



Health Care Reform: Developments in 2011

The Patient Protection and Affordable Care Act (PPACA) made extensive changes to the U.S. health care system with respect to the delivery of health care, consumer protections and coverage options. Some provisions are effective now, while others become effective years from now.

Many of PPACA's reforms require agency guidance to be implemented. Since PPACA became law in 2010, the Departments of Labor (DOL), Health and Human Services (HHS) and Treasury (collectively, the Departments) have been regularly issuing guidance to implement PPACA's reforms.

In addition, PPACA is a "hot button" issue that has been the subject of congressional and court action since its enactment. While congressional attempts to entirely repeal PPACA have been unsuccessful, two individual components of the law were repealed through the legislative process. In addition, a number of courts have addressed the constitutionality of PPACA, and reached different conclusions.

This Hylant Group Legislative Brief outlines PPACA developments that have taken place in 2011.

REPORTING REQUIREMENTS

W-2 Reporting

PPACA requires employers to report the aggregate cost of employer-sponsored group health plan coverage on their employees' Forms W-2. The purpose of the reporting requirement is to provide information to employees regarding how much their health coverage costs. This requirement was originally effective for the 2011 tax year and the W-2 Forms that would be provided in January 2012. However, in 2010, the IRS announced that 2011 reporting would be optional for all employers.

In March 2011, the IRS further delayed the reporting requirement for small employers (those who file fewer than 250 Forms W-2) by making it **optional** for these employers until further guidance is issued. For the larger employers, the requirement will be **mandatory for the 2012 Forms W-2** (that must be issued in January 2013).

1099 Reporting

PPACA would have expanded 1099 reporting by requiring businesses to file a Form 1099 for any company from which it bought more than \$600 in goods or services in a single year. This requirement was scheduled to go into effect in 2012. Although not directly related to health care, the expanded 1099 reporting requirement was designed to raise money for the health care reform plan as well as improve tax compliance. In April 2011, PPACA's expanded 1099 reporting requirement was **repealed** by Congress.

PREVENTIVE CARE FOR WOMEN

Under PPACA, non-grandfathered health plans must cover preventive health services without imposing cost-sharing requirements for the services. PPACA's preventive care mandate is generally effective for plan years beginning on or after **Sept. 23, 2010**. In August 2011, HHS issued new preventive care guidelines for women. These new guidelines, which are effective for plan years beginning on or after **Aug. 1, 2012**, require non-grandfathered health plans to cover women's preventive health services (such as well-woman visits, breastfeeding support, domestic violence screening and contraceptives) without charging a copayment, deductible or coinsurance.

SUMMARY OF BENEFITS AND COVERAGE

PPACA adds to the list of group health coverage disclosures by requiring health plans and health insurance issuers to begin providing a summary of benefits and coverage to applicants and enrollees. Both non-grandfathered and grandfathered plans will need to provide the summary. The summary is intended to be a concise document providing simple and consistent information about health plan benefits and coverage. Its purpose is to help health plan consumers better understand the coverage they have and, when selecting new coverage, to help them make apples-to-apples comparisons of different coverage options.

Employers and health insurance issuers had waited for the Departments to issue guidance on specific requirements for the summary. In August 2011, the Departments announced proposed regulations for the summary. The proposed regulations included guidance on:

- Providing the summary, such as who must provide the summary and timing requirements; and
- Preparing the summary, such as content, appearance and language requirements.

The Departments issued a proposed template for the summary, including a glossary of terms, and additional instructions and sample language for completing the proposed template. The proposed guidance is **not final**, although it does provide information on the standards the Departments are considering for the summary.

The proposed regulations contained a deadline of **March 23, 2012** for plans and issuers to start providing the summary. However, on Nov. 17, 2011, the DOL issued a set of Frequently Asked Questions (FAQs) that delayed the compliance deadline. The FAQs provide that plans and issuers are not required to start providing the summary **until after the Departments issue final regulations** on the summary requirement. According to the DOL, the final regulations will contain an applicability date that will give plans and issuers sufficient time to comply with the summary requirement.

CLAIMS AND APPEALS REQUIREMENTS

Under PPACA, non-grandfathered group health plans and health insurance issuers must adopt an improved internal claims and appeal process and follow minimum requirements for external review, effective for plan years beginning on or after **Sept. 23, 2010**. In June 2011, the Departments issued **amended guidance** to their claims and appeals regulations to assist health plans and issuers achieve full compliance with the new claims and appeals requirements.

Among other changes, the amended guidance:

- Made significant changes to the Department's original claims and appeals regulations, including reverting back to a 72-hour time limit for urgent health care claims and simplifying the criteria for determining when notice must be provided in a culturally and linguistically appropriate manner;
- Extended the transition period for state external review processes through Dec. 31, 2011 and clarified when the federal standard of review will apply to external reviews; and
- Temporarily narrowed the scope of claims eligible for external review under a federal external review process.

In connection with these changes, the Departments also issued updated model claims and appeals notices.

EARLY RETIREE REINSURANCE PROGRAM

PPACA established the Early Retiree Reinsurance Program (ERRP) to provide reimbursement to eligible employers (and employment-based plans) for part of the cost of providing health care coverage to early retirees and their families. The ERRP has \$5 billion in funding and is set to expire no later than Jan. 1, 2014. To participate in the ERRP, the plan must submit an application to HHS. Once certified to participate, the plan is eligible to submit claims for reimbursement. In April 2011, HHS announced that it would no longer accept applications for the ERRP after **May 5, 2011**, consistent with PPACA's provisions regarding the availability of funding. Employers and plans that were approved to participate in the ERRP before the application deadline may continue to submit claims for reimbursement.

ANNUAL LIMIT WAIVERS

PPACA generally prohibits lifetime or annual limits on the dollar value of essential health benefits, effective for plan years beginning on or after **Sept. 23, 2010**. Although annual limits are generally prohibited, “restricted annual limits” are permitted for essential health benefits for plan years beginning before **Jan. 1, 2014**. In 2010, HHS released guidance establishing a waiver program for the restricted annual limit requirements.

In June 2011, HHS issued new guidance on the waiver program. Under the new guidance, the waiver program closed to applications effective **Sept. 22, 2011**. Under HHS’s original guidance on the waiver program, plans were required to reapply for the annual limit waiver every year until 2014 when all annual limits will be prohibited. Under the new guidance, reapplication is not required; the waivers will generally apply until the first plan year beginning on or after Jan. 1, 2014.

Plans and issuers that received waivers must provide a notice to participants annually. In addition, plans and issuers that received waivers must provide HHS with annual updates and must retain records relating to the waivers.

INSURANCE RATE REVIEWS

PPACA required HHS to establish a process for the annual review of “unreasonable increases in premiums for health insurance coverage.” In May 2011, HHS issued a **final regulation** aimed at controlling large health insurance premium increases. The rule provides that:

- Effective **Sept. 1, 2011**, rate increases of 10 percent or more by insurers in the small group and individual markets must be reviewed by state or federal officials;
- Starting **Sept. 1, 2012**, the 10 percent threshold will be replaced with a state-specific threshold to reflect insurance and health care cost trends particular to that state; and
- Insurance companies will be required to justify significant rate increases and provide information to consumers about the reasons for the increases.

Grandfathered plans and excepted benefits (such as separate dental-only and vision-only plans) do not have to meet these requirements.

HEALTH INSURANCE EXCHANGES

PPACA requires states to establish health insurance exchanges (Exchanges) to provide a competitive marketplace where individuals and small businesses will be able to purchase affordable private health insurance coverage, effective Jan. 1, 2014. Rules related to some aspects of the Exchanges have been proposed, but are **not yet final**.

On **July 11, 2011**, HHS issued **proposed regulations** regarding the establishment of Exchanges and Qualified Health Plans, as well as proposed standards related to reinsurance, risk corridors and risk adjustment. The proposed guidance is designed to help states design and implement their Exchanges in two key areas:

- Setting standards for establishing the Exchanges, setting up a Small Business Health Options Program (SHOP), performing the basic functions of an Exchange and certifying health plans for participation in the Exchanges; and
- Ensuring premium stability for plans and enrollees in the Exchanges.

On **Aug. 12, 2011**, HHS and Treasury released three additional proposed rules related to the Exchanges:

- **Exchange Eligibility and Employer Standards:** An HHS proposed rule details the standards and process for enrolling in qualified health plans and insurance affordability programs. It also outlines basic standards for employer participation in SHOP.
- **Health Insurance Premium Tax Credit:** Treasury Department proposed regulations lay out how individuals and families will receive premium tax credits to help defray insurance costs.

- **Medicaid Eligibility:** Another HHS proposed rule expands and simplifies Medicaid eligibility and coordinates Medicaid and CHIP with the new Exchanges.

FREE CHOICE VOUCHERS

Under PPACA, certain employers would have been required to provide free choice vouchers to “qualified employees” to purchase health care coverage through a state exchange beginning in 2014. A qualified employee was one who did not participate in the employer’s health plan and whose household income and health plan contribution amount satisfied certain percentages. The voucher was to be equal to the monthly amount that the employer would have contributed toward the plan for which the employer pays the largest portion of plan costs, for either self or, if elected by the employee, family coverage. In April 2011, PPACA’s free-choice voucher provision was **repealed** by Congress.

CLASS PROGRAM

PPACA established a voluntary, consumer-funded, long-term care insurance program known as the Community Living Assistance Services and Supports Program (CLASS Program). The CLASS Program technically became effective on Jan. 1, 2011 and program details were to be established in Oct. 2012. However, **implementation of the CLASS Act was suspended on Oct. 14, 2011**, due to concerns about fiscal sustainability and affordability.

COURT DECISIONS

A number of legal challenges to the health care reform law have been filed in federal court since the law was passed in 2010. The main issue has been whether Congress had the constitutional authority to pass the individual mandate under health care reform. The court rulings, to date, are split. Some courts have upheld the law as constitutional, while others have concluded that a portion of the law, or the entire law, is unconstitutional.

In June 2011, the 6th Circuit upheld the constitutionality of the individual mandate. However, in August 2011, the 11th Circuit ruled that the health care reform law’s individual mandate is unconstitutional. In early September 2011, the 4th Circuit dismissed challenges to the health care reform law’s constitutionality based on procedural grounds. In November 2011, the District of Columbia Circuit upheld the constitutionality of the individual mandate.

The U.S. Supreme Court has announced that it will review the issue of the law’s constitutionality in 2012