Schulte Roth&Zabel

Employment & Employee Benefits Developments

Health Care Reform Highlights | winter 2012

Over the past year, the Departments of Labor ("DOL"), the Treasury and Health and Human Services ("HHS") (collectively, the "Departments") have made various changes to the Patient Protection and Affordable Care Act ("PPACA"). In this issue we provide an overview of those changes, update the last issue of our *Employment & Employee Benefits Developments Newsletter* [1] and summarize some of the key requirements that are set to take effect in 2014. Employers and trustees that sponsor group health plans ("plan sponsors") should consider the effect that these changes will have on financial and administrative planning, now and in the coming years.

Amended Rules

***Grandfathered Plans*:** PPACA allows individuals and employers to keep their existing plans if the plans meet certain conditions. If a health plan was in existence prior to March 23, 2010 and continually enrolled an individual from that date onward, the plan could have elected "grandfathered" status. Grandfathered plans do not have to comply with certain PPACA provisions until a later date (for example, the requirement to offer certain patient protections and preventive care without cost-sharing).

- **Initial Rule:** The initial regulations provided that if an employer or employee organization participating in a grandfathered, collectively bargained health plan entered in to a new policy, certificate or contract of insurance after March 23, 2010 that policy, certificate or contract of insurance would not be considered a grandfathered health plan with respect to any individuals in such health plan.
- **Amended Rule:** The DOL amended the regulations to permit group health plans to change health insurance coverage and enter in to new policies, certificates or contracts of insurance without losing grandfathered status, as long as the coverage meets the other grandfather requirements (for example, not decreasing an employer's contribution rate toward the cost of coverage by more than five percent and not eliminating or significantly reducing coverage for a certain condition, which includes eliminating an element necessary to diagnose or treat a condition). The amendment does not apply to changes in group health coverage that became effective before Nov. 15, 2010.

***Dependent Coverage to Age 26*:** Effective Jan. 1, 2011, all group health plans that provide dependent coverage, grandfathered or not, had to cover participants' dependent children up to age 26.

- **Initial Rule:** Plans could not impose any conditions, such as residency, tax-dependency or marital status, on dependency.
- **Amended Rule:** In an answer to a Frequently Asked Question posted on the DOL website, the DOL stated that a plan or issuer will not fail to satisfy the requirement to offer coverage

Continued on page 3

in this issue

[1] Available at http://www.srz.com/employment_employee_benefits_summer_2010/.

Impending Health Care Reform Effective Dates		
	Action Item	**Effective Date**
2012	Compliance With Nondiscrimination Rules	Effective date delayed pending guidance
	Summary of Benefits and Coverage	Effective date delayed pending final regulations
	Compliance With Claims and Appeals Rules	January 1, 2012
2013	W-2 Reporting of Medical Benefits	January 1, 2013
2014	Requirement to Maintain Minimum Essential Coverage	January 1, 2014
	Individual Penalty	January 1, 2014
	Employer Penalty	January 1, 2014
	Premium Tax Credits	January 1, 2014
	Cost-Sharing Reductions	January 1, 2014
	Requirement to Offer Essential Health Benefits (Insured Plans Only)	January 1, 2014
2018	Excise Tax on "Cadillac Plans"	January 1, 2018

Continued from page 1

to dependents up to age 26 if the plan limits dependent health coverage to sons, daughters, stepchildren, adopted children and foster children. For other dependents, such as grandchildren, a plan may impose additional conditions on eligibility.

***Waivers From the Annual Limit Requirement*:** For plan years beginning after Sept. 23, 2011 (e.g., Jan. 1, 2012 for calendar year plans), group health plans that have not obtained a waiver cannot impose an annual limit on the dollar value of health benefits below $1,250,000 per individual.

- **Initial Rule:** Plans could apply for a waiver from the restricted annual limit requirement for the plan or policy year beginning between Sept. 23, 2010 and Sept. 23, 2011 if they offered coverage before Sept. 23, 2010.
- **Amended Rule:** Applications for new waivers are no longer being accepted. All plans or policies that have not submitted waiver applications must now comply with the restricted annual limit amount required by PPACA for the current plan year.

***Waiver Extensions*:** Plans that already received waivers from PPACA's minimum annual limit requirement for the plan year beginning after Sept. 23, 2011 can apply to extend that waiver for the plan year beginning on or after Sept. 23, 2011. The waiver extension is valid for only one year.

The waiver extension applies only to plan years beginning on or after Sept. 23, 2011 and before Jan. 1, 2014 (when no annual limits on essential health benefits will be permitted, except in the case of grandfathered individual market policies).

Each waiver extension recipient must distribute an updated annual notice to eligible participants and subscribers for each plan year for which the waiver applies.

***Nondiscrimination*:** PPACA extends the nondiscrimination requirements that currently apply to self-insured plans to fully-insured plans.

- **Initial Rule:** For plan years beginning on or after Sept. 23, 2010, all employees covered by non-grandfathered self-insured plans must have access to the same benefits and plan options.
- **Amended Rule:** Because PPACA requires fully insured plans to comply with rules "similar" to those that apply to self-insured plans, and because guidance has yet to be issued on what rules specifically apply to fully-insured plans, the IRS has delayed the effective date of the nondiscrimination requirement until the first plan year beginning a specified period after such guidance is issued.

***Internal Claims and Appeals and External Review Process*:** PPACA gives consumers the ability to appeal decisions made by plans. PPACA's requirements regarding internal claims and appeals and external review processes currently apply only to non-grandfathered plans.

Non-grandfathered group health plans must update their existing internal appeals process to meet certain additional requirements, including an expansion of the information provided to participants regarding the grounds for the denial of their claim or the rescission of their coverage. In addition, plan sponsors generally have only 24 hours to respond to urgent care claims, reduced from the 72 hours provided under the 2002 DOL claims regulations.

- **Initial Rule:** PPACA initially required non-grandfathered health plans to amend their internal claims processes for the first plan year beginning on or after Sept. 23, 2010.
- **Amended Rule:** There is a delayed effective date for compliance with some of PPACA's internal claims and appeals requirements. For example, the requirement that urgent care claims be decided as soon as possible, but no later than 24 hours after the plan receives the claim, is now effective for plan years beginning on or after Jan. 1, 2012. Similarly, the requirement that a notice to a claimant include the diagnosis and treatment codes of the claim, and the requirement that such notice be provided in a linguistically and culturally appropriate manner, are also now effective for plan years beginning on or after Jan. 1, 2012. Self-insured non-grandfathered plans must also comply with certain external review processes depending on which state they are located in. For example, self-insured non-grandfathered plans located in states that do not extend external review processes to self-insured health plans must contract with at least two independent review organizations by Jan. 1, 2012, and with at least three independent review organizations by July 1, 2012, and rotate assignments among them.

***W-2 Reporting of Medical Benefits*:** PPACA requires employers to report the cost of coverage that an employee receives under the employer's health plan.

- **Initial Rule:** PPACA initially required employers to report this information for tax years beginning after Dec. 31, 2010.

- **Amended Rule:** The IRS made this reporting requirement optional for the 2011 tax year. This means that the cost of coverage will not have to be included on employees' Forms W-2 until January 2013 (the date Forms W-2 are due for the 2012 tax year). There is a small employer exception for employers that filed fewer than 250 W-2 Forms for the 2011 tax year, which provides relief from this new reporting requirement until the IRS issues further guidance.

***Summary of Benefits and Coverage*:** Initially intended to be effective March 23, 2012, all health plans, grandfathered or not, will have to provide a summary of benefits and coverage ("SBC") to participants and beneficiaries, including individuals who are eligible for, but who are not necessarily receiving, coverage. The SBC generally must be given to participants and beneficiaries with initial enrollment materials, within seven days of a special enrollment or the participant's request, and 60 days before a mid-year material change. The SBC must include, among other items, uniform definitions of standard terms to ease comparability, a description of the coverage offered (including cost-sharing) and the exceptions to, and limitations on, coverage offered.

In the summer of 2011, the Departments issued proposed regulations that provide standards for group health plans to use in compiling and providing the SBC. Because the goal of the SBC is to enable participants to easily understand and compare their options for health coverage, the SBC must be a stand-alone document not to exceed four double-sided pages in length using language and examples that the average reader would understand. For fully-insured plans, health insurance carriers must develop the SBC. For self-insured plans, the plan sponsor must develop the SBC. This requirement applies jointly to group health plans and health insurance carriers; the requirement to provide the SBC will be satisfied when either party provides the SBC, though the proposed regulations do not provide rules on how to determine who is responsible for providing the SBC in cases of dual responsibility.

On Nov. 17, 2011, in an answer to a Frequently Asked Question on the DOL website, the Departments stated that they intend to issue final regulations as soon as possible to take into account the comments and other feedback they received and that, until final regulations are issued and applicable, group health plans and health insurance issuers do not have to comply with the SBC requirement. The Departments also stated that they anticipate that the final regulations, once issued, will include an applicability date that will give group health plans and health insurance issuers adequate time to comply with the SBC requirement.

***Preventive Services*:** In the summer of 2011, the IRS, Employee Benefits Security Administration and Centers for Medicare and Medicaid Services jointly issued an amended interim final rule requiring non-grandfathered health plans to cover preventive health services for women without cost-sharing. The amended rule supplements the initial interim final rule that was issued on July 19, 2010 and applies to plan or policy years beginning on or after Aug. 1, 2012. Examples of covered preventive services include: well-woman visits, domestic violence screening, human immunodeficiency virus screening and counseling, and FDA-approved contraceptives (with an exemption available for religious employers maintaining group health plans).

***Exchanges*:** In the summer of 2011, HHS issued proposed rules to help implement state health insurance exchanges. PPACA requires these exchanges to be operational by Jan. 1, 2014. The exchanges are intended to help further competition in the health insurance marketplace by allowing individuals and small employers (employers with up to 50 employees) to compare private health insurance options based on a number of factors, including price. Because the proposed rule does not address how multiemployer plans will interact with state exchanges, HHS requested comments on how multiemployer plans can potentially provide coverage through an exchange. Comments were due by Oct. 31, 2011.

On Aug. 12, 2011, HHS and the Treasury released three proposed rules to help establish small-business state exchanges.

- One proposed rule, issued by HHS, details the standards and process for enrolling in qualified health plans and insurance affordability programs through a simplified, coordinated system. The rule explains that, beginning in 2014, income eligibility for Medicaid and the premium tax credit will be determined using a simplified calculation based on the taxpayer's modified adjusted gross income.
- Another proposed rule, also issued by HHS, similarly simplifies enrollment by coordinating the exchanges with Medicaid and Children's Health Insurance Program eligibility.
- A proposed rule issued by the Treasury explains how individuals and families can receive premium tax credits. Beginning in 2014, taxpayers with household income between 100 percent and 400 percent of the Federal Poverty Level ($22,350-$89,400 for a family of four in 2011) will be eligible for premium tax credits for coverage purchased through an exchange for themselves and

for members of their families who are not eligible for other health coverage. The Congressional Budget Office estimates that the premium tax credit will help over 20 million people afford health insurance and will provide these individuals with an average subsidy of over $5,000 per year. ■

Health Care Reform in 2014 and Beyond

***Minimum Essential Coverage and the Individual Mandate*:** For each month beginning after 2013, PPACA requires an "applicable individual" to maintain "minimum essential coverage" for both the individual and any of the individual's dependents who are also applicable individuals. An "applicable individual" is anyone who is not exempt from the requirement to maintain minimum essential coverage. For example, under PPACA, individuals with certain religious beliefs do not have to obtain minimum essential coverage.

"Minimum essential coverage" includes coverage under:

- A government sponsored program (such as Medicaid, CHIP, Medicare Part A or TRICARE for Life);
- An employer-sponsored plan;
- Plans offered in the individual market;
- Grandfathered health plans; and
- Any other coverage recognized by HHS, in coordination with the Secretary of the Treasury.

Though PPACA does not define what benefits must be included in minimum essential coverage, it does specify that minimum essential coverage does not include certain excepted benefits including, but not limited to, accident-only coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, credit-only insurance, and limited-scope dental or vision benefits if provided under a separate policy, certificate or contract of insurance.

***Individual Mandate*:** If an applicable individual fails to maintain minimum essential coverage for him or herself and his or her applicable dependents for any month beginning after 2013, that individual will be subject to a penalty that must be included with his or her tax return for the taxable year during which the failure to maintain coverage occurred.

The amount of the monthly individual penalty depends in part on the year in which it is assessed:

Year	Monthly Penalty Amount
2014	The greater of: (i) 1/12 of $95 (the "applicable dollar amount"); or (ii) 1% of the individual's household income
2015	The greater of: (i) 1/12 of $325; or (ii) 2% of the individual's household income
2016 & Beyond	The greater of: (i) 1/12 of $695; or (ii) 2.5% of the individual's household income

For applicable individuals under age 18, the applicable dollar amount will be reduced by 1/2 for the calendar year in which the month occurs. The total family penalty is capped at 300 percent of the applicable dollar amount for the calendar year (i.e., $285 in 2014, $975 in 2015 and $2,085 in 2016).

***Employer Penalties*:** Effective in 2014, employers with 50 or more "full-time employees" ("large employers") will face penalties if one or more full-time employee obtains a premium credit through an exchange. PPACA defines a "full-time employee" as an employee who works an average of at least 30 hours of service per week. "Full-time equivalent" employees are included when calculating the number of employees for purposes of determining whether the employer is a "large employer" and thus subject to the penalty.

Example

An employer has 40 full-time employees who work 30 or more hours per week and 30 part-time employees who each work 24 hours per week (or 96 hours per month). The employer would have 64 full-time employees based on the following calculation as required by PPACA:

30 employees x 96 hours/120 = 24

Penalty for Large Employers Not Offering Health Coverage: For any month after 2013, large employers who: (i) do not offer their full-time employees and their dependents the opportunity to enroll in their plan; and (ii) have at least one full-time employee who has enrolled in another qualified health plan and received a premium tax credit or cost-sharing reduction for such coverage

will be subject to a penalty. The amount of the penalty is the product of the "applicable payment amount" and the number of full-time employees employed during the month in which the employer did not offer coverage. The first 30 full-time employees, and part-time employees included in the calculation of how many full-time employees an employer has, are excluded for purposes of calculating the amount of the penalty.

***Penalty for Large Employers Offering Health Coverage*:** For any month after 2013, large employers who do offer their full-time employees and their dependents the opportunity to enroll in their plan but nevertheless have at least one full-time employee who has enrolled in another qualified health plan and who received a premium tax credit or cost-sharing reduction for coverage under such plan will also be subject to a penalty. The amount of the monthly penalty is the product of the number of full-time employees receiving a premium tax credit and/or cost-sharing reduction during the month and 1/12 of $3,000. Part-time employees included in the calculation of how many full-time employees an employer has are excluded for purposes of calculating the amount of the penalty.

The IRS and Treasury proposed a potential wage-based safe harbor for employers facing a penalty under PPACA in Notice 2011-73, issued on Sept. 13, 2011. Because an employer may face a penalty if the coverage it offers is "unaffordable," and because affordability is determined based on an employee's household income, which may hinge on certain factors that an employer may not know about (such as the adjusted gross income of the employee's spouse and dependents), the proposed safe harbor would allow large employers to determine the affordability of the coverage they provide based on the wages the employer pays to employees instead of the employees' household income.

Notice 2011-73 states that the IRS and the Treasury assume that a large employer will not be subject to a penalty, even if an employee receives a premium tax credit, if: (i) the large employer offers its full-time employees and their dependents minimum essential coverage and (ii) the employee portion of the self-only premium for the lowest-cost option the employer provides does not exceed 9.5 percent of the employee's W-2 wages. The purpose of the safe harbor is to provide a more practical method for employers to measure the affordability of the coverage they provide.

Individual Subsidies: Premium Tax Credits and Cost-Sharing Reductions

***Premium Tax Credits*:** Effective in 2014, applicable taxpayers will be eligible for premium tax credits toward their required purchase of health insurance. PPACA defines an "applicable taxpayer" as anyone whose household income for the taxable year equals or exceeds 100 percent of the Federal Poverty Level ("FPL," $22,350-$89,400 for a family of four in 2011) but does not exceed 400 percent of the FPL. Individuals with household incomes above 400 percent of the FPL will not be eligible for the credit. Generally, the premium assistance amount will be based on the premium of the second lowest cost silver plan available to the applicable taxpayer offered through an exchange, and the applicable individual's household income. For example, applicable taxpayers with household incomes between 300 percent and 400 percent of the FPL will have to pay no more than 9.5 percent of their incomes in premiums. Applicable taxpayers at or below 133 percent of the FPL will have to pay no more than two percent of their incomes in premiums.

Bronze Plan: provides benefits that are actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan

Silver Plan: provides benefits that are actuarially equivalent to 70% of the full actuarial value of the benefits provided under the plan

Gold Plan: provides benefits that are actuarially equivalent to 80% of the full actuarial value of the benefits provided under the plan

Platinum Plan: provides benefits that are actuarially equivalent to 90% of the full actuarial value of the benefits provided under the plan

To be eligible for the credit, applicable individuals must be enrolled in a plan offered through an exchange and must be lawful residents of the state offering the exchange. In addition, applicable individuals generally cannot be eligible for other minimum essential coverage and receive the premium tax credit. However, individuals eligible for, but not enrolled in, employer-sponsored health coverage may be eligible for the credit if the employer-sponsored health coverage is not affordable or does not provide "minimum value." Employer-sponsored coverage is not affordable if the employee's required contribution with respect to the plan exceeds 9.5 percent of the applicable taxpayer's household income. Employer-sponsored coverage does not provide minimum value if the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs (i.e., the plan does not meet the requirements of the bronze plan). Thus, even if an employer offers minimum essential coverage, if the cost-sharing requirements for such coverage are too high, the

employer may face a penalty if one full-time employee of the employer is eligible for, and receives, the premium tax credit.

***Cost-Sharing Reductions*:** Effective in 2014, individuals who qualify for a premium tax credit and are enrolled in an exchange plan at the silver level will be eligible for cost-sharing reductions. The cost-sharing subsidies will reduce eligible individuals' out-of-pocket maximums by 2/3 for individuals with household incomes between 101 percent and 200 percent of the FPL; by 1/2 for individuals with household incomes between 201 percent and 300 percent of the FPL; and by 1/3 for individuals with household incomes between 301 percent and 400 percent of the FPL.

***Essential Health Benefits*:** Effective in 2014, PPACA requires health plans to offer an "essential health benefits package." Self-insured plans are exempt from this requirement. The essential health benefits package, which differs from "minimum necessary coverage," is coverage that provides essential health benefits, limits cost-sharing and provides either the bronze, silver, gold or platinum level of coverage.

PPACA requires that the following categories of benefits be considered essential health benefits:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Health plans that are required to offer the essential health benefits package must also limit cost-sharing. Effective in 2014, cost-sharing incurred under such plans cannot exceed the individual and family limits for high deductible health plans then in effect. PPACA defines cost-sharing to include deductibles, co-insurance, co-payments and other similar charges.

In guidance issued in December of 2011, HHS outlined its proposal to define essential health benefits, and explained that, after reviewing the relevant regulatory framework and surveying the benefits offered by both large and small employers, it intends to define essential health benefits through benchmark plans selected by each state. The benchmark plan must cover all 10 categories of services listed above; if a category is missing from the benchmark plan, health plans required to offer essential health benefits must nevertheless offer that category of benefits to participants.

The benchmark plan would fall into one of the following four categories: (i) the largest plan by enrollment in any of the three largest small group insurance products in the state's small group market; (ii) any of the largest three state employee health benefit plans by enrollment; (iii) any of the largest three national Federal Employees Health Benefits Program plan options by enrollment; or (iv) the largest insured commercial non-Medicaid HMO operating in the state. HHS believes that this method would both preserve state flexibility and reflect the scope of benefits and limitations offered by the "typical" employer-sponsored plan within that state.

***Excise Tax on Cadillac Plans*:** Effective Jan. 1, 2018, a 40 percent excise tax will be assessed on high-cost, or "Cadillac," plans offering health coverage valued at more than $10,200 for an individual and $27,500 for a family, indexed to inflation. If the plan is insured, the insurer is responsible for payment of the tax.

***PPACA's Constitutionality*:** To date, four federal appellate courts have rendered different decisions on PPACA's constitutionality. Because of the various decisions among the circuits, on Nov. 14, 2011, the Supreme Court granted the National Federation of Independent Businesses' petition for review of PPACA's constitutionality. The Supreme Court will review the constitutionality of PPACA in its entirety, the constitutionality of the individual mandate, whether the individual mandate is severable from PPACA and whether the Anti-Injunction Act bars challenges to PPACA. The Court will hear oral arguments over March 26-28, 2012. ■

How to Prepare

2014 is just around the corner — employers and other plan sponsors should keep their eye on the provisions of PPACA that have yet to become effective, such as the prohibition on nondiscrimination for fully-insured plans and the requirement to provide a SBC, as these requirements are likely to have serious administrative and financial implications on all group health plans once they do become effective, and we will provide updated information as new guidance becomes available.

If you have questions about PPACA's effect on your health plan, or if you need help implementing any of PPACA's requirements, preparing participant communications or other plan materials, or preparing for the administrative and financial costs of PPACA's impending requirements, please contact one of the authors below. ■

For more information, please contact:

Mark E. Brossman is a partner and co-chair of the Employment & Employee Benefits Group. His areas of focus are ERISA, employment discrimination, labor relations, education law, and related litigation.

+1 212.756.2050 | mark.brossman@srz.com

Ronald E. Richman is a partner and co-chair of the Employment & Employee Benefits Group and a member of the frim's Executive Committee. He represents employers and employees on executive compensation, non-competition, non-solicitation, confidentiality, equal employment opportunity, and related litigation.

+1 212.756.2048 | ronald.richman@srz.com

Holly H. Weiss is a partner in the Employment & Employee Benefits Group, where she focuses her practice on the representation of employers in all aspects of employment law and employee relations.

+1 212.756.2515 | holly.weiss@srz.com

Susan E. Bernstein is a special counsel in the Employment & Employee Benefits Group, where she focuses on ERISA issues for single, multiple and multiemployer qualified and nonqualified benefit plans, including designing and amending plans, and plan administration and regulatory compliance.

+1 212.756.2056 | susan.bernstein@srz.com

Melissa A. Jacoby is an associate in the Employment & Employee Benefits Group, where she focuses her practice on health and retirement plan adminstration and regulatory compliance.

+1 212.756.2163 | melissa.jacoby@srz.com

Schulte Roth&Zabel

New York
Schulte Roth & Zabel LLP
919 Third Avenue
New York, NY 10022
+1 212.756.2000
+1 212.593.5955 fax

Washington, DC
Schulte Roth & Zabel LLP
1152 Fifteenth Street, NW, Suite 850
Washington, DC 20005
+1 202.729.7470
+1 202.730.4520 fax

London
Schulte Roth & Zabel International LLP
Heathcoat House, 20 Savile Row
London W1S 3PR
+44 (0) 20 7081 8000
+44 (0) 20 7081 8010 fax

www.srz.com