The Supreme Court Upholds the Patient Protection and Affordable Care Act: Now What?

Employee Benefits and Compensation Planning Alert

June 2012

On Thursday, June 28, the United States Supreme Court issued its long awaited decision on the constitutionality of The Patient Protection and Affordable Care Act (PPACA). While lawyers, scholars and pundits will spend lots of time debating various aspects of the decision, plan sponsors have to be more focused on the practical implications. Essentially, the decision tells us that we have to continue to work to comply with the Act.

Compliance for health plans requires specific changes to the benefits being provided by the plan. It is essential that plan sponsors not overlook the ERISA implications of making changes to comply with PPACA. Fiduciaries have to make sure not only that required changes were made, but also that they were made correctly and that there is appropriate documentation demonstrating the amendments to their plans.

As of today, some of the key changes required by PPACA should already be in effect. Plans should have been amended to include:

Auto Enrollment. Employers with more than 200 employees that offer coverage must automatically enroll new full-time employees in coverage with the opportunity to opt-out.
Pre-existing Exclusions. No pre-existing exclusions for enrollees under age 19.
Dependent Coverage. Extension of coverage of adult children to age 26.
Coverage Rescissions. Coverage cannot be rescinded absent fraud or intentional misrepresentation by the enrollee.
Lifetime Limits. No annual or lifetime dollar limits on "essential" benefits.
Appeals Procedures. Appeals process required to allow for appeals of coverage determinations and claims (includes internal appeals and external review).
External Appeals. The regulations require group health plans and insurers to comply with applicable external review process in states that have implemented such a process.
Emergency Services. Must cover emergency services without prior authorization and in-network.
Primary Care Provider. Must allow designation of OB/GYN and pediatrician as Primary Care Provider.
Preventative Care. Must cover preventive care without cost sharing.

Now, with the Act being upheld, plan sponsors have to address the upcoming compliance issues.

For 2012:

W-2 Reporting. Employers must include aggregate cost of employer-sponsored health coverage on annual Form W-2.
Summary of Benefits Coverage. Insurers and plan sponsors of self-funded plans must provide summary of benefits to all participants and applicants, based on format set by Secretary, using

uniform definitions and stating whether the plan provides minimum essential coverage and whether ensures the plan's share of costs is at least 60 percent of actuarial value.
Advance Notice of mid-year changes. Plan must provide 60-days advance notice of changes to summary of benefits.
Quality of Care Reporting. Plans and insurers must report on plan benefits and reimbursement structures that provide incentives for the implementation of case management, care coordination, chronic disease management and medication and care compliance activities for treatment or services under the plan or coverage; the implementation of activities to prevent hospital readmissions; improving patient safety and reducing medical errors through best clinical practices, evidence based medicine and health information technology; and the implementation of wellness and health promotion activities.
Nondiscrimination. While originally intended to be effective in 2011, nondiscrimination rules will generally apply to fully insured plans just as they apply to self-insured plans as soon as guidance is issued. We expect that guidance will be issued in 2012.

Now that we are no longer waiting for a decision, plan sponsors should be especially focused on making sure their plans and reporting practices comply with these components of the Act.

When 2013 comes around, there are a couple of other key components that have to be considered:

Flexible Spending Account Changes. Limits FSA contributions to $2,500, indexed in future years.
Employer notice requirements. Effective March 1, 2013, Employer requirement to provide written notice informing employees about the Exchange, and their potential eligibility for premium credits if the employer's share of costs is less than 60 percent of the allowed total cost of benefits.

There will certainly be more clarification on these requirements, particularly the notice requirement, once the rules related to the exchanges are finalized.

If you have not complied with the pre-2012 changes, or you have question or concerns about compliance with the 2012 and 2103 requirements, you are not alone. Your attorneys at Fox Rothschild are prepared to assist in all aspects of compliance from education to assistance in drafting amendments and notices you need to fully comply with PPACA.

If you have questions about this Alert, please contact Keith R. McMurdy or Sarah K. Ivy or any member of Fox Rothschild’s Employee Benefits and Compensation Planning Practice.