

ADVISORY | EMPLOYEE BENEFITS

April 19, 2011

AFFORDABLE CARE ACT DEVELOPMENTS

The Patient Protection and Affordable Care Act (“PPACA”) was enacted a little over a year ago on March 23, 2010. The Departments of Treasury, Labor, and Health and Human Services (the “Departments”) have issued several pieces of guidance implementing PPACA since it was enacted. In the past month, the Departments have released additional guidance on various issues under PPACA. Moreover, there have been several recent case law and legislative developments regarding PPACA. Below are the highlights of the recent regulatory, case law, and legislative developments.

REGULATORY DEVELOPMENTS

Extension of Enforcement Grace Period for New Requirements for Internal Claims and Appeals

The Departments published interim final regulations on July 23, 2010, implementing PPACA’s new standards requiring non-grandfathered health plans to make changes to their internal procedures for resolving benefit claims and to adopt an external review process for claim denials, effective for plan years beginning on or after September 23, 2010. *See Covington memorandum Guidance on New Claims Procedures and External Review Processes (July 27, 2010)*. In Technical Release 2010-02, the Departments provided an enforcement grace period until July 1, 2011, for some changes to the requirements for internal claims and appeals procedures (but not for any of the requirements for external review processes) provided in the interim regulations. *See Covington memorandum Guidance Implementing Affordable Care Act (September 26, 2010)*.

In Technical Release 2011-01, released on March 18th, the Departments extended the enforcement grace period established in Technical Release 2010-02. The changes to which the grace period applies now take effect on January 1, 2012, for calendar year plans. The chart in Appendix A to this Memorandum shows the dates that the provisions of the interim final

HIGHLIGHTS

- The Departments have extended the transition period for implementing PPACA’s requirements for internal claims and appeals procedures until January 1, 2012 for calendar year plans.
- The Departments have published additional guidance clarifying some issues regarding retention of grandfathered plan status.
- Treasury and IRS have issued guidance regarding how to report the value of health coverage on Form W-2s. The reporting requirement first applies Form W-2s issued in January 2013 by large employers.
- The NAIC has issued recommended standards for four-page uniform benefit summaries of benefits and coverage.
- HHS has announced that the Early Retiree Reinsurance Program will stop accepting new applications after May 5th and is now requiring employers to submit detailed claims data in connection with reimbursement requests.
- PPACA continues to be challenged in courts.
- Congress has passed, and the President has signed into law, a bill that repeals PPACA’s expansion of the Form 1099 requirements.
- The bill for the federal budget, which the President has signed into law, repeals PPACA’s provision for free choice vouchers.

regulations will first be enforced.

During the enforcement grace period the Departments will not take any enforcement action against a self-insured health plan for failure to

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comply with the new standards. Technical Release 2011-01 eliminates the requirement set forth in Technical Release 2010-02 for plans to work in good faith to implement the requirements in order for the enforcement grace period to apply.

Implementation FAQs on Grandfathered Status

On April 1, 2011, the Departments jointly issued additional Frequently Asked Questions interpreting interim final regulations implementing PPACA's grandfathering provision that were published in the *Federal Register* on June 17, 2010. See Covington memorandum *Guidance on Grandfathered Status of Group Health Plans (June 17, 2010)*. The Frequently Asked Questions make the following clarifications:

- A grandfathered group health plan or benefit package will not lose its grandfathered status if employees are transferred into the plan or package from another group health plan or benefit package that is eliminated for one of the following safe harbor "bona fide employment-based reasons":
 - because the issuer is exiting the market,
 - because the issuer no longer offers the product to the employer (for example, because the employer no longer satisfies the issuer's minimum participation requirement),
 - when low or declining participation in a benefit package makes it impractical for the employer to continue offering it,
 - for any reason if multiple benefit packages covering a significant portion of other employees remain available to the transferred employees, or
 - pursuant to a collective bargaining agreement.
- Moving a brand-name drug into a higher cost-sharing tier will not cause a plan to lose grandfathered status if the change relates to a generic alternative becoming available and the generic drug will be offered under a lower cost-sharing tier.
- A group health plan will not lose grand-

fathered status if it adopts a value-based insurance design under which a copayment is required when a preventive service is provided at an in-network outpatient hospital setting but not when the preventive service is provided at another setting, such as an in-network ambulatory surgery center. The plan must waive the copayment if it would be medically inappropriate to provide the preventive service to the individual in an ambulatory setting.

- A group health plan or benefit package will lose grandfathered status when a plan amendment that triggers a loss of grandfathered status becomes effective—not when the amendment is adopted.
- If a grandfathered plan that covers retirees determines the employer's annual contribution to the plan on behalf of each retiree pursuant to a formula—for example, \$300 times a retiree's years of service up to \$10,000 per year—the employer will not be considered to have reduced its contribution rate towards the cost of coverage (and therefore trigger a loss of grandfathered status), regardless of any increase in the total cost of coverage. However, if the employer changes the formula—for example by changing the dollar amount multiplied by the years of service or reducing the \$10,000 cap by more than five percentage points—the plan may cease to be a grandfathered plan.

Interim Guidance on Reporting the Cost of Coverage on Forms W-2

PPACA requires employers to report on Forms W-2 the aggregate cost of certain employer-sponsored health coverage. The reporting requirement does not cause excludible employer-provided health coverage to become taxable. PPACA would have required employers to comply with this requirement for Forms W-2 required for 2011 (that employers are required to furnish to employees in January 2012). However, in November 2010, the Treasury Department and Internal Revenue Service issued relief from this reporting requirement for 2011 until they could issue guidance regarding the requirement.

On March 29th, the Department of Treasury and IRS issued interim guidance on the reporting requirement. The interim guidance applies to large employers (*i.e.*, employers that are required to file 250 or more Forms W-2) with respect to Forms W-2 that must be furnished to employees in January 2013 for calendar year 2012. Smaller employers (that are required to file fewer than 250 Forms W-2) are not required to report the cost of health coverage until further guidance is issued.

Employers Subject to the Reporting Requirement.

Employers, including state and local government entities (but not Indian tribal governments), churches and other religious organizations, and employers that are not subject to the COBRA continuation coverage requirements, are subject to the reporting requirements if they (1) provide applicable employer-sponsored health coverage (discussed below) during a calendar year and (2) were required to file at least 250 Forms W-2 for the preceding calendar year. However, as discussed below, the interim guidance excludes plans that are not subject to COBRA from the reporting requirement.

Costs That Must Be Reported.

Employers subject to the reporting requirement must report the aggregate cost of coverage under all “applicable employer-sponsored coverage.” Applicable employer-sponsored coverage includes coverage under any employer-sponsored group health plan which is excludible from an employee’s gross income; it does not include the following:

- Account-based plans, including
 - Health Flexible Spending Arrangements (“FSAs”) (except for amounts contributed to a health FSA that exceed an employee’s salary reduction contribution, such as an employer matching contribution or flex credit),
 - Health Savings Accounts (“HSAs”) (but the value of any high deductible health plan associated with an HSA must be reported pursuant to the interim guidance; the value of employer

contributions to an HSA are already required to be reported in Box 12 using Code W),

- Health Reimbursement Arrangements (“HRAs”), and
- Archer MSAs (employer contributions to which are already required to be reported in Box 12 using Code R),
- Dental or vision coverage that is provided under a separate policy, certificate, or contract of insurance or that is otherwise not integral to a group health plan that is subject to the reporting requirements,
- Self-insured group health plans that are not subject to federal COBRA continuation coverage requirements, such as self-insured group health plans sponsored by churches,
- Governmental group health plans maintained primarily for members of the military and their families,
- Coverage provided through a multiemployer plan,
- Coverage for only certain excepted benefits, such as long-term care benefits, accident and/or disability benefits, or coverage only for a specified disease or illness, and
- Certain types of insurance, such as automobile liability insurance, workers’ compensation insurance, automobile medical payment insurance, and credit-only insurance.

Certain on-site medical clinics are subject to this reporting requirement, but the Notice does not include any guidance regarding how to determine the value of on-site medical clinics for this purpose.

The aggregate reportable cost of coverage under an employer’s applicable employer-sponsored coverage includes both the portion of the cost paid by the employer and the portion of the cost paid by the employee (including costs attributable to the employee’s covered spouses or dependents), regardless of whether the employee paid for the cost through pre-tax or after-tax contributions or whether the cost is includible in the employee’s gross income. For example, if an employee has elected to cover himself and his

age 28 adult child (who, for example, has remained eligible for employer coverage after age 26 pursuant to COBRA), the employer must include the cost of the health coverage for the adult child on the employee's Form W-2 even though (1) the employee pays for the costs attributable to his adult child on an after-tax basis and (2) the fair market value of the coverage is included in the employee's income.

How to Determine the Cost of Coverage.

Generally, an employer must calculate the cost of coverage for a calendar year using a good faith, reasonable interpretation of the statutory requirements for determining the COBRA premium for the coverage. If the group health plan is insured, the employer may use the COBRA premium charged by the insurer for the employee's coverage. If a plan charges a composite rate for coverage — for example, one premium for family coverage regardless of the number of family members covered — the employer may report the COBRA composite rate of coverage. The reportable cost must take into account any increases or decreases in cost during the calendar year. Accordingly, if an employer calculates the COBRA premium for the plan on a fiscal year basis, the employer will need to reflect any increase or decrease attributable to the newly calculated COBRA premium in its reported costs for the calendar year.

How to Report the Cost of Coverage.

The aggregate reportable cost of coverage must be reported on Form W-2 in box 12, using code DD. Employers are not required to report the cost of coverage on a Form W-2 that an employee requests to receive before the end of the calendar year in which he terminates employment. In addition, employers are not required to issue Forms W-2 to individuals to whom the employer is not otherwise required to issue Forms W-2, such as to retirees, merely to report aggregate cost of coverage information.

Effective Date of Guidance.

The interim guidance is generally applicable beginning with Forms W-2 required for the calendar year 2012 that employers are required to furnish to employees in January 2013. The guidance is applicable until further guidance is

issued. If any future guidance expands the application of the guidance to additional employers, types of coverage, or otherwise, it will apply prospectively only for calendar years beginning at least six months after the guidance is issued.

Comments.

The Department of Treasury and IRS have requested comments on the interim guidance. Comments are due July 17, 2011.

Uniform Benefit Summaries

PPACA requires the Department of Health and Human Services to develop, in consultation with the National Association of Insurance Commissioners ("NAIC"), standards for group health plans and insurers to compile and provide to applicants and enrollees an accurate, four-page summary of benefits and coverage explanation. The statute required the Department to issue the standards by March 23, 2011; however, the Department has been delayed in issuing the standards.

The NAIC has submitted recommendations to the Department for standards that should be used by insurers which are available at http://www.naic.org/committees_b_consumer_information.htm. Although the NAIC's proposed standards are not intended for self-insured group health plans, they give some indication regarding the standards that may be imposed on self-insured plans.

Many of the standards would be incompatible with self-insured group health plans or unworkable for employers. For example, the NAIC proposed standards require a separate four-page summary to be provided for each benefit option under a plan, which would generate multiple benefit summaries for each plan and may duplicate summaries that employers already provide regarding the benefit options under their self-insured plans. Moreover, the NAIC proposal requires the use of a model four-page summary, prescribes certain statements that must be included in the summary, and requires the use of a glossary of insurance terms that appear in the summary with definitions prepared by the NAIC. The prescribed statements and NAIC definitions may be inconsistent with the provisions of self-insured group health plans. Em-

employers should voice any concerns regarding the NAIC's proposed standards for the summaries to their representative trade organizations or to one of the members of Covington's Employee Benefits and Executive Compensation Group.

Early Retiree Reinsurance Program

The Department of Health and Human Services has announced that the Early Retiree Reinsurance Program will not accept any new applications after May 5th. As of as of March 2nd, the Program had made \$1.8 billion in reimbursements to more than 1,300 employers. The Department continues to issue more guidance regarding submission of claims for reimbursement under the Program.

- The Department has announced that starting April 1, plan sponsors must submit with each reimbursement request detailed claims data for each eligible early retiree. Previously, the Department accepted summary cost data that showed only aggregated claims data for each early retiree.
- In addition to existing requirements that a reimbursement request may not be made (1) more than quarterly or (2) within 30 days after a previous reimbursement request, on March 17th, the Department issued guidance prohibiting employers from submitting reimbursement requests within 15 days after the Department has issued a determination on a previous reimbursement request.

Guidance for Requesting State Innovation Waivers

The Internal Revenue Service and Department of Health and Human Services have jointly issued proposed regulations providing a procedural framework through which states may apply for waivers from certain health reform provisions, including requirements relating to qualified health plans, exchanges, reduced cost-sharing, refundable tax credits for certain individuals, the play or pay penalty tax on certain large employers, and the individual mandate.

The waivers currently can be made for plan years beginning on or after January 1, 2017.

CASE LAW DEVELOPMENTS

Federal Court Finds Individual Coverage Mandate Unconstitutional

On January 31st, Judge Roger Vinson, a senior federal judge in the Northern District of Florida, held that PPACA's requirement that individuals purchase health insurance (*i.e.*, the "individual mandate") exceeded Congress's authority under the Commerce Clause of the Constitution. Moreover, the court held that the individual mandate "is indisputably necessary to the . . . purpose of the Act" and struck down the entirety of PPACA.

The case, *State of Florida v. U.S. Department of Health and Human Services*, Case No. 3:10-cv-91-RV/EMT (N.D. Fla.), was brought by the attorneys general and/or governors of 26 states, two private citizens, and the National Federation of Independent Business, against the Departments. The court granted partial summary judgment to both the plaintiffs and the defendant federal government.

The court's opinion focuses on the constitutionality of the provision of PPACA that, beginning in 2014, requires every U.S. citizen, other than those falling within specified exceptions, to maintain a minimum level of health insurance coverage or pay a tax penalty. The court, in granting summary judgment to the plaintiffs on this issue, held that Congress can only regulate "activity" under the Commerce Clause, stating that "it would be a radical departure from existing case law to hold that Congress can regulate inactivity under the Commerce Clause." Because PPACA imposes a penalty on someone who "fails" to buy health insurance, the court concluded that PPACA impermissibly attempts to regulate inactivity.

The court further found that the individual mandate was so "indisputably necessary" to the Act, that excising only the insurance portions of PPACA would require judicially rewriting the entire Act. The decision, therefore, held that the individual mandate was not severable from the rest of the Act and struck down the entire law.

Before striking down the entire Act, the court granted partial summary judgment to the federal

government on the state plaintiffs' Spending Clause challenge to the expansion of the Medicaid program. The court noted that a state's initial decision to participate in the Medicaid program was voluntary and rejected the argument that economic dependency on federal matching funds forces continued participation.

The federal government appealed the decision to the Eleventh Circuit on March 8th. The district court declined to enjoin implementation of PPACA pending appeal.

District of Columbia Court Upholds Individual Mandate

In contrast to the Florida case, on February 22nd, Judge Gladys Kessler of the U.S. District Court for the District of Columbia dismissed a lawsuit challenging PPACA's individual mandate as unconstitutional in *Mead v. Holder*, Case No. 1:10-cv-00950 (D. D.C.). The court held that Congress had the power to enact the individual mandate as a regulation of interstate commerce under the Commerce Clause because the decision not to purchase health insurance is an "activity" and individual decisions not to purchase insurance have a cumulative impact on interstate commerce.

Status of Court Cases

These two cases bring to five the number of significant decisions challenging PPACA. Three suits have been dismissed, including the *Mead* case, and two of the dismissed cases are pending in the U.S. Courts of Appeal. Two suits (the Florida case and a case brought by the Attorney General of Virginia) have held that the individual mandate is unconstitutional, and Virginia has petitioned the U.S. Supreme Court for an early review of its case.

LEGISLATIVE DEVELOPMENTS

Repeal of PPACA.

On January 19th, the House approved legislation to repeal PPACA on near party lines. The bill is not expected to gain any traction in the Senate.

Repeal of Free Choice Voucher

Beginning 2014, PPACA would have required

each employer that offers minimum essential coverage and pays any portion of the cost of coverage to offer a free choice voucher to an employee whose household income does not exceed 400% of the federal poverty line, whose required contribution to the employer's health plan would exceed 8% but not 9.8% of the employee's household income, and who is not covered under the employer's plan.

The legislation adopting a federal budget for the remainder of the fiscal year eliminated the requirement for employers to provide free choice vouchers. The legislation also cuts \$2.2 billion in funding for a program that would have encouraged the development of health-care cooperatives to compete with for-profit health-insurance companies in the provision of health coverage. The legislation was signed into law by the President on April 15th.

Repeal of Expansion of Form 1099 Reporting Requirement.

Current law requires businesses to send Form 1099s to all individuals who provide more than \$600 worth of services to the business in a calendar year. Payments to corporations and payments for goods are generally exempt from the reporting requirements. However, PPACA would have removed these exemptions for payments for goods and payments to corporations made after this year. Expansion of the Form 1099 reporting requirement was generally intended to collect tax on unreported income and to partially offset the cost of PPACA, but the new requirements are unpopular because of the compliance burden they impose on businesses.

In early April, Congress passed a bill that repealed PPACA's Form 1099 requirements. The President signed the bill into law on April 14th. The bill includes an offset to pay for the cost of repeal. Under the offset, taxpayers who receive tax credits to help them purchase coverage through an exchange will be required to repay the tax credit if they earn too much income for the year (*e.g.*, if their household income exceeds 400% of the federal poverty line). The amount of the repayment is capped at an amount determined on a sliding scale based on the taxpayer's income in relation to the federal poverty line. Before the bill, repayments were capped at \$400

(\$250 for single filers) regardless of the taxpayer’s household income in relation to the federal poverty line.

Expanding State Waiver Provisions.

Three senators have introduced the “Empower States to Innovate Act” to allow state innovation waivers from certain PPACA provisions, such as

the individual mandate, three years earlier than under current law (*i.e.*, for 2014 rather than 2017). President Obama has expressed support for the bill. Some states have expressed an interest in developing alternatives to PPACA’s approach to increasing the number of individuals who have health coverage while reducing the cost of coverage.

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The lawyers in Covington & Burling LLP’s Employee Benefits & Executive Compensation Group play a leading role in advising and representing employers on employee benefits and executive compensation matters. We frequently appear before Congress, federal agencies, and federal courts to resolve major issues of law, policy, and finance. Our employee benefits practice covers all types of benefit arrangements, including retirement plans, welfare plans, fringe benefits, equity and incentive compensation, and programs for executives and directors.

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APPENDIX A
EFFECTIVE DATES OF PPACA’S INTERNAL CLAIMS AND APPEALS PROCEDURE STANDARDS

Enforcement Begins	Internal Claims Procedure Provision
<p>The first day of the plan year beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans)</p>	<p>Treat rescissions of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time) as claims eligible for review under the plan’s internal claims and appeals procedures.</p>
	<p>Automatically provide a claimant with any new or additional evidence considered, relied upon, or generated by the plan in connection with an appeal of the claim or any new or additional rationale on which a final determination on appeal is based, sufficiently in advance of the deadline for issuing a final claim denial to give the claimant a reasonable opportunity to respond before the appeal decision is issued.</p>
	<p>Ensure that individuals deciding claims are free to adjudicate claims on a free and impartial basis.</p>
<p>The first day of the plan year beginning on or after July 1, 2011 (January 1, 2012 for calendar year plans)</p>	<p>Provide additional content in notices of claim denials, including:</p> <ul style="list-style-type: none"> ■ information sufficient to identify the claim involved (other than the diagnosis and treatment codes and the meanings of these codes), such as the date of service, health care provider, and claim amount; ■ the denial code and its meaning, a description of the standard applied to deny the claim, and if the claim denial is in response to an appeal, a discussion of the decision; ■ a description of the internal appeals and external review processes, including information regarding how to initiate an appeal; and ■ disclosures regarding the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman. The current list of relevant consumer assistance programs and ombudsmen is provided in the Appendix to Technical Release 2011-01.
<p>The first day of the plan year beginning on or after January 1, 2012 (January 1, 2012 for calendar year plans)</p>	<p>Notify a claimant of a benefit determination regarding a claim for urgent care as soon as possible, but not later than 24 hours (instead of 72 hours) after receiving the claim.</p>
	<p>Provide notices of claim denials in a non-English language if at least a threshold number of participants are literate only in the same non-English language.</p>
	<p>Implement the “strict adherence” standard under which a claimant may initiate an external review of a claim or pursue the claim in court without exhausting the plan’s internal claims and appeals procedures if the plan fails to <i>strictly</i> (instead of <i>substantially</i>) follow the claims procedures.</p>
	<p>Include diagnosis and treatment codes (and their corresponding meanings) in notices of claim denials.</p>