

The ABCs of Health Care Reform

President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law on March 23, 2010. While many of the changes to group health plans mandated by this 2,409 page law will take effect in 2014, a number of high-impact items will become effective within the next nine months. The new law's provisions discussed below impact all employer sponsored plans – both self-insured and fully-insured group health plans.

The reforms discussed below are effective generally for plan years beginning six months after the date PPACA was signed into the law. This means calendar year group health plans must be amended to comply with PPACA before January 1, 2011. The fundamental purpose of the PPACA is to require all individuals to be covered by either an employer-sponsored group health plan or by an individual health insurance policy providing “minimum essential coverage.” To make sure individuals can purchase health insurance at a reasonable price, the individual states must establish “insurance exchanges” to help individuals find coverage. Tax credits are also available to help lower income earners pay for health insurance premiums. The new law contains a “pay or play” feature. Employers must either offer compliant group health plan coverage for employees or face significant tax penalties.

Existing employer-sponsored group health plans are called “grandfathered” plans and include any employer-sponsored group health plan in existence on March 23, 2010 (the day the law was signed into law). “New” group health plans are those plans that were not in existence on the date the law became effective. Except as otherwise noted, the following requirements apply to plan years beginning on or after September 23, 2010 for existing employer-sponsored group health plans.

- 1. Annual and Lifetime Limits** – Plans may not establish lifetime limits on the amount of plan benefits and annual limits cannot be “restrictive” as determined by the Secretary of Health and Human Services (“HSS”). For plan years beginning on or after January 1, 2014, group health plans may not impose any annual limit. PHSA § 2711¹.
- 2. No Rescissions of Group Health Plan Coverage** – Group health plans may not rescind an individual's coverage except in cases of fraud or intentional misrepresentation. PHSA § 2712.
- 3. No Cost Sharing for Preventative Care** – Plans must cover “evidence-based” preventative care (such as immunizations, well-baby care, breast cancer screenings, etc.) without co-pays or deductibles. PHSA § 2713.
- 4. Extension of Dependent Coverage** – Unmarried children who have not yet reached the age of 26 are eligible dependants. There is no requirement to cover the children of covered dependent children. PHSA § 2714.
- 5. New “Uniform Explanation of Coverage” Document** – Not later than 24 months after March 23, 2010, all employer sponsored health plans must prepare and distribute a paper or electronic summary of coverage to all plan participants both at the time of initial enrollment and annual enrollment. This new “Uniform Explanation of Coverage” must be provided in addition to the Summary Plan Description required under ERISA.

¹PPACA was enacted as amendments to the Public Health Service Act (PHSA) and was incorporated by reference into ERISA and the Internal Revenue Code.

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The “Uniform Explanation of Coverage” must conform to standards and definitions developed by the Secretary of HHS, including but not limited to: (i) a 4-page maximum with print no smaller than 12 point type; (ii) written in a culturally and linguistically appropriate manner; and (iii) containing mandatory contents concerning the covered benefits, exclusions, cost-sharing, and continuation. The HHS Secretary must establish the standards for this new disclosure document within 12 months of the date of enactment. This new Uniform Explanation of Coverage must be provided to applicants for health plan coverage and health plan enrollees within 24 months after March 23, 2010.

The new law also requires enrollees to be notified at least 60 days in advance of any material changes to the coverage reflected in the most recent summary. Failure to comply with this new disclosure rule may result in a \$1,000 penalty for each failure. PHSA § 2715.

6. New Reporting Requirements – Group health plans are required to report to the Secretary of HHS, the applicable State Insurance Commissioner, and the public the following information: claims payment policies and practices, financial disclosures, enrollment (and disenrollment) data, data on denied claims and rating policies, information on cost-sharing and payments with respect to out-of-network coverage, information on participant rights under the Act, and other information as determined by the HHS Secretary. PHSA § 2715A.

7. Prohibition of Discrimination in Favor of Highly-Compensated Employees – The non-discrimination rules for self-funded medical plans found at Internal Revenue Code section 105(h) will now also apply to insured group health plans. Group health plans will not be allowed to favor highly-compensated employees as to either eligibility or as to the benefits offered. PHSA § 2716.

8. Pre-existing Condition Exclusions – Group health plans are required to eliminate pre-existing condition exclusions for enrollees under the age of 19.

9. Ensuring the Quality of Care – Not later than two years after the date of enactment (March 23, 2010,) the HHS Secretary shall develop reporting requirements for group health plans. This report, which must also be made available to enrollees (during each open enrollment), is to focus on ways to improve the group health plan, such as case management, disease management, and wellness and health promotion activities. PHSA § 2717.

10. Cost-Reporting and Rebate Requirements – Effective January 1, 2011, health insurance companies offering group health plan coverage must submit a report to the HHS Secretary showing that at least 85% of the premiums collected (for 50 or more employee plans) are used to pay claims. If this standard is

not met for large plans (50 employees or more) then the amounts that do not meet this ratio must be rebated to enrollees. PHSA § 2718.

11. New Claims Review Procedures – The group health plans’ appeal processes must be rewritten. The new law states the review procedures must: (1) provide notice in a “culturally and linguistically appropriate manner” of the review process and availability of any applicable health insurance ombudsman created by a state to assist claimants with appeals; (ii) allows claimants to review the entire claim file and present evidence; (iii) allows claimants to continue receiving coverage during the appeal process; and (iv) initially incorporates the claims review procedure set forth in DOL regulations that apply to ERISA-covered plans. Plans must also establish an external review process for medical claims that complies with applicable state law. PHSA § 2719.

12. New Patient Protections – Companies that require an enrollee to designate a primary care provider must permit each enrollee to designate any participating primary care provider who is available and that primary care provider must accept the enrollee. PHSA § 2719A.

13. New Electronic Transaction Standards – New electronic transaction standards apply to group health plans and group health plans must certify their compliance to the HHS Secretary. The timing of the certification varies depending on the type of transaction. For example, a group health plan must certify compliance with electronic fund transfer, health claim status, and health care payment and remittance advice standards established by PPACA by no later than December 31, 2013. PPACA § 1104.

14. Total Elimination of Pre-Existing Condition Exclusions – This becomes effective for Plan years beginning on or after January 1, 2014. PHSA § 2704.

15. No Discrimination Based on Health Status – PPACA adopts HIPPA’s rules that group health plans may not discriminate as to benefits or coverage based on health status. This anti-discrimination rule is effective January 1, 2014. PHSA § 2705.

16. Cost-Sharing Allocations – As of January 1, 2014, out-of-pocket expenses cannot exceed that applicable to Health Savings Accounts and cannot exceed \$2,000 for single coverage or \$4,000 for family coverage (as indexed). PHSA § 2707.

17. Uniform Waiting Periods – Effective January 1, 2014, waiting periods cannot exceed 90 days.

18. Automatic Enrollment – As of January 1, 2014, employers who have more than 200 full time employees (defined as employees who work more than 30 hours per week) must offer at least one group health plan and must automatically enroll all

new employees. The automatic enrollment feature must allow the employee to opt out of this coverage and elect another option, or opt out altogether. PPACA § 1511.

19. Notification of Available State Exchange Coverage and Federal Subsidies – Beginning in plan years after January 1, 2014, employers must notify each employee at the time of hiring about: (i) the existence of state exchanges; (ii) that the employee might be eligible for a subsidy under the exchange when the employer's share of the total cost of benefits is less than 60%; and (iii) that if the employee purchases a policy through a state exchange, he or she will lose the employer contribution to any health plan benefits offered by the employer (except as set forth in the Free Choice Statute requirement). PPACA § 1512.

20. Free Rider Penalty – Beginning on January 1, 2014, employers who have more than 50 full-time employees must pay a penalty if a full-time employee receives a federal subsidy to purchase health insurance from a state exchange. If the employer does not offer coverage and has at least one full-time employee receiving the premium assistance tax credit, then the employer must pay a monthly fine equal to \$166.67 (\$2,000 annually) per full-time employee (but excluding the first thirty employees from the fine's calculation.) If the employer offers coverage, but has at least one full-time employee receiving the premium assistance tax credit, the employer must pay the lesser of a monthly fine of \$250 (\$3000 annually) for each employee receiving the credit or a monthly fine of \$166.67 (\$2000 annually) for each of their full-time employees (excluding the first thirty employees.) PPACA § 1513.

21. Reinsurance Program for Early Retirees – Effective upon enactment a \$5 billion fund has been created to finance a temporary reinsurance program to help employers offset the costs of expensive health claims for retirees between the ages of 55 and 64 and their dependents. PPACA § 1102.

22. Inclusion of Costs of Employer-Sponsored Coverage on Form W-2 –For taxable years beginning after December 31, 2010, employers will be required to report the annual cost of health plan coverage received by employees. PPACA § 9002.

23. Limit on Flexible Spending Arrangement Contributions – Beginning with tax years after December 31, 2012, annual contributions to employer-sponsored health care FSAs are capped at \$2,500 (indexed) and reimbursement for over-the-counter medicines are limited to those that have been required by a prescription. PPACA § 9005.

24. Additional Medicare Taxes – For tax years beginning after December 31, 2012, an additional tax of .9% on wages and 3.8% on unearned income will be imposed on individuals receiving

wages in excess of \$200,000 (single taxpayers) or \$250,000 (couples). These new taxes are imposed only on the employee portion of the Medicare tax, not on the employer portion. PPACA § 10906.

25. Medicare Part D Retiree Drug Subsidy – For tax years after December 31, 2012, employers receiving the Medicare Part D retiree drug subsidy will have to include the payment in income for tax purposes. PPACA § 9012.

26. Long-Term Care Program – The law includes the Community Living Assistance Services and Supports (CLASS) program which is a voluntary federal program for long-term care insurance. Only active workers are eligible to participate. The law requires the Secretary to establish program by October 1, 2012. PPACA § 8002. The Congressional Budget Office estimates that the monthly insurance premium will average about \$123 in 2011.

27. Expanded Wellness Programs – As of January 1, 2014, the law allows employers to provide expanded financial incentives for participation in wellness programs. Plans will be allowed to provide wellness program participation incentives to plan participants of up to thirty percent of the total cost of coverage (including both the employer and employee contribution). The Secretaries of Labor, Health and Human Services and Treasury have the authority to increase the limit to up to fifty percent of the cost of coverage. PPACA § 2705.

Next Steps

Group health plan sponsors should look at both the short-term and long-term impact of PPACA on their group health plan. A compliance and administration strategy must be implemented within the next few months to safely comply with PPACA's fast approaching effective dates.

Briefing

What appears above is very brief and cursory summary of this 2,409 page new law. Winston and Strawn has established a Health Care Reform Task Force to assist you in developing effective compliance strategies. Please feel free to contact the following Task Force members for assistance:

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