Health Care Reform Increases Employer Exposure to Claims, Penalties and Litigations

RESOURCE LINKS

Senate Reform Bill
http://docs.house.gov/rules/hr4872/111_hr3590_engrossed.pdf

Reconciliation Bill
http://docs.house.gov/rules/hr4872/111_hr4872_amndsub.pdf

Amendment to the Reconciliation Bill
http://docs.house.gov/rules/hr4872/111_managers_hr4872.pdf

Summary of the Reconciliation Bill
http://www.rules.house.gov/111_hr4872_secbysec.html

Summary of the Amendment to the Reconciliation Bill
http://www.rules.house.gov/amendment_details.aspx?NewsID=4611

EBG Client Alert: Consumer Product Safety Improvement Act
http://www.ebglaw.com/showclientalert.aspx?Show=8910

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The Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 (the "Act") implements significant changes to the provision of health care and health coverage applicable to all aspects of health care delivery, operation and administration. The Act imposes many different requirements on employers that become effective over time. These requirements are discussed in more detail in our Client Alert of April 8, 2010, entitled "Health Care Reform: What Employers Need to Know."

In implementing the requirements under the Act, employers face new challenges and increased exposure to claims and penalties if they fail to satisfy the new obligations under their benefit plans and programs. The Act includes new statutory provisions that specifically allow employees and agencies to file or impose additional claims, penalties and litigations. Certain highlights of the statutory provisions are set forth below.

Prohibition Against Discrimination with Respect to Participation in Health Programs or Activities on Grounds Set Forth in Other Statutes

- The Act provides that no individual shall, on any ground prohibited under Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975 or Section 504 of the Rehabilitation Act of 1973 (the "Employment Statutes"), be excluded from participation in, be denied the benefits of or be subjected to discrimination under:
  - o any health program or activity, any part of which is receiving federal financial assistance, including credits, subsidies or contracts of insurance; or
  - o under any program or activity that is administered by an Executive Agency (such as the Department of Health & Human Services ("HHS")) or any entity established under Title I of the Act.

- Although it would appear that these protections generally extend only to federal assistance, Title I of the Act provides many different credits, subsidies and other elements that benefit employers in general, and those employers would be subject to this prohibition of discrimination.

- The enforcement mechanisms available under the Employment Statutes will apply to violations of this subsection of the Act. In other words, an aggrieved individual would be permitted to pursue a claim under the Employment Statutes. Further, nothing in Title I of the Act will be construed to invalidate or limit the rights and remedies available under the Employment Statutes, or to supersede state laws that provide additional protections against discrimination.

- This provision is effective immediately.

Prohibition on Discrimination Based on Health Status

- The Act prohibits discrimination against individual plan participants and beneficiaries based on their "health status." This means that group health plans and health insurance issuers offering group or individual coverage may not establish rules for eligibility (including continuing eligibility) of any individual to enroll based on health status. (There are special exceptions for wellness programs.)

- Health status is defined to mean:

  - health status;
  - medical condition (including physical and mental illnesses);
  - claims experience;
  - receipt of health care;
  - medical history;
  - genetic information;
  - evidence of insurability;
  - disability; or
  - any other health status-related factor determined appropriate by the Secretary of HHS (the "Secretary").

- It would appear that the Secretary has the authority to enforce these protections.

- This provision is effective January 1, 2014.

Requirement to Provide Uniform Explanation of Coverage Documents

- The Act requires group health plans and health insurance issuers to provide to enrollees a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage. These standards are in addition to any disclosure requirements under the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

- The Secretary is required to develop standards for the summary and explanation by March 23, 2011. These standards must prescribe a uniform format, not to exceed four pages in length, and ensure that the summary is presented in "a culturally and linguistically appropriate manner" and uses terminology understandable by the average plan enrollee.

- The standards must further ensure that the summary contains:

  - uniform definitions of standard insurance and medical terms;

  - a description of the coverage, including cost sharing, for each of the categories of "essential health benefits" defined under the Act;

  - the exceptions, reductions and limitations on coverage;

  - the cost-sharing provisions, including deductible, coinsurance and co-payment obligations;

  - the renewability and continuation of coverage provisions;

  - a coverage facts label that includes examples to illustrate common benefits scenarios;

  - a statement of whether the plan or coverage provides "minimal essential coverage" defined under the Act and ensures that the plan or coverage share of the total allowed cost of benefits provided is not less than 60 percent of such costs;

  - a statement that the outline is a summary and the coverage document itself should be consulted to determine the governing provisions; and

  - a Web address where the actual individual policy or group certificate of coverage can be reviewed and obtained and a contact number for the consumer to call with questions.

- By March 23, 2012, health insurance issuers, plan sponsors or designated administrators of group health plans (whether insured or self-insured) must, prior to any enrollment restriction, provide the summary to applicants at the time of application, enrollees prior to enrollment/reenrollment and policy or certificate holders at the time of issuance.

- Health insurance issuers, plan sponsors and administrators also are required to provide notification of any "material modification" (defined under ERISA) 60 days *prior to* the effective date of the modification.

- Health insurance issuers, plan sponsors and administrators who willfully fail to provide the required information will be subject to a fine of up to $1,000 for each such failure with respect to each enrollee. Thus, it will behoove employers to ensure that the required summary is timely provided.

- Please note that the required standards preempt any related state standards that require less information, as determined by the Secretary.

New Claims and Appeals Procedures for Health Benefit Claims

- The Act requires group health plans and health insurance issuers to establish internal claims appeal and external review procedures. The group health plans and health insurance issuers must, at a minimum:

  - establish an internal claims appeal process;

  - provide notice to enrollees "in a culturally and linguistically appropriate manner" of the availability of internal and external appeals procedures and the availability of the office of health insurance consumer assistance or ombudsman to assist the enrollee with the claims procedures (which office or ombudsman must be established by the states);

  - allow the enrollee to review the enrollee's file and present evidence and testimony as a part of the appeals process; and

  - allow the enrollee to continue to receive health coverage pending the outcome of the appeals process.

- To establish an external review process, group health plans and health insurance issuers must comply with any applicable state external review process or implement an effective external review process that meets minimum standards to be established by the Secretary.

- These requirements are in addition to any ERISA claims procedures, although the existence of ERISA claims procedures may be used to establish the existence of an internal claims appeal process.

- This provision is effective for plan years beginning on and after September 23, 2010.

Significant Amendments of the FLSA Regarding Mandatory Automatic Enrollment in Health Plans, Non-Discrimination/Whistleblower Protections and Breaks for Nursing Mothers

- The Act adds new requirements to the Fair Labor Standards Act ("FLSA") that impact employers. The FLSA requirements are set forth in more detail under our Client Alert of April 23, 2010, entitled "Health Care Reform Legislation Amends the Fair Labor Standards Act to Give the U.S. Department of Labor Increased Enforcement Authority Over Health Care."

- Effective upon the promulgation of regulations by the DOL, the FLSA is amended to require employers with 200 or more full-time employees that sponsor a health plan to automatically enroll all new full-time employees in one of the health plans offered by the employer and to

continue the enrollment of current employees in the health plans offered. Employees may opt-out of the employer plan if they demonstrate that they have coverage from another source. In addition, the FLSA requires employers to provide a detailed notice to employees of significant provisions of the Act regarding the American Health Insurance Exchange.

- The FLSA also is amended to prohibit employers from taking adverse action against any employee because the employee challenged an employer's implementation of the requirements of Title I of the Act, and to establish a complaint procedure for employees who believe their rights under this provision have been violated. These protections are effective immediately, do not diminish any other rights under federal or state law or under a collective bargaining agreement and are not waivable.

- Finally, the FLSA now requires employers to provide unpaid, reasonable break time and an appropriate place other than a bathroom for nursing mothers to express breast milk for one year after the child's birth. An employer with less than 50 employees will not be required to implement this provision if doing so would cause the employer an "undue hardship."

- These provisions generally are effective immediately.

For more information about this issue of *IMPLEMENTING HEALTH AND INSURANCE REFORM*, please contact one of the authors below or the member of the firm who normally handles your legal matters.

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