Health Care Reform Update: The Regulations Keep Coming... External Review Processes and Preventive Health Services for Non-Grandfathered Plans

July 27, 2010 by Kelley Kaufman

This post was contributed by Eric N. Athey, Esq., a Member in McNees Wallace & Nurick LLC's Labor and Employment Law Practice Group.

Our June 17, 2010 posting discussed the interim regulations on "grandfathered" health plan status under the Patient Protection and Affordable Care Act ("PPACA") and the benefits of maintaining that status. Grandfathered plans are exempt from a host of statutory requirements that apply only to non-grandfathered plans. Until recently, little was known about the additional statutory requirements that apply to non-grandfathered plans. However, the Internal Revenue Service, the Department of Health and Human Services and the Department of Labor (referred to collectively as "the agencies") recently issued interim regulations which explain two of the most significant requirements: (1) the internal claim and appeal and external review processes; and (2) availability of certain preventive health services at no cost. These new requirements will take effect for plan years beginning on or after September 23, 2010.

Internal Claims and Appeals and External Review Processes

On July 23, 2010, the agencies jointly published interim final regulations governing a plan's internal claims and appeals procedures and external review processes. The interim regulations require that non-grandfathered group health plans and health insurance issuers offering such plans have an internal claim and appeal procedure which complies with existing Employee Retirement Income Security Act ("ERISA") regulations (29 C.F.R. §2560.503-1). However, the interim regulations impose several additional requirements over and above existing ERISA regulations, including expedited notification of benefit determinations involving urgent care within 24 hours and additional notice requirements.

Non-grandfathered plans also are subject to external review of claims appeals. Currently, 44 states have laws providing some level of external review. Plans operating in states which already have laws that afford at least the same level of consumer protection as the Uniform Health Carrier External Review Model Act will satisfy the external review requirement. The Model Act is a template statute published by the National Association of Insurance Commissioners ("NAIC"). Plans operating in states that have not adopted Model Act will be subject to either a state-run external review process that complies with the new interim regulations or a comparable federal review process. Pennsylvania state law allows for review of claims *only* under managed care plans; this process will either be expanded by amendment of the state law or supplemented by the federal review process set forth in the new interim regulations.

Preventive Health Services

PPACA requires that certain preventive health services be made available under non-grandfathered plans at no cost to participants. On July 19, 2010, the agencies issued interim regulations regarding this requirement. The new regulations prohibit plans from imposing any cost-sharing requirements (e.g. copay, co-insurance or deductible) on any of the following:

1. Services that have a Grade A or B rating in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved. The current Grade A and B rating recommendations are included in the preface to the interim regulations and currently include 45 services, including screening for alcohol misuse, high blood pressure, breast cancer, cholesterol abnormalities, colorectal cancer, depression, diabetes, hepatitis B, obesity and sexually transmitted diseases.
2. Certain immunizations recommended by the Centers for Disease Control ("CDC");
3. Certain screenings recommended by the Health Resources and Services Administration.

Office visits to obtain free preventive services may be subject to cost-sharing only if the visit is billed (or tracked) separately from the preventive service provided or if the service was not the primary purpose of the visit. Plans are not required to waive cost-sharing requirements for services rendered out-of-network. Plans are permitted to use reasonable medical management techniques to determine the frequency, method, treatment or setting for a preventive service covered under the regulations.

These new interim regulations are the first of a series that explain the statutory requirements that apply solely to non-grandfathered plans. We will keep you apprised as additional regulations are issued. For additional information regarding health care reform, please click here to view the McNees Whitepaper regarding *What Employers Need to Know about Health Care Reform*.