement effort

H.R. 3801 – Employer Reporting Improvement Act

H.R. 3797 – Paperwork Burden Reduction Act

ACA Employer Reporting Changes

- Form 1095 Distribution
  - Copies must be provided to full-time employees AND individuals covered under an employer's level-funded or self-funded plan by hand, by mail, electronically with consent, or NEW - by posting a notice of availability
- Alternative Method (still waiting on formal IRS guidance)
  - Current IRS Instructions for Form 1095-B
    - Clear and conspicuous notice on employer's website (or intranet, benefits portal, etc. if also available to terminated employees) with an email address, physical address and telephone number where individuals can reach out with requests and questions
    - Example:

IMPORTANT HEALTH COVERAGE TAX DOCUMENTS

2024 Form 1095s are prepared and available upon request. The Form 1095s illustrate information about offers of coverage made to full-time employees [*as well as coverage information for those who enrolled in ABC Company's group health plan – if level-funded or self-funded*]. To request a copy of your Form 1095 or to ask questions about Form 1095s, you can reach out to _____ via (email address, physical mailing address AND telephone number).

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RxDC Reporting

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RxDC Reporting

- Overview
  - Collects data on drug costs and medical spending with the hope that the data can be used to lower drug costs (federal government will issue an annual report on Rx costs)
  - Reporting required by June 1 annually for all group health plans, but not account-based plans (e.g., HRAs) or excepted benefits (e.g., limited-scope dental or vision)

"Reporting Entities" must set up account in CMS HIOS system

- Multiple entities may report for a single plan (e.g., TPA, PBM, employer)

Submit a plan file, 8 separate data files, and narratives

- Employer must determine who has the necessary data and ensure all files and narratives are completed

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Rx Cost Reporting – The Process

- Plan Files and Data Files
  - ~~P1. Individual and student market plan list~~
  - P2. Group health plan list
  - ~~P3. FEHB plan list~~
  - D1. Premium and Life-Years
  - D2. Spending by Category
  - D3. Top 50 Most Frequent Brand Drugs
  - D4. Top 50 Most Costly Drugs
  - D5. Top 50 Drugs by Spending Increase
  - D6. Rx Totals
  - D7. Rx Rebates by Therapeutic Class
  - D8. Rx Rebates for the Top 25 Drugs

D1	Plan Details (vendors, # covered individuals, premiums, etc.)
D2	Medical spending information
D3-D8	Detailed drug spending information
P2	Plan identifying information

CMS encourages carriers, PBMs and TPAs to submit aggregate data rather than report on a plan-by-plan basis

- CMS provided templates for each file

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RxDC Reporting

- **Responsibility for Reporting**
  - **Fully-Insured Group Health Plans**
    - Carriers will report on behalf of the plan
    - Employer must provide average monthly premiums (employer/employee contributions)
    - Employer might have to complete P2 and D1 forms
  - **Self-Funded Group Health Plans**
    - TPAs and PBMs likely to report on behalf of the plan, but may only file some of forms
    - Employer must provide average monthly premiums (employer/employee contributions)
    - Employer might have to complete P2, D1 and any other forms not completed by TPA/PBM

Form 5500 Reporting

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Form 5500 – Who Must File

- ERISA Large Plans & Funded Plans
  - Large Plan = Plan covers 100 or more participants as of the beginning of the plan year
    - "Participant" includes employees and former employees, but not spouses or dependents
  - Funded Plan = Plan funding held in a separate account or trust (e.g., VEBA) rather than the plan being funded from employer's general assets

Common ERISA Plans		Non-ERISA Plans
Medical, Rx, Dental, Vision	Employee Assistance Programs	Cafeteria plans
HRAs and Health FSAs	Onsite Medical Clinics	Dependent Care FSA (or DCAP)
Telehealth	Onsite Daycare Centers	Qualified Transportation Plans
Life and AD&D	Prepaid Legal	HSAs
Fully-insured STD and LTD	Business Travel Accident Plans	Identity Theft
Hospital Indemnity	Executive Reimbursement Plans	Pet Insurance
Critical Illness and Disease-Specific		Educational Assistance
		Adoption Assistance

Note: Government employers and church plans are exempt

Form 5500 – Details

- Due Date
  - 7 months following the end of the plan year (e.g., July 31st for calendar year plan)
  - 2 ½ month extension available if requested
- Number of Forms Required
  - One Form 5500 for each ERISA plan
    - Multiple employers might share a single ERISA plan, in which case only one filing is required
    - Multiple benefits may be bundled into a single ERISA plan via a wrap document, in which case only one filing is required
- Form 5500 Submission
  - Must be filed electronically via EFAST2
  - All filings must include the Form 5500 main body
    - Fully-insured plans should also include a Schedule A

PCORI Fees

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PCORI

- PCORI Fee
  - Requires group health plans to pay $1-3 per covered life
  - Effective for group health plan years ending in 2012 – 2029
  - Helps fund the institute https://www.pcori.org/

PCORI

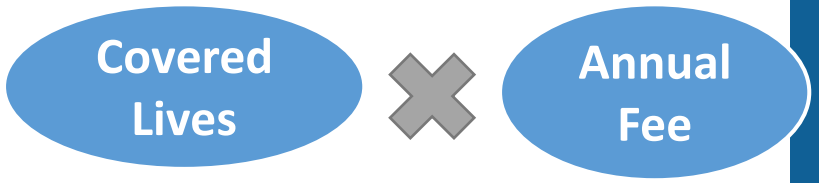
- Affected Plans
  - Group health plans, but not excepted benefits, so primarily major medical and HRAs

- Reporting & Fee Responsibility

Insurance Carrier
- **Fully-insured plans**

Employer/ Plan Sponsor
- **Self-funded plans**

- Fee Calculation



- Covered Lives
  - Primary subscribers, spouses and dependents
  - Counting methods: actual count method, snapshot method, Form 5500 method

- Fee – Adjusted Annually
  - $3.22 for plan ending Jan – Sept 2024
  - $3.47 for plan ending Oct – Dec 2024

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PCORI

- Due Date
  - July 31 in the year after the end of the plan year
    - Fees must be reported and paid by July 31, 2025 for plan years ending during 2024
    - Remember to report and pay for short plan years

- Reporting Method
  - Form 720 - https://www.irs.gov/pub/irs-pdf/f720.pdf
  - Must file for 2nd quarter ending June 30th
  - Use Lines 133(c) and (d) to report for self-funded group health plans

Gag Clause Attestations

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Gag Clause Attestations

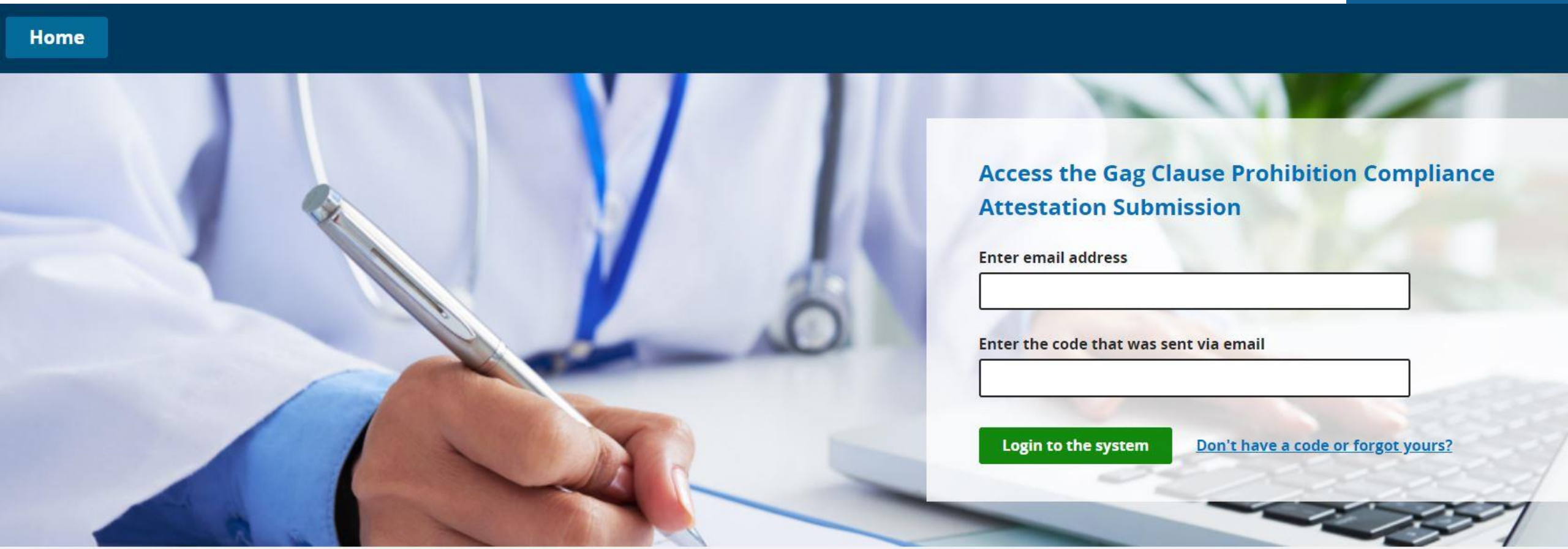
Required to attest to compliance annually by Dec. 31 of each year

- Group health plans must attest to not having gag clauses in contracts with service providers
  - Does not apply to excepted benefits, HRAs or retiree-only plans
- First attestation was required for 2021 – 2023 by Dec. 31, 2023
- Annually thereafter, the "attestation period" is from the date of the previous attestation up through the current attestation date

Example: Employer last attested Dec. 14, 2024. Employer attests again on Oct. 22, 2025.

Attestation Period = Dec. 15, 2024 – Oct. 22, 2025

Gag Clause Attestation



https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/gag-clause-prohibition-compliance

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Gag Clause Attestation

- **Responsibility for Attestation**
  - **Fully-Insured Group Health Plans**
    - Carriers likely to attest on behalf of the plan
  - **Self-Funded Group Health Plans & Other Group Health Plan Arrangements**
    - TPAs/PBMs may attest on behalf of the plan, but otherwise employer must attest

- **Employer Steps**
  - If service provider will attest, it is recommended to have this confirmed in writing
  - If service provide will NOT attest, ask for a certification of compliance for applicable contracts and save it in files for purposes of attesting

MHPAEA Comparative Analyses

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Mental Health Parity & Addiction Equity Act (MHPAEA)

- Applies to group health plans that provide mental health or substance use disorder benefits offered by employers with 50 or more employees
  - Non-federal group health plans offered by employers with 100 or more employees
  - Not applicable to excepted benefits or retiree-only plans
- General Requirements
  - Requirements and limitations for mental health or substance use disorder benefits cannot be more restrictive than those applied to medical/surgical benefits (must be "in parity")

- **Financial Requirements & Quantitative Treatment Limitations (QTLs)**
  - Determine whether a type of financial requirement or QTL applies to "substantially all" (2/3) medical/surgical benefits
  - If yes, determine the "predominant level" (>1/2) that applies and use that level

- **Non-Quantitative Treatment Limitations (NQTLs)**
  - No mathematical test
  - Comparative analysis used to analyze and document parity

MHPAEA – Compliance Responsibilities

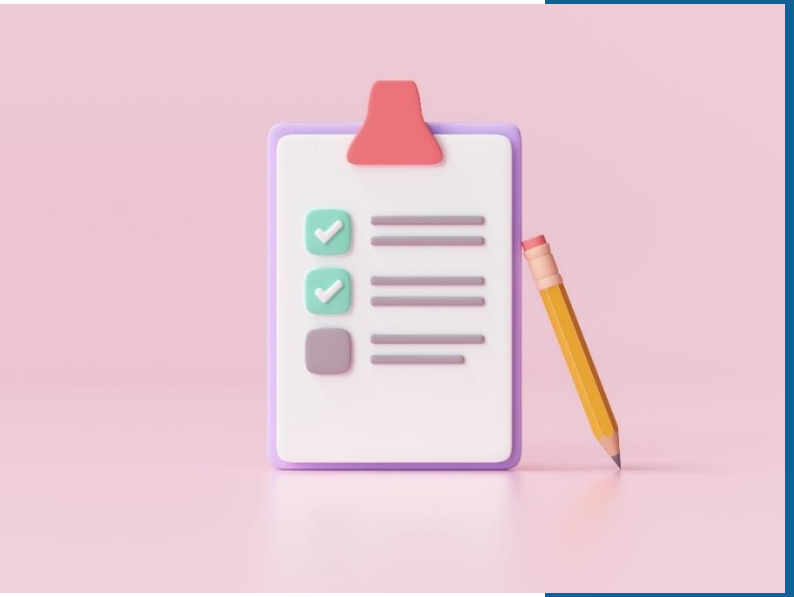
- **Fully-Insured Group Health Plans**
  - Carrier is directly responsible for compliance
  - Carrier is required to complete a written comparative analysis

- **Self-Funded Group Health Plans**
  - Employer as plan sponsor is directly responsible for compliance
    - TPA, PBM and other service providers may be co-fiduciaries and jointly liable
  - Action items
    - Review plan design for parity
    - Request information from service providers about efforts to comply in plan design and claims processing
    - Confirm whether service provider will prepare a comparative analysis or provide necessary data for another vendor to prepare a comparative analysis

Written Comparative Analysis

- **Required Content**

1. Description of NQTL, which benefits are subject to the NQTL, and which benefits are in which classification
2. List and definitions for any factors and evidentiary standards used to design or apply the NQTL
3. Description of how factors are used in the design and application of the NQTL
4. Demonstration of parity for the NQTL, as written
5. Demonstration of parity for the NQTL, in operation, including material differences in access and reasonable action taken to address the material differences (NOT REQUIRED UNTIL 2026)
6. Findings and conclusions



***Must be certified by one or more named plan fiduciaries beginning in 2025**

***Must be available upon request**

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Questions

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Webinar Wrap-Up

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A link to the recording of today's session will be available early next week from the Assurex Global Partner Firm who invited you to today's event.

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