ROPES & GRAY

Health Care Reform Guidance Update

As September 23, 2010 approaches, the U.S. Departments of Treasury, Labor, and Health and Human Services have continued to issue interim final rules for group health plans and health insurance coverage clarifying or implementing provisions under the *Patient Protection and Affordable Care Act*. This update covers recently released guidance by the IRS, DOL, and HHS on required coverage for preventive care, guidance from the IRS on limitations on permissible reimbursements for over-the-counter drugs, and guidance from the DOL and HHS on internal and external claims and appeal processes.

Preventive Care

On July 14, 2010, the IRS, DOL, and HHS issued joint interim temporary regulations clarifying the requirement to provide "first dollar" preventive care coverage. The rules do not explain what constitute recommended preventive services. Instead, a current list of recommended preventive services is available at http://www.healthcare.gov/center/regulations/prevention.html, and it will be continually updated by the United States Preventive Services Task Force. In addition, the CDC Advisory Committee on Immunization Practices' recommendations and any comprehensive guidelines on care for infants, children, adolescents, and women's care supported by the Health Resources and Services Administration will both constitute recommended preventive services.[1] Note that if a state imposes stricter requirements regarding coverage of preventive care services, they will not be preempted by federal law.

Although the rules do not define "preventive services," they do offer guidance on how to interpret existing guidelines. The rules make clear that the plan or issuer may use "reasonable medical management techniques" to adapt the recommendations for practical use. A plan is not required to provide "first dollar" coverage for a recommended preventive service until the plan year starting on or after the one year anniversary of the recommendation's effective date.

The rules clarify that insurers may not impose cost sharing requirements on office visits that have the delivery of a recommended preventive service as their primary purpose. However, insurers may impose cost sharing requirements on office visits where recommended preventive services are provided, if the provision of such service is not the primary purpose of the office visit. In addition, cost sharing requirements may be imposed on office visits with the primary purpose of providing recommended preventive services, if the office visit is billed as a separate charge from the provided preventive services. The rules also clarify that insurers may impose cost sharing requirements on recommended preventive services provided by out-of-network providers.

Finally, the rules clarify that a plan is not required to continue to provide coverage for a preventive service once it ceases to be a recommended preventive service; however, a plan that eliminates or changes coverage

[1] Note that United States Preventive Services Task Force's recommendations regarding breast cancer screening, mammography, and prevention issued in or around November of 2009 are not considered current recommendations. Thus, the recommendations issued in 2002 regarding breast cancer screening, mammography, and prevention will be considered current until new recommendations are issued by the United States Preventive Services Task Force or appear in comprehensive guidelines supported by the Health Resources and Services Administration concerning preventive care and screenings for women.

for a benefit will still be required to comply with other requirements of federal or state law regarding mid-year changes in coverage. Please note that none of these requirements regarding coverage for preventive care apply to grandfathered plans, discussed in more detail here.

Reimbursements Under Health Flexible Spending Accounts

On September 3, 2010, the IRS issued Notice 2010-59 and Revenue Ruling 2010-23, clarifying the treatment of drug reimbursements under Health Flexible Spending Accounts ("Health FSAs"), Health Savings Accounts ("HSAs"), and Archer MSAs. This guidance clarifies that tax-free reimbursements from Health FSAs are not available for purchases of over-the-counter medicines or drugs, unless such medicines or drugs are obtained following receipt of a prescription. In addition, this guidance clarifies that items that are not drugs (such as crutches, bandages, and blood sugar test kits) are only eligible for reimbursement if they meet existing requirements to qualify as "medical care." Similar rules apply to HSAs and Archer MSAs.

The guidance also establishes new restrictions on the use of Health FSA and Health Reimbursement Account ("HRA") debit cards. Since current debit card systems are not configured to comply with the new restrictions on over-the-counter drug reimbursements, beginning on January 1, 2011, FSA/HRA debit cards may not be used to purchase these drugs. The guidance provides limited transition relief by allowing the continued use of debit cards to purchase over-the-counter drugs until January 15, 2011. All over-the-counter drug purchases made after January 15, 2011 must be substantiated with appropriate documentation (such as a prescription or a receipt that includes the Rx number) before they can be reimbursed.

These limits on Health FSAs, HSAs, and Archer MSAs are effective for all expenses after December 31, 2010, and must be complied with immediately, irrespective of when the plan year ends, if a plan allows for a grace period, or if a plan is a grandfathered plan. Any amendments required to bring a cafeteria plan into compliance with these rules which are adopted by June 30, 2011 may be made effective retroactively to December 31, 2010.

Claims and Appeals

On July 22, 2010, the DOL and HHS issued joint interim temporary regulations on internal and external claims and appeals processes applicable to non-grandfathered plans. The DOL issued additional guidance, including model notices for denials of claims, on August 23, 2010. The regulations generally set out a two tier review process for any adverse benefit determination, including a rescission of coverage. First, the rules provide that fully insured group plans must adopt and comply with the same internal claims review and appeal requirements currently imposed by ERISA on self-insured plans. The regulations expand these requirements, as they apply to both group health plans and health insurance issuers, in several key respects: (1) rescissions of coverage are treated as appealable adverse determinations, (2) participants receiving emergency medical services generally must be notified of claims decisions as soon as possible, but not later than 24 hours after the receipt of the claim by the plan or issuer, (3) the plan or issuer must provide a participant with all evidence used in reaching a claims decision, and an explanation of the rationale behind the determination, both at no charge to the participant, (4) all decisions must be independent and impartial, (5) notice of all adverse determinations must be provided to participants in a culturally and linguistically appropriate manner, and must contain information such as sufficient information to identify the relevant claim, and a description of the available internal and external review processes, and (6) if the plan or issuer fails to comply with the required claims and appeals process, then the participant must have access to the external review process, and may be able to sue the plan or issuer under federal or state law, on the basis that the plan or issuer has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

In addition, the rules provide that all plans must comply with state imposed external review procedures, as long as they meet requirements similar to those of the Uniform Health Carrier External Review Model Act, as promulgated by the National Association of Insurance Commissioners, including: (1) providing for review based on the issuer's (or plan's) requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, (2) requiring the plan or issuer to pay the fees for an independent review organization ("IRO") to conduct a review of the determination, (3) allowing appeals to be made without regard to the dollar amount at issue, and (4) a requirement that any decisions made by this external review process be binding on all parties.

Plans not currently subject to state review (including most self-insured plans) and certain plans subject to state review procedures in states which do not meet these requirements must comply with interim federal requirements, including requirements to conduct preliminary reviews or appeals within five days of receipt, to maintain contracts with at least three IROs and assign appeals to these IROs in an unbiased manner, to provide expedited review under certain circumstances, and to immediately provide coverage if the independent review organization reverse's the adverse termination. Under a safe harbor set out in DOL technical release 2010-01, the DOL, IRS, and HHS will not take corrective actions against plans which comply with these interim federal requirements, or with a state external review process (if the state has chosen to expand access to its internal review process to self-insured plans). This safe harbor is only available during a transition period starting with plan years beginning on or after September 23, 2010, and ending when final guidance is released.

Certain linguistic requirements are also imposed for any notices that group health plans are required to send to plan participants whose claims are denied or when external review determinations are made. Generally, plans covering less than 100 participants must make all notices and other communications related to the claim and appeals process available in any language in which 25% or more of such participants are solely literate, and for plans with 100 or more participants, notice must be made available in any language in which the lesser of 10% of participants or 500 participants are solely literate. Model notices (in English) have been provided by the DOL and HHS. These notices are available at http://www.dol.gov/ebsa and http://www.hhs.gov/ociio.

A plan or issuer must continue to provide coverage while the appeals process is ongoing. These rules on internal and external review procedures do not apply to grandfathered plans, discussed in more detail here.

We expect that your insurance carriers or third-party administrators will take steps to ensure your group health plans and insurance coverage are in compliance with these new rules. You should contact them promptly to discuss any modifications to your claims and appeals procedures and whether they will be contracting with accredited IROs. While the DOL is expected to issue model language that plan sponsors may use in their summary plan descriptions to describe internal claims and appeals procedures and the external review process, we remain ready to assist you in preparing any necessary modifications to your plan documents and SPDs and to review any modifications to your contracts with your insurers and TPAs.

If you have questions about this series of guidance or about PPACA implementation generally, please contact your usual Ropes & Gray advisor or any member of our Employee Benefits practice or Benefits Consulting Group, or visit the Ropes & Gray Health Reform Resource Center.

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