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Articles in this Edition

RECENT LEGISLATIVE ACTIVITY

Senate Committee Examines PPACA Impact on Health Insurance Premiums

On August 2, the U.S. Senate Health, Education, Labor and Pensions (HELP) Committee held a hearing, Health Reform and Health Insurance Premiums: Empowering States to Serve Consumers, to examine the impact of the Patient Protection and Affordable Care Act (PPACA) on health insurance premiums. Committee Chairman Tom Harkin (D-IA) opened the hearing by touting the success of PPACA in bringing increased competition to health insurance markets, but lamented that the law's provisions have not had the desired effect of reducing premiums in the small group and individual markets.

Ranking Republican committee member Michael Enzi (R-CA) argued that premium increases are being driven by increases in health care costs, which have been exacerbated by the enactment of PPACA. He suggested that the health care law's reductions in payments to Medicare providers have shifted costs to private payers.

Senator Diane Feinstein (D-CA) appeared first before the committee to provide a statement in which she cited evidence that recent premium increases have outpaced both inflation and wage growth while decrying record insurance company profits and CEO pay. She urged the committee to pursue legislation that would give state insurance commissioners the authority to block or modify unjustified premium rate increases.

The first official witness to testify before the committee was Steve Larsen, director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services. He described CMS' efforts to enhance review of insurance company rate increases, including outreach to states and development of medical loss ratio standards.

The committee also heard testimony from the following witnesses:

- John Dicken, director of health care at the U.S. Government Accountability Office, revealed the results of a report, Private Health Insurance: State Oversight of Premium Rates, commissioned by Harkin and Feinstein. He noted that nearly all (48 of 50) of the state officials who responded to the GAO survey reported that they reviewed rate filings in 2010, though the practices reported by state insurance officials varied in terms of the timing of rate filing reviews, the information considered in reviews, and opportunities for consumer involvement in rate reviews.
- Teresa Miller, administrator for the Oregon Insurance Division of the Department of Consumer and Business Services, discussed her experience reviewing rate increases in Oregon and outlined improvements the state is pursuing with funding through grants under PPACA.
- Daniel C. Withrow, president of CSS Distribution Group, Inc. (a packing and distribution company in Louisville, KY), testifying on behalf of the U.S. Chamber of Commerce, described the burdens that PPACA has placed on businesses to grow and create jobs. "Despite efforts to expand coverage options and curtail dramatic health insurance premium increases, the law in fact is having a negative impact on our ability to continue to offer our employees' health care benefits," he said.

While much of the question-and-answer period was devoted to a discussion of whether the PPACA is contributing to the premium increases or helping to mitigate them, legislators

demonstrated more bipartisan consensus on the need for both businesses and state insurance commissioners to exert more negotiating leverage over insurance rates.

RECENT REGULATORY ACTIVITY

Administration Proposes Regulations on Required Summary of Benefits Under PPACA

On August 17, the U.S. Treasury Department, Department of Labor (DOL) and Department of Health and Human Services (HHS) ("the departments") jointly released proposed regulations for implementation of the Summary of Benefits and Coverage (SBC) and uniform glossary requirements of the Patient Protection and Affordable Care Act (PPACA). As explained in the departments' news release and fact sheet, the SBC is intended to provide consumers with consistent and comparable information regarding health plan benefits and coverage. The departments simultaneously issued guidance in the form of a Solicitation of Comments (SOC) that proposes a template for SBCs, instructions, sample language other appendices for use by insurers and health plans to satisfy the requirements of the NPRM. Both documents solicit general and specific comments on a range of implementation issues of concern to plan sponsors.

*Notice of Proposed Rulemaking*Section 2715 of the Public Health Service (PHS) Act, as added by PPACA, directs the regulatory departments to develop standards for use by a group health plan and a health insurance issuer in compiling and providing to participants an SBC that "accurately describes the benefits and coverage under the applicable plan or coverage."

The proposed regulations generally parallel the content elements set forth in the statute. The statutory provision generally provides that the SBC must include:

- uniform definitions of standard insurance and medical terms;
- a description of coverage; exceptions, reductions or limitations in coverage;
- cost-sharing provisions of the coverage;
- renewability and continuation of coverage provisions;
- a "coverage facts label" — referred to as "coverage examples" in the proposed rules and similar to a "Nutrition Facts" label required for packaged food — to illustrate three common benefit scenarios: having a baby, treating breast cancer and managing diabetes;
- a statement about whether the plan provides "minimum essential coverage" as defined under PPACA's individual responsibility provision;
- a statement that the SBC is only a summary and that the plan document should be consulted to determine the governing contractual provisions of coverage; and
- a contact number to call with questions and an Internet web address where a copy of the group certificate of coverage can be obtained.

PPACA specifically directed the departments to consult the National Association of Insurance Commissioners (NAIC) in the development of these standards. The NPRM released on August 17 proposes implementing the NAIC recommendations without modification. These regulations generally propose standards for group health plans (and their plan administrators), and health insurance issuers offering group or individual health insurance coverage. The standards govern who provides and receives an SBC, when and how it will be provided, and its contents.

The NPRM and the SOC document detailed below request general and specific comments on many implementation issues with the departments in recent months. Several sections of the preamble to the NPRM outline and invite comment on potential approaches to major elements of the SBC "in the interest of streamlining standards and making implementation of the components as user-friendly and as workable and efficient as possible. According to the preamble, the departments have already heard "concerns about the potential redundancies and additional cost[s] associated with elements of the SBC requirement — including the uniform glossary and the coverage facts labels (referred to as "coverage examples" in the proposed rules) — particularly for those plans and group health insurance issuers that already provide a Summary Plan Description (SPD)" under current law. Comments are invited on the subject of "whether the SBC should be allowed to be provided within an SPD if the SBC is intact and prominently displayed at the beginning of the SPD and if the timing requirements for providing the SBC are satisfied," as well as other issues that may affect implementation of the regulations.

PHS Act Section 2715 generally directs group health plans and health insurance issuers to comply with the SBC requirements beginning on or after March 23, 2012. The departments request comments "regarding factors that may affect the feasibility of implementation within this timeframe." The departments, in recognition of existing disclosure requirements for those health plans that already provide SPDs to participants "and concerns raised about providing SBCs by the statutory deadline" solicit comments on practical considerations that might affect timing of implementation, including potential phase-in of the implementation of the coverage example requirements.

"Solicitation of Comments" (SOC) Document

In conjunction with the NPRM, the departments issued the SOC to provide materials to help group health plans satisfy these requirements, including:

- a template for an SBC;
- instructions, sample language, and a guide for coverage example calculations to be used in completing the template; and
- a uniform glossary that would satisfy the disclosure requirements under the PHS Act.

The materials, provided in the SOC in appendix form, were developed in consultation with the NAIC. The guidance acknowledges that "changes to the SBC template may be appropriate to accommodate various types of plan and coverage designs, to provide additional information to individuals, or to improve the efficacy of the disclosures recommended by the NAIC," and requests comments on suggested modifications. The SOC also notes that the SBC template and related documents were drafted by the NAIC primarily for use by health insurance issuers and additional modifications may be needed for some group health plans. Clearer versions of these appendix documents are also available on DOL's PPACA website.

Administration Proposes New Rules on Subsidy Eligibility, Health Insurance Exchanges

On August 12, the Obama Administration issued proposed regulations implementing certain elements of the Patient Protection and Affordable Care Act (PPACA): an Internal Revenue Service (IRS) notice of proposed rulemaking (NPRM) on the Health Insurance Premium Tax Credit and Department of Health and Human Services (HHS) proposed regulations on exchange functions in the individual market (including eligibility determinations and standards for employers).

Under PPACA, the state-based, competitive marketplace-style "Affordable Insurance Exchanges" (exchanges) are scheduled to be operational beginning January 1, 2014. Individuals and small businesses will be able to purchase insurance through these exchanges. This is the second round of regulations issued regarding state health insurance exchanges; the Department of Health and Human Services (HHS) previously issued proposed regulations for establishment of exchanges.

Notice of Proposed Rulemaking on Premium Tax Credit Section 1401 of PPACA amended the Internal Revenue Code (Code) to add Section 36B, allowing a refundable tax credit to help individuals and families afford health insurance coverage by reducing a taxpayer's out-of-pocket premium cost. The exchange will determine whether an individual meets the income and other requirements for advance credit payments (based in part on the affordability of employer-sponsored coverage) and the amount of the advance payments. Penalties are imposed on employers for failing to provide affordable coverage thereby making employees eligible for the subsidy. The NPRM provides a number of safe harbors for employers and employees to encourage affordability of coverage.

Most significantly, the NPRM clarifies that the "affordability test" in Code section 4980H(b), for purposes of determining whether an employer-sponsored plan imposes a premium that is affordable or unaffordable, will be based on an employee's Form W-2 rather than an employee's total household income.

The NPRM also clarifies that the Code section 4980H(b) "affordability test" will be based on the employee's premium cost for self-only or individual coverage under the employer-sponsored plan, rather than the premium cost for dual or family coverage as may apply. Basing the test on the premium cost of individual coverage — which is typically much less than the premium cost for dual or family coverage — will allow companies to more easily meet the affordability test and thereby avoid penalties for having provided unaffordable coverage.

Under PPACA, to qualify as "minimum essential coverage," for purposes of the individual and employer mandates, small group insurance policies must provide coverage for certain "essential benefits," which will be set forth in a to-be-enumerated list of federally mandated benefits. The regulatory agencies suggested in today's guidance an intention to exclude self-funded plans and fully-insured large group plans from having to provide these "essential benefits."

There are a number of items that require additional clarification. This includes, for example, how certain of today's proposed rules interact with PPACA's "shared responsibility" provisions, which require employers to make affordable minimum qualifying health coverage available to all full-time employees or otherwise pay a penalty. For example, one potentially open question is whether, for purposes of Code section 4980H(a), an employer must make minimum qualifying coverage, *i.e.*, minimum essential coverage, available only to full-time employees in the form of self-only coverage or if (as some have asserted) an employer must also provide coverage to the spouse and/or dependents of a full-time employee.

Additionally, the regulators appear to be reserving their right to issue additional clarifying guidance regarding how to determine "minimum essential coverage" in the context large group insurance coverage and self-funded coverage. Today's guidance indicates that the regulators mandates do not apply to large group plans and self-funded coverage. It remains to be seen, however, whether and/or how future guidance will expand upon the existing statutory definition regarding "minimum essential coverage."

A public hearing has been scheduled for November 17 in Washington D.C.

Proposed Regulations on Exchanges The HHS proposed regulations on exchange functions in the individual market set forth the specific standards for participation in the exchanges and insurance affordability programs as well as participation in the Small Business Health Options Program (SHOP) as outlined in the original proposed regulations for establishment of exchanges.

Generally, the proposed regulations interpret the relevant PPACA sections to establish a system of streamlined and coordinated eligibility and enrollment through which an individual may apply for enrollment in a qualified health plan and insurance affordability programs (e.g., the premium tax credit, as detailed above) and receive a determination of eligibility for such programs. The regulations also interpret the PPACA statute to mean that the eligibility and enrollment function should be consumer-oriented, minimizing administrative hurdles and unnecessary paperwork for applicants.

French Tax Law Creates Compensation Compliance Issues for Employers

In 2010, the French legislature amended its tax law to impose a withholding tax on profits made by nonresident French taxpayers on stock option gains, stock compensation and certain stock warrants. The law generally applies to gains realized on or after April 1, 2011.

This law creates a possible compliance issue for employers and financial institutions in the U.S. (and other countries) that may sponsor and/or administer equity-based compensation plans in which French taxpayers participate.

The Amending Finance Bill for 2010 raises a number of interpretive questions for U.S.-based companies and financial institutions, particularly whether those entities have responsibility for withholding and paying the tax. This issue is significant because a failure to comply with the law carries not only a fine but potential criminal penalties.

A detailed memo, prepared by Groom Law Group, is now available.

SEC Delays Certain Executive Compensation Rules

The Securities and Exchange Commission (SEC) recently modified its list of upcoming activity to reflect a delay in the adoption of the four outstanding regulations relating to executive compensation under the Dodd-Frank Wall Street Reform and Consumer Protection (Dodd-Frank) Act. The SEC has moved rulemaking on the following topics to the agenda for the January-June 2012 period:

- Pay-versus-performance disclosure, including the relationship between executive compensation actually paid and the financial performance of the company;
- Disclosure of “pay ratio” comparisons of CEO compensation and the median total compensation for all employees;*
- Compensation clawback policies, providing for recovery from current or former executive officers of “erroneously awarded” incentive compensation; and
- Disclosure of hedging policies used by executives or directors with respect to the receipt or holding of company stock.

**Representative Nan Hayworth (R-NY) has introduced the Burdensome Data Collection Relief Act (H.R. 1062), a bill to repeal the pay ratio requirements of the Dodd-Frank Act. The bill has been approved by the U.S. House of Representatives Committee on Financial Services but a floor vote has not yet been scheduled.*

These issues are explained in greater detail in a recent legal update prepared by McGuire Woods LLP. Rules regarding disclosure of say-on-pay votes by institutional investment managers and guidelines for compensation committee and adviser independence are still expected to be issued prior to 2012.

Rules Issued for Women's Preventive Care under PPACA, Original IFR Amended

On August 1, the Department of Health and Human Services (HHS) Health Resources and Services Administration (HRSA) issued detailed guidelines for group health plans and health insurance issuers relating to coverage of preventive services under the Patient Protection and Affordable Care Act (PPACA). A fact sheet is also available at the HealthCare.gov portal.

The guidelines specifically address preventive health services that must be offered to women at no additional cost, such as:

- well-woman visits;
- screening for gestational diabetes;
- human papillomavirus (HPV) DNA testing for women 30 years and older;
- sexually-transmitted infection counseling;
- human immunodeficiency virus (HIV) screening and counseling;
- FDA-approved contraception methods and contraceptive counseling;
- breastfeeding support, supplies, and counseling; and
- domestic violence screening and counseling.

These guidelines supplement the IFR on general preventive care requirements issued in July 2010 and have the effect of expanding on the list of preventive health care services that must be covered on a first dollar basis. Specifically, all non-grandfathered health plans (both insured and self-insured plans) will need to include these services without cost sharing for plan years beginning on or after August 1, 2012.

The U.S. Treasury Department, Department of Labor (DOL) and HHS released an amendment to the original preventive care IFR, providing an exemption for "religious employers" from the provisions of PPACA regarding coverage for contraceptive services for women and sets forth a definition for "religious employer" for that purpose. As explained in background to the amendment, it "is intended to reasonably balance the extension of any coverage of contraceptive services under the HRSA Guidelines to as many women as possible, while respecting the unique relationship between certain religious employers and their employees in certain religious positions."

CCIIO Releases Guidance on Annual Limit Waivers for HRAs

On August 19, the Center for Consumer Information & Insurance Oversight (CCIIO) (a division of the Centers for Medicare and Medicaid Services at the U.S. Department of Health and Human Services (HHS)) issued a bulletin providing supplemental guidance on annual limit exemptions for health reimbursement arrangements (HRAs).

The guidance specifically exempts, as a class, all HRAs (in effect prior to September 23, 2010) that are subject to annual dollar limits on essential health benefits under Section 2711 of the Patient Protection and Affordable Care Act (PPACA) from having to apply for annual limit waivers. The CCIIO issued guidance in 2010 establishing a temporary program under which the requirements related to restricted annual limits may be waived if compliance with the IFR would result in a significant decrease in access to benefits or a significant increase in premiums. The waiver process is intended to ensure that individuals with certain coverage (including coverage under "mini-med" plans) would not be denied access to needed services or experience more than a minimal impact on premiums. HHS recently revised the process for plans seeking waivers from the annual limits.

The new supplemental guidance effectively eliminates the need for HRAs, including stand-alone HRAs, to apply individually for waivers or waiver extensions from the restrictions on annual limits applicable to plan years beginning before January 1, 2014. If an employer that maintains an HRA also maintains other coverage, whether or not that coverage is integrated with the HRA, that other coverage must still meet the annual limit or obtain a waiver. An HRA that is exempt from applying for an annual limit waiver must still comply with the record retention and Annual Notice requirements to participants and subscribers as indicated under the revised waiver process.

IRS Issues Guidance on Annuity-Long-Term Care Contracts

On August 14, the Internal Revenue Service (IRS) issued Notice 2011-68, providing interim guidance and a request for comments on the federal income tax treatment of long-term care insurance products combined with either annuities or life insurance as authorized by the Pension Protection Act of 2006 (PPA).

The guidance specifically addresses the application of certain PPA amendments that changed the tax rules for annuity and life insurance contracts issued after December 31, 1996 (but only with respect to taxable years beginning after December 31, 2009) and tax-free exchanges occurring after December 31, 2009.

PPA allows the combination of products by modifying a few rules. Specifically, PPA clarified that payment of long-term care insurance premiums will not be included in income when made through a charge against the cash value of an annuity contract or cash surrender value of a life insurance contract if the long-term care insurance contract is part of or a rider to the annuity or life insurance contract. PPA also added Internal Revenue Code Section 844, which allows taxpayers to exchange long-term care policies (along with annuity and life insurance contracts) under Section 1035 of the code. Notice 2011 confirms that all premiums paid for these annuity-long-term care products are generally included in investment in the contract, as long as the combination premiums are credited to the contract's cash value (rather than directly to the long-term care insurance contract that is part of or a rider to the contract) and coverage under the contract is paid for by charges against the cash value of the contract.

Notice 2011-68 also requests comments on additional issues to be addressed in future guidance. The deadline for these comments is November 9.

Regulatory Agencies Issue Final Plans for Streamlining Rules

Pursuant to the White House's Executive Order 13563, in which President Obama directed his administrative departments to improve the regulatory review process, and a series of requests

for information (RFI) asking how regulatory agencies can improve any of their significant regulations, the U.S. Departments of Treasury, Labor (DOL) and Health and Human Services (HHS), along with the Pension Benefit Guaranty Corporation (PBGC), have each released final plans based on input received from various stakeholders. Preliminary plans were first issued in May.

All of the final plans prepared by the departments and agencies outline current and future procedural changes to increase the collection of stakeholder input on regulatory projects, including identification of both proposed regulations and final regulations in need of retrospective review. Each department/agency also highlighted several specific projects that will be subject to the streamlined regulatory review process.

Department of the Treasury
Most notably, in its final plan, Treasury confirms that the Internal Revenue Service (IRS) is currently "reviewing certain regulations pertaining to retirement plans to determine whether any modifications could better achieve the objective of promoting retirement security by facilitating the offering of benefit distribution options in the form of retirement income. This initiative is expected to include projects that would facilitate the delivery of lifetime income in qualified plans and, to some extent, IRAs, and would reduce administrative burdens for retirement plan sponsors that would like to expand employees' retirement income options."

The DOL Employee Benefits Security Administration (EBSA), in its Semi-Annual Regulatory Agenda issued July 7, indicated that its forthcoming proposed benefit statement regulations (expected to be published in December 2011) will require some form of lifetime income disclosure statement.

Department of Labor
The DOL final plan confirms that proposed regulations will soon be issued to amend the "abandoned plan program," which facilitates the termination and winding up of defined contribution retirement plans that have been abandoned by their plan sponsors. The proposed revisions will "reflect recent changes in the U.S. Bankruptcy Code that would expand the program to include plans of businesses in liquidation proceedings," which DOL believes will substantially reduce burdens on these plans and bankruptcy trustees.

This proposal was also previewed in the EBSA Semi-Annual Regulatory Agenda. Proposed regulations are expected to be issued in December 2011.

Department of Health and Human Services
The HHS final plan includes an appendix, in chart form, listing the regulations that are candidates for further review. The most noteworthy of these are the proposed regulations to implement the application and approval process for states that seek waivers (known as "state innovation waivers") of certain provisions of the Patient Protection and Affordable Care Act (PPACA). The HHS final plan indicates the department's intention to "increase flexibility for States," though the exact meaning of this is unclear.

Also included in the HHS list of regulations to review are the proposed regulations modifying the HIPAA Privacy Rule's accounting for disclosures requirement as required under the Health Information Technology for Economic and Clinical Health (HITECH) Act. Again, HHS does not specify the intended modifications.

Pension Benefit Guaranty Corporation
The PBGC final plan focuses primarily on procedural changes to the proposed regulation process, in which they indicate that, moving forward, they will hold public hearings on major regulations, rather than relying solely on written comments.

The final plan anticipates substantive review of the following regulatory projects, many of which were included in the PBGC's Semi-Annual Regulatory Agenda for spring 2011, issued on July 28:

- Re-proposal of the regulations addressing "reportable events" – events that may be indicative of a need to terminate a plan – under ERISA Section 4043.
- Reconsideration of proposed regulations on ERISA Section 4062(e), which provides for reporting of, and liability for, "partial" terminations of single-employer defined benefit pension plans.
- Simplification of filing premium filing, including (1) waivers of premium payment penalties assessed solely because the payment was late by seven days, (2) revision of the premium penalty policy to be more flexible in case of clerical or administrative errors and (3) addressing the variable rate premium "check box" issue that created a number of inadvertent filing errors.
- PBGC will review rules under Section 4010 of ERISA, which imposes costly reporting requirements on certain sponsoring employers, most notably those with plans that have a funding target attainment percentage for the preceding year of less than 80 percent.

RECENT JUDICIAL ACTIVITY

Appeals Court Decision Strikes Down PPACA Individual Mandate, Upholds Remainder of Law

On August 12, a panel of judges for the Eleventh Circuit Court of Appeals ruled that the Patient Protection and Affordable Care Act's (PPACA) individual mandate — which requires that all individuals have health insurance — "exceeds Congress's enumerated commerce power," with reference to the Commerce Clause of the Constitution, which gives Congress the power to regulate interstate commerce. The court did determine, however, that the mandate is severable from the rest of PPACA, and therefore the entire law is not invalidated simply because the mandate was struck down.

While the court makes plain that Congress may continue to regulate commercial entities and forbid certain commercial activity, "what Congress cannot do under the Commerce Clause is mandate that individuals enter into contracts with private insurance companies for the purchase of an expensive product from the time they are born until the time they die. ... We cannot ignore these structural limits on the Commerce Clause because of the seriousness and intractability of the problem Congress sought to resolve in the Act."

The Eleventh Circuit's decision also addresses the government's assertion that the individual mandate penalty is essentially a tax, which does not cease to be valid because it regulates, discourages or deters certain activities. The court responded, noting the unanimity of judicial rulings thus far (despite diverging opinions on the mandate itself), that "the plain language of the statute and well-settled principles of statutory construction overwhelmingly establish that the individual mandate is not a tax, but rather a penalty. The legislative history of the Act further supports this conclusion. And as the Supreme Court has repeatedly recognized, there is a firm distinction between a tax and a penalty."

In ruling that the rest of PPACA is not invalidated by the separate finding of the mandate's unconstitutionality, the court cites the U.S. Supreme Court's test of severability: "Unless it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law." With regard to the prior ruling of the U.S. District Court for the Northern District of Florida, the court noted that "in light of the stand-alone nature of hundreds of the Act's provisions and their manifest lack of connection to the individual mandate, the plaintiffs have not met the heavy burden needed to rebut the presumption of severability. We therefore conclude that the district court erred in its wholesale invalidation of the Act." Of course, as a practical matter (if not a legal one) the individual mandate is closely connected with other significant aspects of PPACA, such as the provisions barring exclusions from coverage for persons with pre-existing health conditions and the provisions establishing state health insurance exchanges and premium subsidies for people who cannot afford to purchase health coverage.

A panel of judges for the Sixth Circuit Court of Appeals previously ruled that the individual mandate is a valid exercise of congressional authority under the Commerce Clause and therefore is constitutional. The Eleventh Circuit Appeals Court ruling creates a split among the circuits, making a review by the U.S. Supreme Court a near certainty. A decision on the matter is still pending in the Fourth Circuit Court of Appeals. The Thomas More Law Center — the plaintiff in the Sixth Circuit case — filed a petition for review with the Supreme Court on July 26.