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HEALTH CARE REFORM

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Supplementary Materials

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Health Care Reform: Are You Prepared? A Timeline for Employers to Follow

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The Patient Protection and Affordable Care Act was signed into law on March 23, 2010. Amendments to the PPACA were included in the Health Care and Education Reconciliation Act of 2010, which was enacted on March 30, 2010 (these two Acts are collectively referred to as the “PPACA”). The legislation will impose significant new responsibilities on employers, some of which are already effective. While further guidance is expected on the application of these requirements, the following provides a summary and timeline of key provisions of the PPACA. As employers look ahead to the implementation of the PPACA, Littler Mendelson will be providing additional publications to provide employers with compliance strategies in connection with various components of the new law.

Provisions Effective on the Date of Enactment (March 23, 2010) or with No Specified Effective Date

- **Grandfather Provision**: The health care reform law contains health insurance market reforms that will impact employers sponsoring group health plans and health issuers offering group and individual policies. "Grandfathered" plans, those in existence on the date of enactment of the PPACA, are exempt from some, but not all, of the new insurance market reform requirements. Although the statute explicitly allows grandfathered plans to enroll new employees and family members and maintain "grandfathered" status, it is silent about what changes to the plan would cause a plan to lose this status. Therefore, uncertainty exists regarding the scope of permissible changes employers can make to a plan in this regard.

- **In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements that were ratified before the date of enactment of the PPACA, a plan will remain "grandfathered" until the date on which the last of the collective bargaining agreements relating to the coverage terminates.**

- **Small Business Tax Credits**: Employers with no more than 25 full-time equivalent...
employees and annual average wages of less than $50,000 can receive a tax credit for purchasing health insurance for their employees. To receive this credit, employers are required to cover at least 50% of the total premium cost. The number of full-time equivalent employees is determined by dividing (1) the total hours for which the employer pays wages to employees during the year (but not more than 2,080 hours for any employee) by (2) 2,080.

- For tax years 2010 through 2013, the tax credit will be up to 35% of the employer’s contribution, with the full credit of 35% available to employers with 10 employees or less and average annual wages of $25,000 or less.
- Beginning in tax year 2014, the credit will be increased to 50% of the employer’s contribution.

- **Automatic Enrollment**: Employers with more than 200 full-time employees that offer health coverage must automatically enroll new full-time employees in a plan. An employee may opt-out of coverage. The PPACA does not specify an effective date; however, there has been speculation that the automatic enrollment requirement will become effective upon the issuance of regulations.

- **Reasonable Break Time for Nursing Mothers**: The PPACA amends the Fair Labor Standards Act to require employers to provide nursing mothers, up to one year after the birth of their child, a reasonable break time each time the employee needs to express milk. Employers must provide a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which nursing mothers may be use. An employer with less than 50 employees is not required to comply if the requirements would impose a significant difficulty or expense. The PPACA provides that an employer is not required to compensate an employee receiving such reasonable break time for any work time spent for such purpose. The new federal requirement, which became effective on the date of enactment, does not preempt state law.

- **Protections for Employees**: The PPACA amends the Fair Labor Standards Act to prohibit employers from discharging or discriminating against any employee because the employee:
  - received a federal tax credit or cost-sharing subsidy to purchase health insurance;
  - provided or is about to provide to the employer, federal government, or state attorney general information relating to a violation, or what the employee reasonably believes to be a violation, of Title I of the PPACA;
  - testified or is about to testify in a proceeding about such violation;
  - assisted or participated, or is about to assist or participate, in such a proceeding; or
  - objects to or refuses to participate in any activity the employee reasonably believes to be a violation of Title I of the PPACA

The complaint procedure for retaliation claims follows that of the whistleblower protection provisions of the Consumer Product Safety Improvement Act of 2008.

- **Nutrition Labeling of Standard Menu Items at Chain Restaurants**: The PPACA includes a provision that creates a national, uniform nutrition-disclosure standard for chain restaurants and food retail establishments. The statute does not include a specific effective date. However, the mandatory requirements are not expected to take effect until after Food and Drug Administration (FDA) finalizes its regulations. The legislation directs the FDA to propose regulations within one year of the PPACA enactment date of March 23, 2010.

### Provisions Effective 90 Days After Enactment (June 23, 2010)

- **Retiree Reinsurance**: By no later than June 23, 2010, a federal reinsurance program must be established to reimburse sponsors of employment-based plans that provide health benefits to retirees age 55 or older who are not Medicare eligible. Sponsors can apply for reimbursement of 80% of claims paid between $15,000 and $90,000. The sponsor must implement cost-saving programs for high-cost and chronic conditions. Reimbursement must be used to reduce costs for participants. The $5 billion in funds for the
program will only be available until the earlier of 2014 or when the funds are depleted. Plan sponsors that are interested in receiving reimbursement under this program should recognize that it is temporary and should prepare to apply for the reimbursement soon.

- **Temporary High Risk Pool:** A temporary high risk pool must be established to provide coverage for individuals with preexisting conditions who have been uninsured for at least six months. Insurers or employers who are found to have encouraged individuals to disenroll and enroll in the high risk pool must reimburse the pool. The program will exist until January 1, 2014.

**Plan Years Beginning on or After Six Months Post-Enactment (September 23, 2010 Or January 1, 2011 for Calendar Year Plans)**

- **Insurance Market Reforms that Apply to New and Grandfathered Plans**
  - **Extension of Dependent Coverage up to Age 26:** Group health plans and insurers that provide dependent health coverage must extend that coverage to dependents up to age 26. Prior to 2014, a grandfathered group health plan must only extend dependent coverage to age 26 if the dependent is not eligible for other employer-sponsored coverage. Children of the adult dependents (grandchildren of the covered employee) do not have to be offered coverage under the plan. The coverage is not taxable to the employee or dependent. (Before the PPACA, adult dependent coverage was generally taxable with limited exceptions.)
  - **Prohibition on Rescissions:** Group health plans and insurers are prohibited from rescinding, or canceling, health coverage of an enrollee except in the case of fraud or intentional misrepresentation of material fact.
  - **Prohibition on Pre-existing Condition Exclusions:** Group health plans and insurers are prohibited from imposing pre-existing condition exclusions for children under the age of 19. Beginning in 2014, plans are prohibited from including a pre-existing condition exclusion for any participant.
  - **Prohibition on Lifetime Benefit Limits:** Group health plans and insurers are prohibited from imposing a lifetime dollar limit on essential health benefits.
  - **Restriction on Annual Benefit Limits:** Prior to 2014, group health plans may impose annual limits on the dollar value of essential health benefits only as determined by the Secretary of Health and Human Services. Beginning in 2014, annual dollar limits are prohibited for all essential health benefits.

- **Insurance Market Reforms that Apply to New Plans, but Do Not Apply to Grandfathered Plans**
  - **Preventative Care:** Group health plans and insurers must cover certain preventative care services without cost-sharing, including preventative services rated A or B by the U.S. Preventative Task Force, recommended immunizations, preventative care and screenings for infants, children, and adolescents, and additional preventative care and screenings for women. Appeals Process: A new appeals process that includes both internal and external reviews will be required to be provided by employers to employees for appeals of coverage determinations and claims.
  - **Non-discrimination in Favor of Highly-Compensated Employees:** The requirements of Section 105(h) of the Internal Revenue Code will be extended to fully-insured plans. The restriction currently only applies to self-insured plans.
  - **Emergency Services:** Group health plans and insurers must cover emergency services without prior authorization and in-network requirements.
  - **Physician Selection:** Group health plans and insurers that provide for or require the designation of a participating primary care provider must permit each participant to designate any participating primary care provider who is available to accept such individual. The plan must permit a participant to designate a pediatrician as the primary care provider for a child. Plans are prohibited from requiring authorization or referral for an OB-GYN.
Provisions Effective in 2011

- **W-2 Reporting**: Beginning in 2011, employers must report the value of employer-provided health coverage on an employee’s W-2. This requirement does not change the tax treatment of employer-provided health coverage.

- **Qualified Medical Expenses**: Beginning in 2011, over-the-counter drugs will not be eligible for reimbursement from a flexible spending account (FSA), health savings account (HSA), health reimbursement account (HRA) or Archer medical savings accounts (MSAs).

- **Increased Penalty for Nonqualified Withdrawals**: Effective January 1, 2011, the penalty for withdrawals from HSAs that are not used for qualified medical expenses will increase from 10% to 20%, and the penalty for unqualified withdrawals from Archer MSAs will increase from 15% to 20%.

- **Drug Manufacturer and Importer Fee**: An annual fee on manufacturers and importers of branded drugs will be imposed beginning in 2011.

- **CLASS Act**: A voluntary federal insurance program for employees to purchase long-term care becomes effective beginning January 1, 2011. Employers may elect to automatically enroll employees in the CLASS program, and employees may opt-out.

Provisions Effective in 2012

- **Form 1099**: Effective January 1, 2012, businesses must provide a Form 1099 for all corporate service providers receiving more than $600 per year for services or property, not just for non-corporate service providers.

- **Uniform Explanation of Coverage Documents**
  - Upon application, enrollment and re-enrollment, all health insurance issuers and sponsors of self-insured group health plans (including grandfathered plans) must provide a summary of benefits and coverage to enrollees and applicants.
  - By no later than 60 days prior to the effective date of any mid-year change, group health plans also must provide notice of any material changes to the plan coverage. The Secretary of Health and Human Services will establish the format for this summary description, which must begin to be issued no later than March 23, 2012.

- **Quality of Care Reporting**: Not later than March 23, 2012, the Secretary of Health and Human Services must develop reporting requirements for use by plans and insurers regarding plan benefits and reimbursement structures, including those that improve health outcomes and implement wellness and health promotion activities (Not applicable to grandfathered plans).

- **Comparative Effectiveness Research Fee**: For the plan year ending after September 30, 2012, there will be a $1 per enrollee tax on fully-insured and self-funded group health plans to fund comparative effectiveness research. For plan years ending after September 30, 2013, the fee increases to $2 per enrollee. This fee sunsets after 2019.

Provisions Effective in 2013

- **FSA Limits**: Effective January 1, 2013, annual contributions to FSAs will be limited to $2,500. This amount will be indexed to CPI.

- **Medicare Part D Retiree Subsidy**: The employer’s deduction for the amount of the Medicare Part D retiree drug subsidy will be eliminated.

- **Device Manufacturer and Importer Fee**: An excise tax on manufacturers and importers of medical devices will be imposed.

- **Medicare Payroll Tax**: An additional 0.9% Medicare tax will be imposed on employees with wages over $200,000 ($250,000 for joint filers).
Medicare Contribution on Investment Income: A 3.8% tax on unearned income will be imposed on those with income over $200,000 ($250,000 for joint filers).

Executive Compensation: Beginning in 2013 and only with respect to services performed after 2009, the deduction for current and deferred compensation paid to officers, directors, employees, or services providers of health insurance issuers is limited to $500,000 per year.

Employer Notice Requirements: Beginning on March 1, 2013, employers must provide employees written notice: (1) of the existence of the health insurance exchange; (2) of potential eligibility for federal assistance if the employer’s health plan is "unaffordable" based on criteria under PPACA and if employee household income is below certain thresholds; and (3) that they may lose the employer’s contribution to health coverage if they purchase health insurance through the health insurance exchange.

Provisions Effective in 2014

Health Insurance Exchanges: State-established health insurance exchanges (Exchanges) must begin to operate on January 1, 2014. The Exchanges are virtual marketplaces that allow individuals and eligible employers to purchase health insurance. Initially in 2014, only employers with up to 100 employees can purchase insurance for their employees through the Exchange. Prior to 2016, states can limit this to businesses with up to 50 employees. Beginning in 2017, states can allow employers with more than 100 employees to purchase health insurance for their employees through the Exchange.

Individual Responsibility – Penalty: Individuals generally will be required to obtain “minimum essential coverage” or pay a penalty.

- For 2014, the penalty is $95 for each uninsured adult in household or 1% of household income over filing threshold.
- For 2015, the penalty increases to $325 or 2% of household income over filing threshold.
- For 2016 and after, the penalty increases to $695 or 2.5% of household income over filing threshold.

Federal Tax Credits and Cost-Sharing Subsidies: Individuals with household incomes up to 400% of the federal poverty level (currently approximately $88,000 for a family of four) may be eligible for federal premium tax credits or cost-sharing subsidies to purchase insurance through an Exchange. Individuals with employer-sponsored coverage may still be eligible for federal assistance if such coverage is either: (1) unaffordable because the employee’s required contribution is more than 9.5% of their household income; or (2) the plan’s share of the total allowed costs of benefits provided under the plan is less than 60% of such costs.

Employer Responsibility – Penalty: The new health care reform law does not require employers to offer health coverage to their employees. However, large employers will be subject to a penalty beginning in 2014 if they do not: (1) offer coverage; (2) offer coverage that is affordable; or (3) offer coverage that meets the minimum value standards.

- Large Employers: For purposes of the penalty, a large employer is an employer who has 50 or more full-time employees and full-time equivalents. Full-time employees are defined as those that work 30 or more hours a week calculated on a monthly basis. Full-time equivalents are also counted in the determination of whether an employer is a large employer for purposes of the penalty. The monthly number of hours worked by part-time employees is aggregated and divided by 120 for this purpose. To determine whether an employer is deemed a large employer subject to the penalty, the number of full-time employees is added to the number of full-time equivalents. If that number is 50 or more, the employer is subject to a penalty as described below. Employers falling below the threshold will not be subject to a penalty.

Even though the hours of part-time workers are counted for purposes of determining whether an employer is a large employer, the penalty only applies with respect to full-time employees. An employer is not considered a large employer if it employs more than 50 people for 120 days or less during the calendar year and the employees in excess of 50 employed during such 120 days...
period were seasonal workers. The controlled group rules (i.e., the rules under Sections 414(b), (c), (m), and (o) of the Internal Revenue Code of 1986) that apply to qualified retirement plans will similarly apply in determining whether an employing entity is a large employer.

• **Large Employers that Do Not Offer Health Coverage:** A large employer that does not offer to its full-time employees (and dependents) an opportunity to enroll in minimum essential coverage will pay a penalty if at least one of its full-time employees receives federal assistance to purchase insurance through an Exchange. The penalty will be equal to $2,000 multiplied by the total number of full-time employees, subtracting 30 from the total number of full-time employees.

• **Large Employers that Do Offer Health Coverage:** A large employer that offers minimum essential coverage to full-time employees (and dependents) will also be subject to a penalty if the health coverage offered is either: (1) unaffordable because the employee’s required contribution is more than 9.5% of their household income; or (2) the actuarial value of the employer’s plan is less than 60%, meaning the plan pays for less than 60% of covered health care expenses. In either case, the employer will pay a penalty that is the lesser of $3,000 for each full-time employee receiving federal assistance to purchase health insurance through an Exchange or $2,000 multiplied by all full-time employees (subtracting 30 from the total number).

• **Free Choice Vouchers:** Beginning in 2014, employers that offer health coverage to their employees may also have to provide “free choice vouchers” for certain employees that would rather purchase health insurance through the Exchange instead of through the employer. This requirement is not limited to large employers. Employees with household incomes at or below 400% of the federal poverty level and whose premium payment is between 8% and 9.8% of their household income are eligible for the free choice vouchers. The amount of the free choice voucher is the amount the employer would have contributed toward such employee’s coverage (or family coverage at the employee’s option) with respect to the plan to which the employer pays the largest portion of the cost. The employee can keep the difference, if any, between the amount of the voucher and the cost of purchasing insurance through the Exchange. The amount of the voucher is deductible to the employer. No penalties are imposed for employees who receive free choice vouchers.

• **Employer Reporting Requirements:** Employers must annually report to the federal government whether they offer health coverage to their full-time employees and dependents, the total number and names of full-time employees receiving health coverage, the length of any waiting period, and other information about the cost of the plan.

• **Insurance Market Reforms and Benefit Mandates**

  • **Essential Health Benefits:** Qualified health plans and insurers in the individual and small group markets must offer coverage that includes the "essential health benefits package." A small group is defined as one with no more than 100 employees. A health plan providing the essential health benefits package will be prohibited from imposing an annual cost-sharing limit that exceeds the thresholds applicable to Health Saving Accounts (HSAs). Small group health plans providing the essential health benefits package will be prohibited from imposing a deductible greater than $2,000 for self-only coverage, or $4,000 for any other coverage (Does not apply to grandfathered plans).

  • **Excessive waiting periods:** For plan years beginning on or after January 1, 2014, self-insured group health plans and insurers are prohibited from imposing a waiting period greater than 90 days. The waiting period is the time period that must pass before an individual is eligible to use health benefits (Applies to grandfathered plans).

  • **Prohibition on pre-existing condition exclusions:** For plan years beginning on or after January 1, 2014, self-insured group health plans and insurers are prohibited from including a pre-existing condition exclusion for any participant (Applies to grandfathered plans).

  • **Prohibition on annual benefit limits:** Group health plans and insurers are prohibited from imposing a lifetime dollar limit on essential health benefits (Applies to grandfathered plans).
• **Health Status:** Group health plans and insurers are prohibited from basing eligibility on health-status related factors (*Does not apply to grandfathered plans*).

• **Clinical trials:** Group health plans and insurers cannot deny coverage for participation in clinical trials for life-threatening diseases. The benefits must otherwise be covered by the plan and may be subject to out-of-network provider restrictions (*Does not apply to grandfathered plans*).

• **Wellness Program Incentives:** The PPACA codifies the existing HIPAA rules allowing wellness programs to offer an incentive, such as a premium reduction, for achieving a health standard. However, the maximum amount of the incentive is increased from 20% to 30% of the cost of employee-only coverage under the plan, with Secretarial discretion to increase the cap to 50%.

• **Health Insurer Fee:** Beginning in 2014, an annual fee on health insurance providers will be imposed.

### Provisions Effective in 2018

**Excise Tax on High-Cost Insurance Plans:** Beginning in 2018, and with respect to employer-sponsored health plans that provide coverage where the value of such coverage exceeds $10,200 for single coverage and $27,500 for family coverage, a 40% excise tax will be imposed on health insurance issuers and persons that administer plan benefits. The excise tax is imposed on the value of coverage in excess of the threshold. For retirees and employees in high-risk professions, the threshold is $11,850 for single and $30,950 for families. The amount of coverage includes both employer and employee premium payments. The threshold may be adjusted for age and gender demographics that are different from a national pool. It may also be adjusted if actual health inflation exceeds the government’s estimate of health inflation between now and 2018. The threshold will then be periodically adjusted for inflation subsequent to 2018.

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1 The Health Care and Education Reconciliation Act reduced the affordability threshold for a federal subsidy from 9.8 to 9.5% of household income. However, the Act did not make a corresponding change to the free choice voucher provision.
HHS Issues Interim Rule for Early Retiree Reinsurance Program

By Susan K. Hoffman and Ilyse W. Schuman

On May 4, 2010, the Department of Health and Human Services (HHS) issued an Interim Final Rule establishing the temporary early retiree reinsurance program under the Patient Protection and Affordable Care Act (PPACA) signed into law on March 23, 2010. Under the PPACA, $5 billion was appropriated to reimburse the sponsors of employment-based retiree medical plans for the cost of coverage for any retiree age 55 to 65, in the amount of 80% of the costs for any eligible individual between $15,000 and $90,000 of expenses per plan year. The reimbursements must be applied to reduce future increases in employer costs, and/or out-of-pocket costs for the covered early retirees and cannot be used to reimburse the employer’s contributions towards the costs of the plan. The PPACA called for the program to be in place by June 21, 2010, but the Interim Final Rule provides for the program to commence on June 1, 2010. The key features of the Rule are:

Eligible Plans

The early retiree medical plan must apply to the HHS and be "certified" before reimbursements can be made. The plan must be employment-based and a group plan, but can be sponsored by an employer, a trade association, jointly by an employer (or group of employers) and a union (or group of unions), or by a “VEBA” (a trust fund established by a union or employer or a combination of them, to provide health benefits to former employees). In addition, the plan must have certain cost-reduction programs in place to manage care and reduce costs for certain chronic conditions likely to result in expenses in excess of $15,000 per year, and must also have programs in place to reduce fraud, waste, and abuse. The Interim Final Rule does not specify the chronic and high-cost conditions to be addressed. However, sponsors must be able to demonstrate, upon audit, that its programs have generated or had the potential to generate cost savings. The plan can be either insured or self-funded. In addition, state and local government plans are eligible.
Eligible Retirees

The individuals whose expenses can be reimbursed must be former employees of the employer that established the plan or that made contributions to the plan. They must be age 55 or over, and not eligible for Medicare. Spouses, surviving spouses, and dependents of eligible retirees also are included in the program, even if they are under age 55 or eligible for Medicare.

Eligible Expenses

Generally, all medical expenses paid by the plan will be eligible for reimbursement, including prescription drugs, medical, surgical, and hospital benefits. But ancillary benefits such as dental and vision care and long-term care benefits will not be eligible.

The medical expenses must have been actually incurred and paid. Thus, if a plan only reimburses a negotiated amount, or if the plan receives a retroactive discount, the reimbursement will be based on the reduced, net cost to the plan (reimbursements or rebates expected to be received after the plan year must be disclosed). The expenses are measured by plan years, which will be the plan year specified in the plan document or, if not specified, the year used for measuring annual limits under the plan or, if none, the policy year or, if none, the sponsor’s fiscal year or the calendar year. The first eligible plan year is the year in effect on June 1, 2010, (thus, a plan year beginning anytime between June 2, 2009, and June 1, 2010, is eligible for reimbursement). But the costs incurred before June 1, 2010 will count only in determining whether the $15,000 threshold has been reached. Only expenses incurred on or after June 1, 2010, are eligible for reimbursement. An expense is “incurred” at the point in time when the plan or participant becomes legally responsible for payment of the expense.

In determining whether (and to what extent) the costs for any eligible individual have exceeded $15,000, amounts paid out-of-pocket by the covered individual are included. Thus, if a plan has a deductible and co-insurance feature, such that the covered individual has paid $5,000 of a $21,000 medical expense, the sponsor can apply for reimbursement of $6,000, even though the plan itself has spent only $1,000 more than the $15,000 threshold. For insured plans, the cost includes out-of-pocket payments by the eligible individual plus payments to providers by the insurer, but does not include premium payments.

In its initial application, the plan sponsor must estimate the likely reimbursement amounts for the first two plan years it will participate in the program.

For plan years starting on or after October 1, 2011, the $15,000 cost threshold and $90,000 cost limit will be adjusted by the percentage increase in the Medical Care Component of the Consumer Price Index for urban consumers.

Application of Reimbursement Funds

The PPACA requires that the reimbursements received under the program be used to reduce premiums paid by the sponsor, or out-of-pocket costs for retirees in the health plan. In order to implement this requirement, the Interim Final Rule requires the applicant to specify how the reimbursement will be used to reduce costs, and also requires the applicant-sponsor to certify that it will not reduce its own expenditures towards the costs of the program while applying the reimbursement to benefit the participants in the plan (a “maintenance of effort” requirement). For example, reimbursements in one year may be used to keep retiree premiums steady (or reduced) in the next year, or may be used to keep the plan sponsor’s premium costs steady in the next year (but cannot be used to reduce the sponsor’s costs). The recipients of the cost reduction may include other retirees in the plan (e.g., those under age 55 or who are Medicare eligible) as well as active employees if they are in the same plan as the retirees whose expenses are being reimbursed as well as spouses or dependents enrolled in the plan.

Technical Requirements

The Rule sets out various technical requirements for certified plans, in order to facilitate audits of the program. For example, a plan's
sponsormust have a HIPAA associate agreement in place with its plan administrator or insurer, such that protected health information can be provided to HHS upon request. A separate application must be filed for each plan and must specify the first year covered in the request for certification. But once a plan is certified, the certification covers each year in the program (which expires on January 1, 2014, or when the $5 billion has been exhausted). Upon certification, the plan sponsor will enter into a written agreement with HHS designed to facilitate the agency’s monitoring and enforcement functions.

The claim submissions must include a list of each eligible individual and specify the claims incurred on behalf of that individual (including the individual’s out-of-pocket costs) up to $90,000 (claims in excess of that amount are not to be submitted) for the plan year. The sponsor must include evidence that the out-of-pocket cost was actually paid (a receipt, for example). Claims will be paid on a first-in, first-out basis until funds are exhausted.

**What an Employer Should Do Now**

Employers with retiree medical plans that cover individuals age 55 to 65 should begin gathering data concerning eligible individuals whose medical expenses are likely to exceed $15,000 for the current plan year. In addition, the plan should be reviewed to ensure that the proper cost-containment and anti-fraud measures are in place, so that the plan can qualify for the reimbursement. The sponsor also should consider alternative approaches for application of the reimbursements to reduce costs, and select the approach most suitable for its circumstances. Because of the limited funding for the program, it may be advisable to apply for certification as soon as possible.

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Healthcare Reform: Long-Awaited “Grandfathered” Regulations Released – What Do Employers Need to Know?

By Ilyse Schuman and Melissa Kurtzman

On June 17, 2010, the Departments of Labor, Health and Human Services and Treasury published in the Federal Register interim final rules relating to “grandfathered” health care plans under the Patient Protection and Affordable Care Act (PPACA). Under PPACA, as amended by the Health Care and Education Reconciliation Act of 2010 (Reconciliation Act), health plans that were implemented before PPACA was signed into law on March 23, 2010, are exempt from many, but not all, of the law’s consumer protections. Employers have anxiously awaited release of the Interim Final Rules to clarify how health plans may qualify for or lose such grandfathered status.

The grandfathering provisions contained in section 1251 of PPACA have served as the basis for contending that the new health care reform law will allow individuals to keep their current health care coverage. For the 133 million people with employer-sponsored health coverage, the application of the grandfathering rules may significantly impact whether or not this claim proves to be valid over time. For employers, the Interim Final Rules present difficult choices about making changes to their plans that may result in a loss of grandfathered status. As employers evaluate the value of providing grandfathered health coverage in comparison to their need for flexibility, a number of them may well conclude that the benefits of flexibility outweigh those of grandfathering.

Advantages of Grandfathered Status

Grandfathered health plans do not need to comply with many of the new insurance market reform rules under the PPACA. Retiree only health plans, dental and vision only plans and health Flexible Spending Accounts (FSAs) are also generally exempt from the PPACA’s plan operations and design changes. Those employer-sponsored plans that lose their grandfathered status will be considered new plans subject to the full application of PPACA’s consumer protection provisions.
The insurance market reform requirements that new, non-grandfathered plans, are required to meet include:

- Requiring coverage of preventative care (effective for plan years beginning on or after September 23, 2010).
- A new appeals process that includes both internal and external reviews for appeals of coverage determinations and claims (effective for plan years beginning on or after September 23, 2010).
- Prohibiting discrimination in favor of highly compensated employees by fully-insured plans. The nondiscrimination requirements of section 105(h) of the Internal Revenue Code are extended to fully-insured plans (effective for plan years beginning on or after September 23, 2010).
- Requiring coverage of emergency services without prior authorization and in-network requirements (effective for plan years beginning on or after September 23, 2010).
- Allowing the designation of a participating primary care provider and pediatricians (effective for plan years beginning on or after September 23, 2010).
- Prohibiting required authorization or referral for an OB-GYN (effective for plan years beginning on or after September 23, 2010).
- Quality of care reporting regarding plan benefits and reimbursement structures (the secretary shall establish reporting requirements no later than March 23, 2012).
- Requiring “essential health benefits” for insurers in the individual and small group markets (effective for plan years beginning on or after January 1, 2014).
- Prohibiting annual cost-sharing limits that exceed the thresholds applicable to health saving accounts (HSAs) (effective for plan years beginning on or after January 1, 2014).
- Prohibiting small group health plans from imposing a deductible greater than $2,000 for self-only coverage, or $4,000 for any other coverage (effective for plan years beginning on or after January 1, 2014).
- Prohibiting basing eligibility on health-status related factors (effective for plan years beginning on or after January 1, 2014).
- Coverage for participation in clinical trials for life-threatening diseases (effective for plan years beginning on or after January 1, 2014).

Accordingly, the exemptions applicable to grandfathered plans are not insignificant. The exemption from the 105(h) nondiscrimination requirements for grandfathered fully-insured plans may be of particular importance to some employers. However, grandfathered status will not exempt employers from new penalties and taxes included elsewhere in the PPACA. For example, the employer penalties, excise tax on high-cost or “Cadillac” plans, and new restrictions on flexible spending accounts apply regardless of a plan’s grandfathered status. Moreover, the amendments contained in the Reconciliation Act diminished considerably the advantages to grandfathered plans by applying certain consumer protections to both new and existing plans.

The insurance market reform requirements that both grandfathered and new plans, are required to meet include:

- Extending dependent coverage up to age 26. Prior to 2014, grandfathered group health plans must only extend dependent coverage to age 26 if the dependent is not eligible for other employer-sponsored coverage (effective for plan years beginning on or after September 23, 2010).
- Prohibiting rescissions except in the case of fraud or intentional misrepresentation of material fact (effective for plan years beginning on or after September 23, 2010).
- Prohibiting pre-existing condition exclusions. Plans are prohibited from imposing preexisting condition exclusions for children
under the age of 19 effective for plan years beginning on or after September 23, 2010. Beginning in 2014, plans are prohibited from including a preexisting condition exclusion for any participant.

- Prohibiting lifetime dollar limit on essential health benefits (effective for plan years beginning on or after September 23, 2010).
- Restricting annual benefit limits. Effective for plan years beginning on or after September 23, 2010 and prior to January 1, 2014, grandfathered plans may impose annual limits on the dollar value of essential health benefits only as determined by the Secretary of Health and Human Services. Beginning in 2014, annual dollar limits are prohibited for all essential health benefits.
- Uniform explanation of coverage documents (effective no later than March 23, 2012).
- Prohibiting waiting periods greater than 90 days (effective for plan years beginning on or after January 1, 2014).

**Definition of Grandfathered Health Plan Coverage**

Any group health plans in which an individual was enrolled on March 23, 2010, is a grandfathered health plan, even if all of the individuals enrolled in the plan on March 23, 2010, cease to be covered in the future as long as someone is enrolled. Family members enrolling after March 23, 2010 do not impact grandfathered status. Each benefit package under a group health plan is treated as a separate grandfathered plan.

New employees may join an existing plan without causing it to lose grandfathered status. However, the regulations contain an anti-abuse feature to stop employers from using mergers, acquisitions or similar business reorganizations to avoid losing grandfathered status. The regulations also include another anti-abuse provision intended to prevent transferring employees between grandfathered plans for the purpose of retaining grandfathered status. For example, a group health plan offers two benefit packages on March 23, 2010, Options F and G. The plan sponsor then eliminates Option F because of its high costs and transfers employees covered under Option F to Option G. If, instead of transferring employees from Option F to Option G, Option F was amended to match the terms of Option G, then Option F would cease to be a grandfathered plan. In this case, there was no bona fide business reason for the transfer, and Option G would cease to be a grandfathered plan.

**Collectively Bargained Plans**

PPACA contains a special rule for collectively bargained plans. However, the interpretation of this provision in the Interim Final Rule significantly diminishes its apparent intent, scope and utility, and is expected to generate controversy. With respect to health insurance coverage maintained pursuant to one or more collective bargaining agreements ratified before March 23, 2010, the coverage is grandfathered at least until the date on which the last of the agreements relating to the coverage terminates, even if there is a change in issuers. However, this provision applies only to fully-insured health plans maintained pursuant to a collective bargaining agreement. At the termination of the last agreement, the terms of the coverage will be compared to the terms in effect on March 23, 2010, to determine if the coverage remains grandfathered.

Moreover, there is no deferred effective date for collectively bargained plans from the provisions that apply to grandfathered plans, such as the extension of dependent coverage or prohibition on lifetime limits. In essence, these changes may need to be made to the health care coverage before the contract expires just as they must be made to other grandfathered plans. The preamble notes that similar language in previous bills that were not enacted would have provided a delayed effective date for collectively bargained plans. The preamble acknowledges that "questions have arisen as to whether section 1251(d) as enacted in the [PPACA] similarly operated to delay the application of the [PPACA's] requirements to collectively bargained plans." However, the regulators conclude that collectively bargained plans that are grandfathered health plans are subject to the same requirements as other
grandfathered health plans, and are not provided with a delayed effective date for insurance market reforms with which other grandfathered plans must apply. Such an interpretation is likely to face challenge as contrary to statutory language and intent by effectively eviscerating the special rule with respect to collectively bargained plans and giving rise to mid-contract changes that a special rule has historically sought to avoid.

New Policies, Certificates or Contracts

With respect to plans other than collectively bargained plans, if an employer enters into a new policy after March 23, 2010, the employer's plan will no longer be a grandfathered plan. However, for self-funded plans, changing third party administrators will not result in a loss of grandfathered status.

Disclosure and Recordkeeping Requirements

Grandfathered plans must provide a written notice to all participants and beneficiaries about the grandfathered status of the plan. A model notice is contained in the regulations. The notice specifically provides "[b]eing a grandfathered health plan means your plan does not include certain consumer protections of the PPACA, that apply to other plans. For example, the requirement for the provision of preventive health services without any cost-sharing." This language may be problematic in maintaining good employee relations. A grandfathered health plan must retain records regarding the coverage and costs in effect on March 23, 2010. This should not be problematic since record retention is currently required under ERISA.

Changes Causing Cessation of Grandfathered Status

In drafting the Interim Final Rules, the Departments stated that they "sought to provide adequate flexibility to plan sponsors and issuers to ease transition and mitigate potential premium increases while avoiding excessive flexibility that would conflict with the goal of permitting individuals who like their healthcare to keep it and might lead to longer term market segmentation as the least costly plans remained grandfathered the longest." In order to temper the building criticism over a draft of the regulations, Labor Secretary Hilda Solis and Department of Health and Human Services Secretary Kathleen Sebelius held a press conference to outline the new regulations and answer questions. As explained during the press conference and reiterated in a fact sheet, the regulations stipulate that health plans will lose their grandfathered status if they chose to make "significant changes that reduce benefits or increase costs to consumers." However, the Interim Final Rules do constrain an employer's flexibility in making plan changes that, over time, would diminish the value of retaining grandfathered status.

The Interim Final Rules outline those changes that would trigger a loss of grandfathering.

- **Elimination of Benefits.** The elimination of all or substantially all benefits to diagnose or treat a particular condition will cause a plan to lose grandfathered status. For example, eliminating the treatment for cystic fibrosis will cause a plan to lose grandfathered status. The elimination of benefits for any necessary element to diagnose or treat a condition is also an automatic loss of grandfathered relief. For example, if a certain mental illness requires counseling and prescription drugs, the elimination of counseling will cause the plan to lose grandfathered status. Plans may make voluntary increases in benefits without losing grandfathered status.

- **Increase in Percentage of Cost Sharing.** Any increase, measured from March 23, 2010, in a percentage cost-sharing requirement (co-insurance) causes a group health plan to lose grandfathering. For example, an increase from 20% for in-patient surgery to 30% will cause the plan to lose grandfathered status.

- **Increase in Fixed-Amount Cost-Sharing (excluding co-pays).** Any change to the fixed amount cost-sharing (i.e., $500 deductible or $2,500 out of pocket) must be less than the maximum amount determined by a formula. If the total percentage increase in the cost-sharing measured from March 23, 2010, exceeds the maximum percentage increase then a plan loses its
grandfathered status. The maximum percentage increase is medical inflation plus 15 percentage points. The employer must always look back to the data in place on March 23, 2010, to determine if the increase is, in fact, acceptable.

- **Increase in a Fixed-Amount Co-Pay.** Any increase in a fixed-amount co-pay, determined as of the date of the increase, will cause a plan to lose grandfathered status if the total increase in the co-pay measured from March 23, 2010, exceeds the GREATER of: (1) $5 increased by medical inflation ($5 times medical inflation, plus $5) or (2) the maximum percentage increase determined by expressing the total increase in the co-pay as a percentage. To illustrate: on March 23, 2010, grandfathered plan A has a $30 specialist office visit co-pay and the plan is amended to increase the specialist co-pay to $40. On that date the medical care component of the CPI-U is 475. The $10 increase in co-pay is expressed as a percentage (33.33%) (40-30=10; 10 divided by 30 = 33.33%; 33.33%). Medical inflation from March 23, 2010, is .2269. The maximum percentage increase permitted is 37.69% (22.69% + 15% = 37.69%). The change is allowed because 33.33% is less than 37.69%). The employer must look back to the data in place on March 23, 2010, when an increase is made to determine if it is, in fact, acceptable.

- **Decrease in Contribution Rate by Employers.** A grandfathered plan will lose its grandfathered status if the employer decreases its contribution rate towards the cost of ANY tier of coverage for any class of similarly situated individuals by more than five percentage points below the contribution rate for the coverage period that includes March 23, 2010. Although a plan may increase premiums, it may not reduce the percent of the premium the employer pays by more than five percent below the contribution rate in effect on March 23, 2010. Again, employers must always look back to the data in place on March 23, 2010.

- **Increase in Annual Dollar Limits.** Plans that do not have annual or lifetime dollar limits cannot add an annual limit if it wishes to maintain grandfathered status. A plan that had a lifetime limit, but no annual limit, cannot add an annual limit that is lower than the dollar value of the lifetime limit in effect on March 23, 2010. A plan that had an annual limit in effect on March 23, 2010, cannot decrease the dollar value of the annual limit.

It remains uncertain what other plan changes may result in a loss of grandfathering. For example, the regulators are inviting comments on whether the following changes would result in a cessation of grandfathered health plan status: (1) changes to a plan structure (such as switching from a health reimbursement account to major medical coverage or from an insured product to a self-insured product); (2) changes in the plan's provider network; (3) changes to a prescription drug formulary; or (4) "any other substantial change to overall plan design."

**Transition Rules**

Any changes made after March 23, 2010, and before the Interim Final Rules are first officially released to the public can be rescinded retroactively to maintain grandfathered status.

**Implications for Employers**

Employers should consider the following as they prepare for implementation of PPACA:

- Has the necessary disclosure statement been made to participants and beneficiaries about the grandfathered status of the plan?
- Have insurers changed since March 23, 2010?
- Have any changes been made after March 23, 2010, and before the publication of the Interim Final Rules that would trigger a loss of grandfathering? Consideration should perhaps be given to rescinding or modifying such a change.
- Are any plan changes being considered that would result in a loss of grandfathering?
• Are any alternative plan changes being considered that may achieve the same cost-saving objectives without exceeding the permissible thresholds set in the Interim Final Rules?

• Has there been an evaluation of the benefit of maintaining grandfathered status in relation to the value of making plan changes that would lead to a loss of grandfathering?

According to the HHS fact sheet, it is estimated that between 71 and 87 percent of large employer plans will remain grandfathered in 2011, but only 36 to 66 percent will retain this status by the year 2013. As for small employer plans, it is projected that between 58 and 80 percent will remain grandfathered in 2011, while in 2013 this range will drop to between 20 and 51 percent. Employers need to carefully weigh the advantages of grandfathered health plans status relative to the advantages of making plan changes that would result in a cessation of such status. As the value of the grandfathering provision diminishes over time, the choice between maintaining this status or implementing plan changes that prompt a loss of grandfathering will likely become more pronounced.

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2 Pub. L. No. 111-152.
New Health Care Claims and Appeal Rules Will Include a Tax Bite

By Russell Chapman

The Internal Revenue Service (IRS), and the Departments of Labor (DOL) and Health and Human Services (HHS) have issued interim final regulations imposing new requirements on internal appeals of adverse claims decisions under group health plans (both self-insured and insured) and requiring an independent external appeal process for denied group health plan claims under the Patient Protection and Affordable Care Act of 2010, as Amended (the “Act”).

The new requirements will be effective as of the first day of the first plan year beginning on and after September 23, 2010. Grandfathered plans are not subject to these new requirements. As a result, plans, insurance issuers, sponsors, and administrators who do not wish to invest the time, effort and expense of complying with the new rules, have an even greater incentive to avoid losing “grandfathered” status.

What Is Important About the New Internal and External Review Requirements?

The Act’s new provisions add a substantive requirement that did not exist for group health plans before. Prior to the Act, the Employee Retirement Income Security Act (ERISA) simply included a general requirement that a plan provide a “reasonable opportunity” for a claimant to obtain a “full and fair review” of any denied claims by the named fiduciary. However, there were no specific penalties provided for failure of an ERISA-covered plan to provide such a review procedure.

Under common law developed by the courts, Section 503 of ERISA implied a duty on the part of a claimant to a benefit under an ERISA plan to exhaust the plan’s administrative remedies prior to filing a lawsuit. In order to assure that the administrative remedies under a plan, and particularly a group health plan, were fair, the DOL promulgated extensive regulations, which were amended and expanded in 2001, to provide detailed requirements for the administrative claims and appeal
procedures under group health plans. These highly complex regulations (the "Section 503 Regulations") set forth an extremely detailed set of procedures for plan administrators to follow. While the inclusion of a compliant claim and appeal procedure was a substantive requirement of ERISA, the only likely consequence of a failure to either include or follow these regulations generally was that the claimant would be relieved of the obligation to exhaust the plan’s administrative remedies and could proceed directly to court with his or her claim. A substantial body of federal common law arose mitigating this “exhaustion” requirement, including a doctrine that the procedural requirements of the regulations would be deemed satisfied, and the exhaustion requirement would apply, if the plan administrator “substantially complied” with the regulations.3

In contrast to current rules, failure to comply with the Section 503 Regulations as modified by the new internal claims and appeals and external review processes requirements may subject a health plan sponsor or health insurance issuer to a $100 per day per violation excise tax imposed under the Internal Revenue Code, in addition to giving the claimant a green light to file suit.

The New Rules in General

The regulations:

1. provide enhanced requirements for “internal claims and appeal processes;”
2. require the application of external review processes under either state or federal law;
3. require that claim and appeal notices be provided in a “culturally and linguistically appropriate manner;” and
4. authorize the Secretary of Labor to deem certain external review processes in existence on March 23, 2010 (the date of enactment of the Act) as in compliance with the requirement to provide state or federal law external review processes.

Internal Appeal Procedures

The new regulations include six substantive and internal procedural requirements that will be available at the plan level through the plan administrator or insurer. The internal appeals procedures apply irrespective of whether the plan is self-insured or fully insured.

First, the regulations expand the definition of adverse benefit determination to include a rescission of coverage, except for failure to timely pay the covered person’s share of cost of coverage, or where the individual has not met the basic eligibility requirements of the plan. Currently, the term “adverse benefit determination” is all-encompassing, and includes any situation where a plan pays less than the amount submitted for payment.

Second, the regulations modify the Section 503 Regulations (without amending those regulations themselves) by requiring the administrator to notify the claimant of benefits determinations involving an urgent care claim as soon as possible, but not later than 24 hours after receipt of the claim (currently 72 hours under the Section 503 Regulations, which will continue to apply for “grandfathered” plans).

Third, if, during the course of the review, the administrator considers, relies on, or generates new or additional evidence, the new evidence must be provided to the claimant as soon as possible and in sufficient time to respond. Further, the written benefit determination or appeal must provide the claimant, at no cost, with the rationale for the decision, described in the new rules on explanations of benefits as a "discussion of the decision."

Fourth, a ban is now imposed on conflicts of interest on the part of decisionmakers. The regulations prohibit entities that make group health benefit plan decisions from basing hiring, compensation, termination, promotion, bonuses, or other employment decisions on the likelihood that the individual will deny benefits. Further, the regulations require plans to hire medical experts based solely on their professional expertise and not on their reputation for supporting denial of contested claims. These new
rules may require plan sponsors, third-party administrators, and group health insurance issuers, to make adjustments to their employment policies, job descriptions, and third-party services agreements.

Fifth, the regulations add a significant level of detail to the standard explanation of benefits (EOB). Required elements in an EOB denying a claim now include the date of service, provider, amount, diagnosis code, treatment code, reasons for the denial including the denial code, and corresponding meanings of all codes, standards for medical necessity used, and a “discussion of the decision.” Unfortunately for employers, insurers and third-party administrators, the “discussion of the decision” is not otherwise defined.4

Further, the EOB must disclose the availability and contact information of any health insurance consumer assistance office or ombudsman under the Public Health Services Act.

Finally, if the plan fails to strictly adhere to the new regulations, the claimant will be deemed to have exhausted all administrative remedies, and thus may proceed directly to court with his or her claim, even if the plan asserts that it substantially complied with the requirements, or that any error was only de minimis.

The plan must provide continued coverage pending the outcome of an internal appeal and must continue to comply with Section 503 Regulations. Claimants with urgent care claims or who are undergoing an ongoing course of treatment may be permitted to proceed with the next expedited external review claim concurrently with the internal appeal.

**External Review Requirements**

The new rules require plans to provide procedures for an external review by an Independent Review Organization ("IRO"). The regulations do not set forth these external review procedures in detail, and those rules must await further regulatory pronouncements. In general, the anticipated rules are expected to conform to the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners (the "Model Act").

**Insured Group Health Plans**

Generally, if at the time the regulations become effective, the plan is a fully insured plan or not subject to ERISA preemption, and is subject to a state law external review requirement that conforms to the provisions of the Model Act,5 the plan will be deemed to have complied with the external review processes requirement. Further, if the issuer providing benefits under a plan complies with applicable state law external review requirements, which are at least as stringent as the Model Act, the plan itself will be deemed to have complied with the requirements of the regulations.

Generally, fully insured group health plans, or plans not subject to ERISA preemption, that are subject to a state law required external review processes will be deemed to comply with the federal external review processes requirement for plan years beginning before July 1, 2011. During the intervening time, the Secretary of HHS will determine whether state law required external review processes meet the federal standard, by comparing the state law required processes to a list of minimum consumer protections, generally using the Model Act as a guide. These minimum consumer protections will include the following:

- **External reviews must be provided by an Independent Review Organization ("IRO") which is accredited and approved by the appropriate agency or organization, is free of conflicts of interest, and is assigned on a random or rotational basis from a list of approved IROs.**
- **IRO review must be provided for adverse benefit determinations that are based on medical necessity, appropriateness, setting, level of care, or effectiveness.**
- **If the state law requires exhaustion of the internal appeal process before proceeding to IRO review, such exhaustion will not be required if it has been waived by the carrier, or in the case of a request for external review concurrently with an ongoing expedited internal review.**
• The issuer must pay the cost of the external review, and claimants may not be charged more than $25 per IRO review, nor more than $75 for more than three IRO reviews in any one plan year.

• No minimum dollar amount may be imposed for external review of a claim, thus making external review a requirement even for nominal claim amounts.

• Claimants must be allowed at least four months to file a request for IRO review after the adverse benefit determination or final decision on the internal appeal.

• IRO review decisions must be binding on both the issuer and the claimant.

• The IRO must provide a decision within 45 days in the case of standard external review, and within 72 hours in the case of expedited external review.

• The plan must provide a description of the external review processes in summary plan descriptions, insurance policies, certificates of coverage, membership booklets, outlines of coverage or other evidence of coverage provided to participants, and maintain written records as required in the Model Act.

Self-Insured Group Health Plans

The regulations do not provide detailed federal external review processes requirements that would apply to self-insured plans or other plans and issuers that are not subject to a state law external review requirement. Rather, they indicate that these detailed requirements will be provided in future regulatory pronouncements. In general, the federal external review processes requirements will include requirements for: timeframes, rules for urgent care expedited review, time deadlines for providing decisions on external review, rules for accreditation of IROs, and other requirements that appear to be similar to those set forth under the state law external review procedures, and generally will likely follow the Model Act requirements.

"Culturally and Linguistically Appropriate" Notices

This fearsome-sounding requirement in fact adds little to existing DOL requirements that plans with participants who are literate in a non-English language must provide notices upon request in the non-English language if certain thresholds are met. These are: for plans with fewer than 100 participants, if more than 25% are literate in the non-English language, or for plans with 100 or more participants, if more than the lesser of 10% or 500 are literate in the non-English language.

Effective Date

The new requirements will be effective for non-grandfathered plans as of the first day of the first plan year beginning on and after September 23, 2010.

What You Need to Do Now

• Carefully determine the grandfather status of your plan and determine if such status will be maintained. If so, a plan sponsor must be careful with respect to the extent of changes that may be made to the plan.

• Make appropriate changes to employment policies and job descriptions to assure they are free from conflicts of interest.

• Third-party administrator service agreements must be reviewed and revised to assure they are free from conflicts of interest.

• Review plan claim and appeal procedures to determine compliance with current rules.

• Prepare for external appeal procedures compliance for non-grandfathered plans.
• Revise, amend or draft group health plan documents to comply with the new regulations. Documents such as summary plan descriptions, written plan documents, enrollment materials, benefit summaries and all claim related notices should be carefully updated.

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2 29 CFR § 2560.503-1.
3 Other judicially-developed doctrines had the effect of relieving the claimant of the explanation requirement, such the “futility” exception.
4 The dictionary definition of the term discussion suggests that this term means a "detailed consideration or examination of a topic." Therefore, a summary or conclusory explanation of the decision consisting of one or two sentences will no longer suffice for this purpose. For example, the commonly used claim denial language, “The claim is denied because the administrator has determined that the charges for the services exceed an amount that meets the Plan’s standard for Usual and Customary Charges for the services in the relevant medical market” will clearly not meet this expanded standard.
5 At the present time, 44 states have enacted the Model Act.
This worst-case scenario is possible for those staffing firms who offer coverage for permanent employees but not for assigned employees. Such firms will be determined to be employers who do not offer qualifying employer coverage to all full-time employees if, for such firms, even a single full-time employee receives a federal subsidy to purchase health insurance through the newly created health insurance exchanges. Under such circumstances, the Act imposes a $2,000 annual fee, prorated to $166.67 per month, on the staffing firm for each of its full-time employees in excess of 30, with the definition of full-time employee subject to further clarification.

**Definition of Full-Time Employee**

For purposes of the fees, the Act defines a *full-time employee* as one "who, with respect to a month, is employed on average at least 30 hours of service per week." By this definition, in most staffing firms, virtually all staff employees are full-time. The number of a firm's assigned employees who will be deemed full-time will depend on assignment patterns; day labor assignments are typically very short and intermittent, while clerical and professional assignments tend to be longer, with some continuing for years. Unlike earlier legislative proposals, which would have swept all assigned workers' hours together and then divided by 1,560 or 2,080 to produce the number of "full-time equivalents," the Act's fee calculation looks at each assigned worker's full-time status separately.

The fee calculation also depends on further (forthcoming) clarifications of how the definition of "full-time employee" applies to months in which assigned employees are hired, fired, or placed on or taken off assignment in the middle of the month.

Notably, the fee is imposed for all full-time staff or assigned employees, regardless of any coverage they might be receiving from the staffing firm or from other sources (such as a spouse's plan).

**Strategy A for Minimizing Costs: Meet Minimum Affordability**

Potentially less expensive calculation of "play or pay" fees

The Act provides a different fee calculation for employers who do offer qualifying employer coverage to all of their full-time employees ("full-time" as defined by the Act). In that situation, a fee of $3,000 per year (tested and prorated monthly) is charged only for those full-time employees who choose to receive government healthcare assistance, which requires that they have low income (varying by family size) and that the employee cost of the company-offered coverage exceeds 9.5% of their family income or that the employer coverage does not provide a minimum value. The total fees generated by this calculation method might be lower than the worst-case method described above, but they cannot be higher, since they are capped at the amount of the worst-case
method.

**Theoretical basis for minimizing costs**

A staffing firm might offer coverage to all of its full-time staff and assigned employees and pay for just enough of the cost of that coverage to make it "affordable" to most of its lower-paid employees, so that they would not qualify for the government health coverage assistance that triggers the $3,000 fees. The Act requires that offered coverage satisfy certain criteria, but there is no minimum percentage of employer cost contribution required for an offer of coverage. "What the plan must pay in benefits" and "who must pay for the plan" are very different concepts.

This alternative gives rise to a financial balancing act. The degree to which a staffing firm subsidizes its offered coverage will affect the affordability of that coverage and thus will affect the number of the staffing firm's employees who could qualify for tax credits or cost-sharing reductions. The greater the staffing firm's premium contribution, the fewer of its employees could qualify for the tax credits or cost-sharing reductions and the fewer $3,000 fees the staffing firm would have to pay.

So, the question is: Can a staffing firm fashion a health plan for all of its full-time employees that is generous enough in its benefits to satisfy the government's coverage requirements and still be inexpensive enough (after any premium contributions by the staffing firm) to prevent too many of the staffing firm's employees from qualifying for the "unaffordability" tax credits that trigger the $3,000 per year per employee fee?

The financial comparison should be simple:

\[
\text{Cost of additional staffing firm premium contributions to the offered coverage} \\
+ \text{Administrative expense of tracking the insurance and the tax credit status of employees} \\
+ \text{Cost of $3,000 fee for each full-time employee who qualifies for a tax credit}
\]

\[
\text{Total cost of alternative "play or pay" fee calculation}
\]

\[
\text{Compared to:}
\]

\[
$2,000 \text{ per year fee for all of the staffing firm's full-time employees (minus 30)}
\]

The actual "play or pay" fee would be the lesser of the two results shown above. The only problem with this idea is that typical staffing firms cannot precisely predict which of these will be lower, since they do not collect data on the family size and household incomes of their employees and also cannot predict how many employees who qualify for tax credits or cost-sharing reductions will actually go through the administrative process of qualifying. Whether this strategy would be practical would depend on the degree to which these factors could reasonably be estimated and whether they would be stable over time. The staffing industry may lobby to obtain changes that would make this alternative
more promising by relaxing the requirements for offered coverage.

**Strategy B for Minimizing Costs: The 29-Hour Work Week**

An obvious technique for minimizing the cost of the new law would be a practice of limiting assigned workers to a 29-hour work week or monitoring their monthly hours to achieve a sub-30-hour-per-week monthly average.

For purposes of the fees, the Act defines a *full-time employee* as one "who, with respect to a month, is employed on average at least 30 hours of service per week." Therefore, fees will not apply for those assigned employees working fewer than 30 hours on average, because they are not statutory full-time employees.

These workers will nonetheless be expected to either acquire coverage or pay a fee by 2014. It is possible that, long term, these costs will eventually also be shifted to the employer, but for now, it presents a unique opportunity for placement growth of part-time workers.

This technique would seem more workable for assigned employees than for a staffing firm's full-time employees, and the current level of unemployment would seem to make it achievable by giving more people shorter assignments without reducing the total amount of employment provided.

**Fees Not Tax-Deductible**

No matter how these variables and contingencies turn out, these fees are likely to be very expensive. What will make these fees even more expensive is that the law makes them non-tax-deductible (unlike other direct labor costs that are tax-deductible "above the line," such as FICA and workers' compensation premiums). That means that, if the staffing firm is in tax-paying status, additional before-tax gross margin even greater than the $2,000 or $3,000 a year fee for each full-time (or tax-credit-qualified) assigned employee must be generated for the staffing firm to pay the fees without suffering loss of profitability on its assigned employee.

Finally, the basic fee amount will increase every year at the rate that insurance premiums increase. As staffing firms weigh the cost of providing health care coverage against the "play or pay" fees that become effective in 2014, they must also consider the impact and costs associated with the Act's new insurance market reforms.

**Effects on Staffing Firm Sales, Bill Rates and Margins**

For those companies who retain staffing firms and use assigned employees and already provide health insurance coverage to most or all of their employees, the Act may not increase their labor costs or may even decrease them. The labor
costs of staffing firms, however, are sure to increase drastically.

There are only three ways that this extra labor cost can be absorbed – by staffing customers through higher bill rates, by staffing firms through lower operating margins, or by the assigned employees through lower wages.

Staffing Industry Analysts has estimated that, on average, the cost advantage to a staffing customer from using an assigned employee instead of using its own direct employee is in the range of 10% to 20%.

To the extent that staffing customers absorb these costs as higher bill rates, that cost advantage would shrink, staffing customers might accordingly decrease their usage of assigned employees, and aggregate demand for staffing services might drop. To the extent that these costs are imposed on assigned employees through lower wages, recruiting efforts and assigned employee quality might suffer. To the extent that staffing firms absorb these costs, the staffing industry's profitability going forward will be significantly burdened.

**Contractual and Administrative Challenges Caused by the Fees**

Many staffing firms have agreements in place with their customers permitting the staffing firms to pass through to the customers any newly imposed or increased governmental fees, taxes, contributions, or premiums that are directly related to the labor of the assigned employees.

Although the terms of such contractual provisions may vary, such provisions may allow the staffing firm to send a special "no markup" billing to the customer for the new costs until the new costs can be integrated into the customer's contractual billing rates at contract renewal. Therefore, the imposition of "play or pay" fees raises contractual and administrative issues for staffing firms and their customers.

Many assigned employees work irregular schedules, at different rates, for multiple customers. This pattern can raise issues, such as: whether a customer is liable for any portion of the fees when its usage of a full-time employee was less than 30 hours; how the monthly fees should be allocated to multiple customers when the employee is clearly full-time; how to allocate such costs when the pay and bill rates of the various assignments are different; and how customers can audit the allocation of these fees.

Other issues might include: whether the actual cost of the fee to the staffing firm is the before-tax cost or the after-tax cost; how to account to customers for a before-tax cost; making contractual provision for the increases in the basic fee amount after 2014; and, perhaps most daunting in light of the staffing industry's dominant weekly billing cycle, the monthly lag in determining whether each assigned employee qualified as full-time for the previous month. Separate and
delayed billings for these fees would increase and complicate the billing, collection, and accounting functions of staffing firms and their customers.

It would be possible to estimate these costs at an annual staffing-firm-wide level and simply bill customers a flat, prorated fee amount or percentage for each hour worked by assigned employees. That would be administratively convenient, but it might be a disadvantageously blunt instrument for purposes of competition and purchasing efficiency. The per-employee fee amounts to approximately $1.00 per hour, and staffing firms compete over much smaller amounts of hourly cost.

Since many staffing contracts are for terms of three or more years, many contracts now in force or being negotiated will still be in force when the law takes effect. Staffing firms and staffing customers should already be thinking about and talking with each other about how to address these contingencies and calculations to avoid disputes from arising when the "pay or play" fees take effect on January 1, 2014.

Proper planning is all the more important to the extent that fees charged to the staffing firms for staff employees are not directly passable to customers since they are not direct labor costs of the assigned employees.

**Non-discrimination Rules**

A portion of the new law that has not generated much discussion but which may have a significant impact on the staffing industry is a section that will require qualified insured group health plans, and the insurance companies providing them, to offer coverage only on a basis that does not discriminate in favor of highly compensated employees (defined as the highest-paid 25% of all employees). That could mean that, even if a limited value plan could be offered to assigned workers at a cost that would save on the staffing firm's "pay or play" fees, the entire coverage scheme might fail to qualify unless the staff employees are required to have the same low-value plan that is offered to the assigned employees.

It is likely that the top 25% of the most highly compensated employees of staffing firms will cover most or all of the firm's internal employees. Such plans may have difficulty showing that they are not discriminatory in favor of the highly compensated under this new law. If plans are found to be discriminatory, the statutory penalties are very heavy – $100 per day of discrimination for each person against whom the plan discriminates.

If staffing firms are self-insured for health coverage, they are not directly affected by this new provision, because they are expressly excluded from it and because they already have to comply with the non-discrimination requirements for tax purposes. However, this provision may draw new attention to the
enforcement of the non-discrimination rules that the Act borrows from Internal Revenue Code section 105(h), which imposes adverse tax treatment in connection with self-insured plans that discriminate in favor of the 25% who are the highest compensated employees.

For the indefinite future, the Act's nondiscrimination provision will not apply to "grandfathered" health plans, but the catch is that grandfathered status is expected to be extremely difficult for insured health plans to maintain for very long, even assuming that insurance companies continue to make such obsolescent plans available.

Silver Linings

There are also two possible upsides to the legislation.

**Increased Health Care, IT, and Administrative Employment**

The prospect of millions of additional Americans seeking healthcare might suggest a surge in demand for healthcare workers of all kinds, including those provided by staffing firms.

However, very few Americans have actually been going without healthcare. As a matter of policy, ethics, and sometimes law, hospitals and other providers have treated the poor and uninsured without regard for their ability to pay and have passed those costs on to the paying institutions and individuals.

This Act expands insurance options and changes the distribution of costs, but it does not directly expand health care itself. Perhaps people who are newly insured will consume more services in an atmosphere of entitlement than they were receiving on a charity basis, but even this increase in services might be offset by limitations on services under the new system.

It may be that the heavy new administrative burdens placed on employers and others will create new demand for IT services, clerical services, and consulting services.

**Transfers of Staffing Customers' Uninsured Employees to Staffing Firms**

Some staffing customers may have components of their workforces to whom they do not offer health coverage. In order to become employers deemed to offer coverage to all of their full-time employees, such customers might want to transfer these employees to staffing firms. The customers would still be indirectly paying the fees for the transferred employees, but they would be relieved of paying the fees for all of their remaining full-time employees.

**Some Recommended Actions for Staffing Firms**
o Determine the "grandfathered" status of your present health plans.
o Determine (with your insurance company, if you use one) what changes to
health coverage need to be made between now and 2014.
o Learn the various new notice and reporting requirements.
o Estimate the "play or pay" fees for your mix of employees and gross them
up for your marginal tax rate, to determine how much additional gross
margin would be required to cover this extra cost starting in 2014.
o Have your health plans tested for discrimination under the rules of Internal
Revenue Code section 105(h).
o Develop an overall long-term strategy of health coverage for staff and
assigned employees.
o Identify the extent to which existing timecards, purchase orders, and
contracts with your customers enable you to pass on the cost of "play or
pay" fees to those customers.
o Decide upon a strategy for adjusting to "play or pay" costs (e.g., socialize
them in company-wide bill rate levels; pass on to customers the costs of
their assigned employees; absorb the fees with adjustments to specific pay
rates, bill rates, and margins, etc.)
o Develop model language to include in new or renegotiated contracts that
would clarify who has the burden of "play or pay" fees and provide
calculation, billing, and audit procedures for when they are passed on to
customers.
o Identify potential opportunities for customers to transfer uninsured
employee groups to your employ (if that continues to be a viable option).

1 The Act uses the phrase "offer to its full-time employees" to distinguish two
categories of fee-paying employers (those who do offer coverage and those who
don't), but it does not expressly require the offer to be made to "all" such
employees, leaving open the possibility that offering coverage to just some
employees, as staffing firms do, would be sufficient for them to qualify as
employers offering coverage. However, the report of the joint tax committee,
which is the most formal legislative history available at this time, does use the
word "all" when explaining this distinction.

2 The "play or pay" fees apply to "applicable large employers" – those employing
more than 50 full-time employees. Solely for the purpose of determining whether
an employer is an applicable large employer, the hours of part-time workers are
included in calculating whether the employer exceeds this threshold. The number
of full-time equivalents is determined by dividing the aggregate number of hours
of service of part-time employees for the month by 120.

3 The Act allows companies to deduct 30 employees from the total number of
employees taken into account for purposes of calculating this fee. Since employing large numbers of people is the business of staffing firms, that deductible will not be much relief to most staffing firms.

4 For example, assume that a temporary employee is hired and assigned on February 16, 2015, to work 40 hours per week. One view is that his 80 hours for the last two weeks of the month would be averaged over all of February's four weeks, yielding a 20-hour-per-week average that falls below the average-30-hour-per-week threshold for full-time. However, another view is that the definition refers to the average weekly hours for the time that the person "is employed;" our sample employee was not employed during the first two weeks of February, and if his 80 hours are averaged only over the two weeks during which he was employed, his 40-hour-per-week average would qualify him as full-time. The same issue occurs when assignments end in the middle of months.

5 To provide minimum value, the employer-sponsored plan's share of the total allowed costs of benefits provided under the plan must be at least 60% of such costs.

6 The cost of comprehensive health care coverage is usually several times greater than the $2,000 or $3,000 annual fee rates.

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