

## CLIENT BULLETIN

### *Summary of Selected Provisions of the Health Care Reform Bills*

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In this *Client Bulletin* we will take a look at selected provisions of the health care reform bills passed by Congress and signed into law by the President over the past week, focusing on provisions affecting self-insured multiemployer health plans. In another issue, we will take a look at the effect of the law on employers.

To recap, on Sunday March 21, 2010, the United States House of Representatives passed H.R. 3590, *the Patient Protection and Affordable Care Act (PPACA)* that was previously passed by the Senate on December 24, 2009. In addition, the House also passed a reconciliation bill (H.R. 4872) aimed at tweaking the just passed H.R. 3950. After some minor changes related to Pell grants for low-income students, this reconciliation bill was passed by the Senate and repassed by the House. Both bills were signed into law by the President.

That was the easy part. The harder part is to determine exactly what the laws mean and when they are effective. This problem is related to the fact the law is lengthy, complex and uses circular definitions, making it hard to discern the exact meaning of certain parts of the law. Another confusing notion is that upon reading the text of the bills, they are aimed at amending the *Public Health Service Act (PHSA)*. This appears to be confusing, as one would expect the laws to be aimed at amending the *Employee Retirement Income Security Act of 1974 (ERISA)* and the *Internal Revenue Code (Code)*.

But, like many things in the laws, its effect on *ERISA* and the *Code* was hidden away in Sections 1562(e) and (f) of the *PPACA*. Subsection (e) adds a new *ERISA* Section 715 that incorporates by reference the provisions of part A of the Title XXVII *PHSA*, as amended by the *PPACA*, into *ERISA*. Subsection (f) does the same for the *Code*. Both Sections contain certain qualifiers, including the fact that the *PPACA* trumps any *ERISA* or *Code* provisions that contradict the *PPACA*. *PPACA* Sections 1562(e) and (f) are available by "[clicking here](#)." Links to the *PPACA*, the reconciliation bill and other helpful resources are available at the end of this *Client Bulletin*.

As noted above, as people started reading the actual text of the legislation instead of just the House summaries, it has become apparent that not all is clear in the laws. Moreover, the laws are like the structural steel in a building and give only the broad outlines of the shapes of things to come, but the details will need to be fleshed out in regulations and guidance and perhaps even through a technical corrections bill. Even though many of the items discussed below also impact individual insurance policies in addition to group health plans, we will only discuss them in terms of the effect on group health plans.

One should note that the major structural reforms affecting the health insurance market, the employer “play or pay” rules and the mandate for individuals to purchase health coverage if they do not have it do not take effect until January 1, 2014. In the interim, numerous court challenges to the law have already been filed.

### **Introduction**

First, to give one an idea of the complexity of the laws we would note that the *PPACA* clocks in at either 2,409 or 906 pages (depending on the PDF version accessed) and consists of 10 Titles, 60 Subtitles and 440 Sections. The reconciliation bill clocked in at 150 pages with 2 Titles, 8 Subtitles and 57 Sections. To make matters more complicated, Title 10 of the *PPACA* consists of amendments to Titles 1-9 and these Titles must be read in light of those amendments.

As if that wasn't complicated enough, the reconciliation bill then amends the *PPACA*. The complex and apparently contradictory Sections of the bills have been noted in published reports and divergent views of the delayed effective date for group health plans maintained under CBAs already exist. However, in spite of this complexity, we will paint in broad brush strokes the highlights of the law as it pertains to multiemployer group health plans, especially self-insured ones. The law itself addresses many other areas, including the individual and group insurance markets and plans, as well as employer and individual coverage mandates, in addition to other reforms.

## **Group Health Plan Reforms**

The two main questions we have received at the Research Department from our readers are: (1) “what does our health plan have to do?” and (2) “when does it have to comply?” As a prelude, the items discussed below will either be effective for the first plan year beginning on or after September 23, 2010, which would be January 1, 2011 for calendar year plans.

There is a delayed effective date for some group health plans maintained under CBAs, but the effect of that extension was somewhat muddled by the reconciliation bill and the use of circular definitions. We'll take a look at the effective date issue later. When reading what plans must do, keep in mind that when they must comply probably won't be clear for a little while. When the effective date issue for CBA plans is clarified we will report on that immediately.

In addition to muddying the effective dates for some reforms, there is uncertainty as to the application of some reforms to “grandfathered” plans. “Grandfathered plans” are plans in effect as of March 23, 2010. Originally, the *PPACA* exempted grandfathered plans from the *PPACA* reforms (see *PPACA* Section 1251) but the amendments at Section 10103 of the *PPACA* and the amendments at Section 2301 of the reconciliation bill make the reforms concerning annual limits, pre-existing conditions and adult dependent coverage applicable to grandfathered plans effective for the first plan year beginning on or after September 23, 2010, which would be January 1, 2011 for calendar year plans. How this relates to plans covered by CBAs is unclear.

**Remember that group health plans existing on March 23, 2010 (“grandfathered plans”) are NOT required to implement the *PPACA* reforms unless the law specifically requires such, as mentioned above.**

One emerging view holds that the exceptions for excessive waiting periods (Section 2708); prohibition on lifetime limits (Section 2711); rescissions of coverage rules (Section 2712); extension of dependent coverage (Section 2714); uniform explanations of coverage and standardized definitions (Section 2715); and bringing down the cost of health coverage (Section 2718) apply to CBA plans the later of when the expiration of the last CBA relating to coverage expires or the date the changes would otherwise be applicable. It would make sense for CBA plans to have a delayed effective date as was the case with the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*. We have not taken a position on the matter, but anticipate that guidance clarifying the effective dates will be given in a timely manner. In the interim, group health plans maintained pursuant to CBAs may wish to prepare for the worst – no delayed effective date and hope for the best – delayed effective date.

Reading the *PPACA* in conjunction with the reconciliation bill, the items of immediate interest to group health plans are found in Title I of the *PPACA*, as amended. Title I, Section 1001, lists the reforms for the individual and group markets. Section 1001 adds Sections 2711-2719 to the *PHSA*, which as noted above, most of which are incorporated by reference into *ERISA* and the *Code*.

Let’s take a look at each of the above mentioned Sections added to the *PHSA*.

### **Section 2711- Prohibition on Lifetime Limits**

Section 2711 prohibits lifetime limits on the dollar value of benefits for any participant or beneficiary and also prevents “unreasonable annual limits” on the dollar value of benefits for any participant or beneficiary. To make matters clear as mud, Section 2711 allows plans that are not required to provide certain “essential health benefits” to place annual or lifetime limits per beneficiary on “specific covered benefits” to the extent allowed by federal or state law. What that means is anyone’s guess. To be safe, group health plans should be prepared to remove lifetime limits and make sure they don’t have any “unreasonable annual limits.”

### **Section 2712- Prohibition on Rescissions**

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This Section prohibits group health plans from rescinding coverage on an “enrollee” under the plan except for acts that constitute fraud or an intentional misrepresentation of material fact prohibited by the plan. The House summary states the purpose was to prevent health plans from dropping people who become sick, usually people with high-cost claims. However, that “sickness” qualifier is not in the text. Read literally, these are the only two reasons coverage could be rescinded, which is nonsense. If a person does commit fraud or an intentional misrepresentation, they must first be give notice before being dropped.

### **Section 2713 – Coverage of Preventative Health Services**

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Section 2713 requires group health plans to provide coverage for the following “wellness” items. Plans are prohibited from imposing any cost-sharing requirements (meaning the group health plan must “pick up” first dollar expenses) on these benefits:

- (1) evidence-based items or services that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force;
- (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
- (4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- (5) for the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be those considered the most current other than those issued in or around November 2009.

We will provide more detailed information on the specific recommendations in a future publication.

### **Section 2714 – Extension of Dependent Coverage**

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Section 2714, as amended by the reconciliation bill at Section 2301(a), requires that group health plans that provide dependent coverage of children shall continue to make such coverage available until the child turns 26 years of age, even if married. Before January 1, 2014, this extension only applies if the dependent is NOT eligible to enroll in different employer-sponsored health plan. It appears that the “dependent” rules concerning a “qualifying child” or “qualifying relative” under the Code would still apply.

## **Section 2715 - Development and Utilization Of Uniform Explanation of Coverage Documents and Standardized Definitions**

Section 2715 requires the government to develop standards for providing participants a 4-page or less summary that describes benefits coverage under the group health plan and that uses uniform definitions of standard insurance and medical terms, as well as other information. These standards are to be developed by March 23, 2011 and group health plans will be required to use such documents and information for participants and others by March 23, 2012. This is in addition to the current Summary Plan Description (SPD) requirements. If a CBA group health plan's last CBA relating to the plan expires at a later date, the later date may be the effective date.

## **Sections 2716 -2719**

Section 2716 (Prohibition on Discrimination in Favor of Highly Compensated Individuals); Section 2717 (Ensuring the Quality of Care); Section 2718 (Bringing Down the Cost of Health Care Coverage) and Section 2719 (Appeals Process) appear to have little immediate impact on multiemployer group health plans. Sections 2717 and 2718 implement new reporting requirements for some group health plans that are not effective until 2012.

## **Other Group Health Plan Reforms**

Group health plan reforms are also found in other Sections of the PPACA. In particular, *PPACA* Section 1201, as amended by Section 10103 (amending Section 1253 of the *PPACA*) and further amended by the reconciliation bill at Section 2301 prohibits pre-existing condition exclusions for dependents under age 19 for the first plan year beginning on or after September 23, 2010, which would be January 1, 2011 for calendar year plans. The prohibition on preexisting exclusions would generally be applicable to all participants beginning January 1, 2014.

## **Reinsurance for Early Retirees**

Section 1102 of the PPACA provides for a temporary reinsurance (subsidy) to employer-based group health plans for a portion of the cost of providing health care coverage to "early retirees and their eligible spouses, surviving spouses and dependents of such retirees." This program is to be established within 90 days of passage of the law or on or about June 23, 2010 and runs through January 1, 2014.

An "early retiree" is defined as an individual who is not an "active" employee age 55 or older but who is not eligible for Medicare. To participate, such group health plan must: (A) implement programs and procedures to generate cost-savings with respect to participants with chronic and high-cost conditions; (B) provide documentation of the actual cost of medical claims involved and (C) must be certified by the Secretary of Health and Human Services (HHS) as doing so.

To be eligible for reimbursement, a claim must be between \$15,000 and \$90,000, with reimbursement limited to 80% of the amount of the claim between those limits. The amounts reimbursed to the group health plan must be used to reduce the cost of coverage and not as general revenue. For example, such reimbursements should be used to reduce premium contributions, copayments,

deductibles, coinsurance or other out-of-pocket costs to the early retired participants.

The law sets aside five billion dollars to fund these reimbursements.

### **The Effective Date of the PPACA Group Health Reforms**

Section 1004 of the *PPACA* set an effective date of the first plan year beginning six months after the date of enactment or January 1, 2011 for calendar year plans. However, Section 1251(d) had an extended effective date for plan coverage tied to CBAs. This extended date is the date the last CBA relating to coverage terminates. But, reading that Section in light of the amendments made by the reconciliation bill and the definitions in the *PPACA* supported the conclusions that the delayed CBA effective date applied only to insured CBA plans. The path to this conclusion involves looking at the definitions of the *PHSA* Section 2791 which are incorporated into Title I (Sections 1001-1563) of the *PPACA* by *PPACA* Section 1301.

Rather than burden the text of this *Client Bulletin* with this three page discussion and examination of the definitions, interested readers may access this discussion by "[clicking here](#)." As noted earlier, one emerging view is that certain items will not be applicable to CBA related group health plans until the of the expiration of the last CBA relating to coverage expires or the date the changes would otherwise be applicable.

### **Conclusion**

In summary, the detailed answers that we are all looking for are not quite contained within these laws. We will report to you as more information or clarifications of effective dates for CBAs and any other relevant guidance as it is issued. We will also report on the effects of the *PPACA* on employers shortly. The employer "pay or play" rules (i.e. offer coverage or pay a fee) don't take effect until January 1, 2014.

### **Additional Resources**

The text of the H.R. 3590 is available by "[clicking here](#)." The text of the reconciliation bill is available by "[clicking here](#)."

Other helpful general summaries prepared by the House speaker's staff are available at: <http://www.speaker.gov/newsroom/legislation?id=0361>. These summaries are generally for non-CBA plans as far as effective dates, but provide a roadmap for what lies ahead.

The IFEBP has an excellent resource page gathering many industry summaries on its health reform page located at:

<http://www.ifebp.org/Resources/News/TopicsInDepth/Health+Care+Reform+Discussion/EducationalOpportunities.htm>. Go to the tab on the right side of the page entitled *Analysis Of Reform Provisions*.

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