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Health Care Reform Update: Supreme Court Ruling Mandates Timely Employer Actions

by Mark C. Jones, Susan P. Serota, and Christine L. Richardson

The Supreme Court's decision in National Federation of Independent Business v. Sibelius *upholding the Patient Protection and Affordable Care Act (PPACA) leaves in place the market reforms and tax provisions that have become effective under health care reform over the last two years and gives a green light to the continued implementation of these measures. All health plan sponsors and administrators should continue to take action to comply with these requirements as they become effective. Employers whose plans fail the PPACA's minimum standards of coverage or affordability should consider restructuring their benefits to avoid heavy penalties.*

Majority Opinion Upholds Individual Mandate

The majority opinion, written by Chief Justice John Roberts, found that the requirement imposed by PPACA to maintain minimum essential health insurance coverage or make a "shared responsibility payment," while outside Congress' authority under the Commerce Clause, could be read in a manner that comports with Congress' power to tax and spend. The Court also found that the authority given to the Secretary of Health and Human Services (HHS) to withhold all federal Medicaid funding from states that failed to expand Medicaid eligibility in accordance with PPACA exceeded Congress' power under the Spending Clause, but could be severed from the rest of the statute so that only new Medicaid funds are conditioned on a state's compliance.

Impact on Employers

Prior Changes Remain in Place. Because of the Court's ruling upholding PPACA, all of the health insurance reforms that have already been implemented remain in place. These include:

- the prohibition on retroactive rescission of coverage, other than in cases of fraud or intentional misrepresentation of material facts;

- the prohibition on lifetime dollar limits and floors on annual dollar limits for essential health benefits, absent a waiver from HHS;
- the elimination of preexisting condition exclusions for children under the age of 19 (to be extended to adults for plan years beginning on or after January 1, 2014);
- the extension of coverage to adult children under the age of 26, other than children of employees participating in grandfathered plans who are eligible to enroll in another employer-sponsored plan (to be extended to all adult children under the age of 26 for plan years beginning on or after January 1, 2014);
- the prohibition on the imposition of copayments, coinsurance fees and deductibles for recommended preventive services under non-grandfathered plans; and
- new internal and external claims procedures applicable to non-grandfathered plans.

Similarly, the changes to the Internal Revenue Code that have shaped the PPACA's funding and financial incentives remain in place, including:

- the prohibition on the use of flexible spending accounts (FSAs), health savings accounts (HSAs) and health reimbursement arrangements (HRAs) to purchase over-the-counter medicines; and
- the small business tax credit, for employers with no more than 25 full-time employees and average wages of $50,000 or less.

Forthcoming Changes That Require Employer Action

Shared Responsibility. Of greatest importance following the Court's ruling is the shared responsibility (or "free rider") penalty that applies to large employers. This penalty is parallel to the individual mandate, in that it creates a financial incentive for the expansion of quality health insurance coverage. Effective as of January 1, 2014, an employer with 50 or more full-time employees must pay a penalty equal to $2,000 per employee (minus 30, that is, starting with the 31st employee) in any year in which the employer fails to provide "minimum essential coverage" and any full-time employee obtains a federal tax credit or subsidy to obtain coverage under a state health care exchange. If the employer does offer minimum essential coverage but the coverage is unaffordable or does not offer "minimum value," in accordance with PPACA, the employer must pay a penalty equal to $3,000 per employee who obtains a federal tax credit or subsidy to obtain coverage under a health care exchange. Employers that do not currently provide affordable "minimum essential coverage" to their full-time work force (for example, many retailers and employers in the food and restaurant business) must decide whether to amend their health plans to provide coverage to these employees, offer coverage through a state health insurance exchange (available for smaller businesses only), pay the applicable shared responsibility penalty in lieu of expanding coverage, or limit the hours each such employee works to a level that is below the statute's standard for "full-time" employees.

Statement of Benefits and Coverage. One of the most urgent requirements for plan administrators is to prepare and distribute an annual Statement of Benefits and Coverage (SBC). The SBC is intended to allow employees to compare different health care options—such as to compare the employee's benefits options with those of a spouse or domestic partner—by giving them information regarding coverage levels, limitations and cost-sharing provisions using common terminology and a standard template. The initial SBC must be distributed in advance of the first open enrollment period that begins on or after September 23, 2012.

External Claims Reviews. The new claims procedures enacted under PPACA create a temporary safe harbor for self-insured non-grandfathered plans with respect to the provision of external reviews. Plans that intend to comply with the temporary safe harbor must contract with at least three independent review organizations by July 1, 2012, unless the plans have opted to comply with a state external review process that satisfies certain minimum requirements.

Women's Preventive Care. The soon-to-be expanded list of recommended preventive services that must be provided by non-grandfathered plans without the imposition of copayments, coinsurance fees or deductibles includes eight categories of services for women, including well-woman visits and the provision of contraception. All non-grandfathered plans must be amended to cover these items for plan years beginning on or after August 1, 2012. However, there is a limited exemption for religious employers, as well as a temporary exemption, until August 1, 2013, for other nonprofit employers that do not cover contraceptives based on religious beliefs.

W-2 Reporting. Employers must also take action this year to make the systems changes necessary to collect and process data needed to calculate the aggregate cost of employer-sponsored health coverage. This information must be reported on each covered employee's W-2 form for 2012. Generally, these forms must be distributed by January 31, 2013.

Other Market Reforms. Other forthcoming health insurance changes that may require action by employers and plan administrators include:

- the obligation on employers with at least 200 full-time employees to automatically enroll new hires who do not opt out or make an alternative health care election in the health care option with the lowest premium, effective when final regulations are issued;
- the prohibition of non-grandfathered insured plans from imposing eligibility or benefit limits that discriminate in favor of highly compensated employees, effective when final regulations are issued;
- the obligation to provide notice to current employees by March 1, 2013 and subsequent new hires describing their right to obtain health insurance through the state exchanges and possible eligibility for government subsidies;
- the following mandates and reforms effective for plan years beginning on or after January 1, 2014:
    - the elimination of waiting periods longer than 90 days;
    - the limitation on deductibles for coverage under small group health plans that provide essential health benefits equal to $2,000 for single coverage or $4,000 for family coverage;
    - the cap on out-of-pocket limits and other cost-sharing with respect to essential health benefits must be equal to the limits that apply to high deductible health plans;
    - the guaranteed acceptance by insurance providers of every plan sponsor and individual who applies for coverage during an annual or open enrollment period, and guaranteed renewal or continuation of coverage as requested by the plan sponsor or individual;
    - the increase in maximum wellness incentives that may be offered to 30 percent of regular premium costs; and

- the annual reporting to HHS by employers with more than 100 full-time employees disclosing whether they offer essential health benefits and detailing enrollment data, plan finances and material terms.

Other Revenue Provisions. Most of PPACA's revenue-raising and cost control mechanisms have not yet become effective. Forthcoming changes that impact employers and plan administrators include the following:

- the $1 fee per average covered life (increasing to $2 per average covered life in 2014) imposed on health insurers and self-insured plans to fund the Patient-Centered Outcomes Research Institute, effective for plan years ending on or after October 1, 2012;
- the $2,500 limitation on annual salary reduction contributions to health flexible spending accounts, effective for tax years beginning on or after January 1, 2013;
- the exclusion of Medicare Part D subsidies for retiree prescription drug coverage from the health care deductions that an employer may claim, effective for tax years beginning on or after January 1, 2013;
- the additional Medicare hospital insurance tax imposed on wages exceeding $200,000 for single filers or $250,000 for joint filers, effective for tax years beginning on or after January 1, 2013; and
- the 40% excise tax on "Cadillac" health plans whose total annual coverage costs exceed $10,200 for single coverage or $27,500 for family coverage, effective for tax years beginning on or after January 2018.

National Federation is not likely to be the final legal or legislative challenge to PPACA's survival in its current form. Other lawsuits have been filed contesting different provisions of the law, and Democratic control of the Senate and the White House remains uncertain following the November elections. In the meantime, however, PPACA remains intact, and the efforts of employers, plan administrators and regulators to implement it will continue.

We have been advising on health care reform and PPACA since it was enacted in 2010. We welcome the opportunity to give guidance to employers and others on considerations and actions to bring their plans into compliance with PPACA, as well as other applicable health care laws.

If you have any questions, please contact the Pillsbury attorney with whom you regularly work or one of the following members of the Executive & Compensation practice section:

New York

Susan P. Serota (bio)
+1.212.858.1125
susan.serota@pillsburylaw.com

Peter J. Hunt (bio)
+1.212.858.1139
peter.hunt@pillsburylaw.com

Scott E. Landau (bio)
+1.212.858.1598
scott.landau@pillsburylaw.com

Kathleen D. Bardunias (bio)
+1.212.858.1905
kathleen.bardunias@pillsburylaw.com

James P. Klein (bio)
+1.212.858.1447
james.klein@pillsburylaw.com

Bradley A. Benedict (bio)
+1.212.858.1523
bradley.benedict@pillsburylaw.com

Washington, DC / Northern Virginia

Howard L. Clemons (bio)
+1.703.770.7997
howard.clemons@pillsburylaw.com

Justin Krawitz (bio)
+1.703.770.7517
justin.krawitz@pillsburylaw.com

Los Angeles

Mark C. Jones (bio)
+1.213.488.7337
mark.jones@pillsburylaw.com

San Francisco

Christine L. Richardson (bio)
+1.415.983.1826
crichardson@pillsburylaw.com

Marta K. Porwit (bio)
+1.415.983.1808
marta.porwit@pillsburylaw.com

San Diego—North County

Jan H. Webster (bio)
+1.858.509.4012
jan.webster@pillsburylaw.com

Daniel N. Riesenberg (bio)
+1.858.847.4130
daniel.riesenberg@pillsburylaw.com

Lori Partrick (bio)
+1.858.509.4087
lori.partrick@pillsburylaw.com

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