Notes

THE HOLLIS COMPANIES

Patient Protection and Affordable Care Act:
Recent Developments

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Presented by:

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I. Court Challenges. Cases pending in five federal circuit courts of appeals concerning the constitutionality of the Patient Protection and Affordable Care Act ("PPACA").

A. Held constitutional by:

1. *Mead v. Holder*, C.A. No. 10-950 (GK) (D. D.C. 2011). Appeal pending in the D.C. Circuit. *En banc* hearing requested.

2. *Liberty University v. Geithner*, 2010 WL 4860299 (W.D. Va. 2010). Consolidated with *Virginia v. Sebelius (*below). Affirmed by the Fourth Circuit based on lack of standing.

3. *Thomas More Law Center v. Obama*, 720 F. Supp. 2d 882 (E.D. Mich. 2010). Affirmed by the Sixth Circuit holding that the PPACA and its individual mandate are constitutional and that the individual mandate is "a valid exercise of legislative power by Congress under the Commerce Clause." The plaintiffs have sought a writ of certiorari from the U.S. Supreme Court.

4. *New Jersey Physicians, Inc v. President of U.S.*, (3d Cir. Aug 3, 2011) ruled the plaintiffs lacked standing to challenge PPACA.

B. Held unconstitutional by:

1. *Florida v. U.S. Department of Health and Human Services*, Case No.: 3:10-cv-91-RV/EMT (N.D. Fla. 2011) (holding the entire law unconstitutional, but decision stayed). Affirmed by the Eleventh Circuit. *Florida v. U.S. Department of Health and Human Services*, 108 AFTR 2d ¶2011-5187 (11th Cir. August 12, 2011) (holding

only the individual mandate unconstitutional, not the entire law).

2. *Virginia v. Sebelius*, 728 F. Supp. 2d 768 (E.D. Va. 2010. Consolidated with *Liberty University v. Geithner*, above. Reversed by the Fourth Circuit based on lack of standing.

C. *Baldwin v. Sebelius*, ____ U.S. ____, 2010 WL 3617248 (U.S. November 8, 2010). The U.S. Supreme Court refused to directly review a California decision dismissing for lack of standing a case challenging the individual mandate and other health care reform provisions. Affirmed by the Ninth Circuit, 2011 WL 3524287.

D. *Bryant, v. Holder*, civil action no. 2:10-cv-76-KS-MTP (S.D. Miss. 2011). Mississippi Lt. Governor Phil Bryant and private individuals have standing to challenge the constitutionality of PPACA's "individual mandate."

II. Summary of Benefits and Coverage and the Uniform Glossary.

A. On August 22, 2011, the three agencies that have interpretive authority over PPACA (HHS, DOL, and IRS) issued proposed regulations and guidance concerning the summary of benefits and coverage ("SBC").

1. All group health plans (including grandfathered plans) must provide an SBC beginning on March 23, 2012.

2. The agencies interpreted the four page statutory requirement as four double-sided pages.

3. Must be a stand alone document (although the agencies requested comments on whether the SBC could be included in the summary plan description).

B. SBC Template. The guidance proposes an SBC template which includes:

1. Glossary of Health Insurance and Medical Terms;

2. Ten "Important Questions," "Answers" and "Why this Matters";

3. Common Medical Events with examples of "Services You May Need" and the corresponding network and non-network copayment percentages, limitations, and exceptions. The broad categories coincide with the essential health benefits listed in the statute;

4. Excluded services;

5. Rights to continue coverage (with no mention of COBRA);

6. Grievance and appeal rights;

7. Examples to illustrate benefits provided under the plan for common benefits scenarios (having a baby, treating breast cancer, and managing diabetes);

8. For coverage beginning on or after January 1, 2014, a statement of whether it provides minimum essential coverage under PPACA and if the plan's share of the cost meets PPACA's requirements;

9. An Internet address (or similar contact information) for obtaining a list of network providers;

10. An Internet address for more information about prescription drug coverage;

11. An Internet address to review and obtain the uniform glossary; and

12. The full premium or full cost of coverage for self-insured group health plans (without regard to how much of that cost the employee is required to pay).

C. If a plan has multiple coverage options, the employee need only be furnished an SBC for the option chosen.

D. Language. The SBC must be provided in a "culturally and linguistically appropriate" manner, following the rules for providing appeals notices.

1. June 2011 regulations amended these requirements to provide for a single threshold of 10% or more of the population residing in the claimant's county, as determined based on American Community Survey data published by the United States Census Bureau.

2. Each notice sent by a plan or issuer to an address in a county that meets the 10% threshold must include a one-sentence statement in the relevant non-English language about the availability of language services.

E. Requirements Relating to Providing the SBC. A group health plan's obligation to provide the SBC is satisfied if the insurer provides the SBC to participants. In that case, the plan administrator need not also provide an SBC to dependents known to reside at the same address; a separate SBC must be sent to a beneficiary who has a different last known address.

F. Deadlines for delivery to participants.

1. The SBC must be provided with any written application materials or the first day a participant is eligible to enroll, if there are no written application materials.

2. If there are changes to the SBC before coverage becomes effective, a new SBC must be distributed by the first day of coverage.

3. Any special enrollee requesting coverage (e.g., new dependent or loss of other coverage) must be given an SBC within seven days of the special enrollment request.

4. If written application is required for renewal (in either paper or electronic form), the SBC must be provided no later than the date the materials are distributed.

5. If renewal is automatic the SBC must be provided at least 30 days before the effective date of renewal.

6. If a plan has multiple coverage options, at renewal only the SBC for the option in which the participant is currently enrolled (a participant may request SBCs for other options for which he or she is eligible).

7. An SBC must be provided as soon as practical after a participant's or beneficiary's request, but no later than seven days after the request.

8. A single SBC may be provided for a participant and his or her dependents known to reside at the same address; a separate SBC must be sent to a beneficiary who has a different last known address.

9. If the plan or an insurer makes a material modification to the coverage that would affect the SBC, other than at the time of renewal, the plan or the insurer must notify participants and beneficiaries at least 60 days before the change takes effect.

10. If there are changes to the SBC-required information before coverage begins, a new SBC would be required.

G. ERISA plans may deliver an SBC electronically according to the DOL's electronic disclosure regulations.

III. Preventive Services and Guidelines on Required Coverage of Women's Preventive Services.

A. PPACA requires group health plans to provide coverage for certain preventive services delivered by in-network providers without cost-sharing (i.e., with no deductibles, co-payments, co-insurance, or other cost-sharing on these services).

B. Grandfathered plans are exempt.

C. The Department of Health and Human Services (HHS) issued guidelines on required coverage of women's preventive services.

D. Guidelines on Women's Preventive Services. Under the interim final regulations, HHS's Health Resources and Service Administration (HRSA) was to develop comprehensive guidelines on preventive care and screenings for women.

E. HRSA issued those guidelines. They include coverage for a broad range of items and services, including:

1. contraceptive methods and counseling,

2. breastfeeding support and supplies, and

3. screening and counseling for interpersonal and domestic violence.

F. Coverage without cost-sharing is required when these items and services are delivered by in-network providers.

G. Effective for plan years beginning on or after August 1, 2012 (i.e., January 1, 2013 for calendar-year plans).

H. Discretionary Exemption of Religious Employers. HRSA has the discretion to exempt group health plans of certain religious employers from the requirement to cover contraceptive services.

I. A "religious employer" is an organization that meets all of the following criteria:

1. The inculcation of religious values is the purpose of the organization.

2. The organization primarily employs persons who share the religious tenets of the organization.

3. The organization serves primarily persons who share the religious tenets of the organization.

4. The organization is a nonprofit organization that is a church, a church's integrated auxiliaries, a convention or association of churches, or the exclusively religious activities of a religious order.

IV. Proposed Regulations on Exchange and Premium Tax Credit Eligibility, SHOP Participation.

A. July 15, 2011 and August 17, 2011 Proposed Regulations:

1. On July 15, 2011 and August 17, 2011, HHS proposed regulations on individual eligibility and enrollment in a qualified health plan under an Exchange and employer participation in the Small Business Health Options Program (SHOP).

2. On August 17, 2011, HHS proposed regulations related to Medicaid and Children's Health Insurance Program (CHIP) eligibility, enrollment simplification, and coordination by the Exchange.

3. On August 17, 2011, the IRS proposed regulations to implement the premium tax credit.

B. Coordinated Eligibility and Enrollment.

1. The Exchanges would determine an individual's eligibility for coverage through the exchange, premium tax credits, cost sharing reductions, etc.

2. Open Enrollment and Special Enrollment for Individuals in an Exchange.

   a. The initial open enrollment period will be from October 1, 2013 through February 28, 2014.

   b. Annually the Exchanges must provide an open enrollment period from October 15 through December 7. Coverage is effective January 1 of the following year.

   c. Individuals may enroll at other times only if they qualify for special enrollment under certain circumstances, such as:

      i Loss of other minimum essential coverage;

      ii Gaining or becoming a dependent through marriage, birth, adoption or placement for adoption;

      iii Becoming eligible for a federal subsidy to purchase Exchange coverage; and

      iv Becoming a citizen or obtaining other legal immigration status) and enrolled within 60 days.

3. The proposed regulations attempt to streamline and coordinate eligibility and enrollment in qualified health plans, Medicaid, CHIP, and the premium tax credit and other cost-sharing reduction programs.

4. Agents and Brokers.

   a. The proposed regulations allow states to decide what role agents and brokers will have on the Exchanges.

   b. States would be allowed to determine whether agents and brokers may enroll qualified individuals, employers and employees in qualified health plans ("QHP") and assist individuals in applying for federal subsidies.

   c. Exchanges would be allowed to choose whether to include information about licensed brokers and agents on the Exchange's website.

C. Small Business Health Options Program (SHOP).

1. The Exchange proposed regulations create standards for small employers to purchase health insurance through a SHOP on the exchange.

2. Small employers are those with 100 or fewer employees (states may reduce this to 50 before 2016).

3. Which State?

   a. An employer would be allowed to offer coverage through the SHOP of the state where the employer has its principal place of business for all its employees regardless of the state where the employee works.

   b. Alternatively, the employer could offer coverage through the SHOP Exchange serving the employee's primary worksite.

4. Type of Coverage.

   a. Under the proposed rule, the SHOP Exchange must allow a qualified employer to select a level of coverage (bronze, silver, gold, platinum), so that employees may select from all QHPs from various issuers within that level.

   b. For example, if an employer selected the silver level, each employee would choose any silver-level QHP available through that Exchange.

5. States would have the option of whether to allow employers to:

   a. choose any QHP offered in the SHOP at any level;

b. select specific levels from which an employee may choose a QHP;

c. select specific QHPs from different levels of coverage from which an employee may choose a QHP; or

d. select a single QHP to offer employees.

6. Enrollment Periods.

a. The SHOP Exchange would follow the same initial open enrollment date, October 1, 2013, as the individual Exchange.

b. Thereafter, a qualified employer could enter the SHOP Exchange at any time.

c. The employer's coverage year will be the 12 month period beginning with the employer's effective date.

d. Employees may change coverage only once a year unless they qualify for special enrollment. Rates would not change during the plan year.

7. Premium Payments.

a. Employers would receive a single monthly bill for all QHPs in which their employees are enrolled and pay a single monthly amount to the SHOP.

b. The SHOP Exchange would then make payments to the various QHP issuers.

c. SHOP Exchanges are expected to include the employer and employee contribution toward the premium on these bills.

8. Qualified employers participating in a SHOP would be required to make disclosures to their employees about the methods for selecting and enrolling in qualified health plans.

D. Eligibility for and Calculation of the Premium Tax Credit. The IRS proposed regulations provide guidance on eligibility standards for the premium tax credit and how it would be calculated by an Exchange.

1. A credit is not available if the individual is eligible for minimum essential coverage.

2. Minimum essential coverage includes coverage under insured or self-funded coverage under an eligible

employer sponsored plan, which includes a grandfathered plan or other plan offered in the large or small group market.

3. An individual is considered eligible for minimum essential coverage for all of the months in a plan year if the individual had the opportunity to enroll, even if the enrollment period is closed. An individual is not eligible for a credit for that year if the coverage is "affordable" and provides "minimum value."

E. Possible Future Relief and Safe Harbor. If employer-sponsored coverage does not provide "minimum value" and is "unaffordable," a large employer may be subject to a penalty if any full-time employee is certified as having received a premium tax credit or cost-sharing reduction through the Exchange.

1. An individual is treated as eligible for minimum essential coverage through an eligible employer-sponsored plan if the individual *actually* enrolls in the coverage, even if the coverage does not meet the affordability and minimum value requirements.

2. Minimum Value.

   a. An eligible employer-sponsored plan provides "minimum value" if the plan's share of the total allowed costs of benefits is at least 60%.

   b. The preamble said regulations are expected to be proposed later this year and are expected to reflect the fact that employer-sponsored group health plans and health insurance coverage in the large group market are not required to provide each of the essential health benefits or each of the 10 categories of benefits described in PPACA section 1302(b)(1).

   c. The preamble also indicated the agencies are considering providing transition relief with respect to the minimum value requirement for employers currently offering health care coverage.

3. Affordability.

   a. Large employers may be subject to a penalty if the employee's portion of the self-only premium for the employer's lowest-cost plan providing minimum essential coverage is deemed unaffordable.

b. Coverage is not affordable if the employee cost for *self-only* coverage is more than 9.5% of the employee's household income (even if the employee chooses a higher level, such as family coverage).

c. The preamble indicates future regulations are expected to provide an affordability safe harbor under which certain employers offering full-time employees (and their dependents) eligible employer-sponsored coverage could consider only the W-2 wages it pays the employee (rather than household income) in determining if the employee portion of the premium for applicable employer-provided coverage exceeds the 9.5% threshold.

d. However, eligibility for the premium tax credit would continue to be based on the employee's household income.

e. If the exchange determined the employer-sponsored coverage is unaffordable, then:

i Under a safe harbor in the regulations, the coverage is treated as unaffordable for the year, even if the coverage ultimately proves to be affordable based on actual household income for the year.

ii In that case, the employee would not lose the premium tax credit for the year.

iii It is anticipated that regulations under Code section 4890H will provide that the employer will not be penalized merely because the employee benefitted from this safe harbor.

V. Termination of the Mini-Med Waiver Program.

A. On June 28, 2010, the Department of Health and Human Services ("HHS") announced a program under which a group health plan may annually apply for a waiver from the restricted annual benefit limits (a minimum of $750,000 for 2011, $1.25 million for 2012, and $2 million for 2013) required by interim final regulations under PPACA.

B. The program was available only for 2011-2013 and not available after 2013.

C. The plan sponsor had to submit an application not less than 30 days before the beginning of each plan year.

D. The waiver program is available if compliance with the interim final regulations would result in either:

1. a significant decrease in access to benefits or

2. a significant increase in premiums.

E. On June 17, 2011, HHS issued guidance:

1. To set forth the waiver extension process for existing waiver recipients;

2. To describe the conclusion of the waiver program for new applicants; and

3. To revise the compliance requirements for applicants to be granted a waiver or to obtain a waiver extension.

4. Elections for waiver extensions and applications for new waivers received after September 22, 2011 will not be accepted.

5. A plan or policy that has not elected a waiver extension or has not received a waiver approval will be required to comply with PPACA's annual limit requirements.

VI. Stand-Alone HRA Exemption. Stand-alone HRAs that were in effect before September 23, 2010 are exempted from annual minimum dollar limits (August 19, 2011 Supplemental CMS Guidance).

VII. Earlier Deadline for Medicare Part D Notices.

A. PPACA changed the annual coordinated election period for Medicare Part D (prescription drug coverage).

B. The annual election period for Medicare Part D is now October 15 through December 7. The prior election period was November 15 to December 31.

C. An updated model notice of creditable coverage is available on CMS's website.

D. As a result, employers must distribute notices of creditable (or noncreditable) coverage for Medicare Part D before October 15, 2011.

VIII. Appeals Processes.

A. Group health plans must implement an effective internal appeals process. Plans must offer a binding external review process.

B. Grandfathered plans are exempt from these rules.

C. The Department of Labor's Technical Release No. 2010-02 (September 20, 2010) provided for a non-enforcement grace period until July 1, 2011.

1. It did not relieve plans from complying with the rules (required good faith effort).

2. It relieved them of any enforcement for failure to comply with the specific technicalities of the above requirements.

D. Department of Labor's Technical Release No. 2011-01 (March 18, 2011) eliminated the good faith compliance requirement until plan years beginning after July 1, 2011. It delayed enforcement of the following portions of the rules until plan years beginning on or after January 1, 2012:

1. Timeframe for making urgent care claim decisions;

2. Providing notices in a culturally and linguistically appropriate manner;

3. Substantial compliance with claims and appeals standards; and

4. Disclosure of diagnosis and treatment codes, together with their corresponding meanings, to be included in detailed notifications of benefit determinations.

E. June 2011 Amendment to Interim Final Regulations.

1. Urgent Claims Decisions. The 24 hours deadline to decide urgent care claims is modified to require decisions as soon as possible consistent with the medical exigencies involved but in no event later than 72 hours, provided that the plan or issuer defers to the attending provider with respect to the decision as to whether a claim constitutes "urgent care."

2. Culturally and Linguistically Appropriate Requirement.

   a. Under 2010 regulations a plan or issuer was considered to meet the requirement of providing relevant notices in a "culturally and linguistically appropriate manner" if:

      i For a plan that covers fewer than 100 participants at the beginning of a plan year, if the plan or issuer provides notice on request in a non-English language in which 25% or more of all plan participants are literate only in the same non-English language; or

ii For a plan that covers 100 or more participants at the beginning of a plan year, if the plan or issuer provides notice on request in a non-English language in which the lesser of 500 or more participants, or 10% or more of all plan participants, are literate only in the same non-English language.

b. June 2011 regulations amended this requirement to provide for a single threshold of 10% or more of the population residing in the claimant's county, as determined based on American Community Survey data published by the United States Census Bureau.

c. Each notice sent by a plan or issuer to an address in a county that meets the 10% threshold must include a one-sentence statement in the relevant non-English language about the availability of language services.

d. The plan or issuer must also make these language services available and provide a notice in the non-English language upon request.

e. The DOL issued model notices containing sample statements in several non-English languages.

3. Diagnosis and Treatment Codes.

a. Eliminates requirement to provide automatically the diagnosis and treatment codes as part of a notice of adverse benefit determination (or final internal adverse benefit determination).

b. Plans and issuers must provide diagnosis and treatment codes (and their meanings) on request and include a notice of this opportunity in all notices of adverse benefit determination (and notices of final internal adverse benefit determination).

c. A plan or issuer must not consider a request for such diagnosis and treatment information, in itself, to be a request for (and therefore trigger the start of) an internal appeal or external review.

4. Strict Compliance Requirement.

a. Under the July 2010 regulations, if a plan or issuer failed to adhere strictly to all of the regulations' requirements for internal claims and appeals processes (substantial compliance was insufficient):

i The claimant could seek immediate review (either in court or through an external review process).

ii The plan's or issuer's decision was not entitled to any special deference; rather, any reviewer would resolve the dispute de novo.

b. Under the June 2011 regulations, any violation of the procedural rules will permit a claimant to seek immediate external review or court action, as applicable, unless the violation is:

i de minimis,

ii non-prejudicial,

iii attributable to good cause or matters beyond the plan's or issuer's control,

iv in the context of an ongoing good-faith exchange of information, and

v not reflective of a pattern or practice of non-compliance.

c. The claimant must be provided, on written request, with an explanation of the plan's or issuer's basis for asserting that it meets these requirements.

5. Scope of External Review Process.

a. Under the July 2010 regulations any adverse benefit determination (or final internal adverse benefit determination) could be reviewed unless it was related to eligibility.

b. The 2011 regulations limit the scope of external review under the federal external review process to claims that involve:

i A medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer, or

ii A rescission of coverage.

6. Binding Status of External Review Decisions.

a. The July 2010 regulations generally provide that an external review decision by an independent review organization (IRO) is binding on the plan or issuer, as well as the claimant, except to the extent that other remedies are available under state or federal law.

b. The June 2011 regulations provide that:

i A plan or issuer may not delay payment because the plan disagrees and intends to seek judicial review of a decision on external review.

ii While the plan may be entitled to seek judicial review, it must act in accordance with the IRO's decision (including making payment on the claim) unless or until there is a judicial decision otherwise.

iii Even if a final external review decision denies the claim or otherwise fails to require such payment or benefits, the plan may pay benefits.

7. External Review Decisions.

a. Technical Release 2010-01 established an interim enforcement safe harbor from enforcement actions for self-insured plans subject to ERISA and/or the Code if the plan contracts with at least three accredited IROs and rotates assignments among them (or incorporates other independent, unbiased methods for selecting IROs, such as random selection).

b. Under Technical Release 2011-02 self-insured plans qualify for the safe harbor if they contract with at least two IROs by January 1, 2012, with at least three IROs by July 1, 2012, and rotate assignments among them.

F. Consequences if appeals process is not compliant (strict compliance):

1. Excise tax;

2. Deemed exhaustion of administrative remedies;

3. Enforcement action to require compliance;

4. No deference to plan administrator's decision (no decision to which deference can be applied); and

5. New argument that exhaustion is futile since the claim procedure is flawed.