SUTHERLAND

LEGAL ALERT

October 15, 2010

Round-up of Recent Guidance on Health Care Reform

In the last several weeks, the agencies[1] charged with issuing guidance under the Patient Protection and Affordable Care Act (PPACA) have issued a number of additional items to clarify previously issued rules or to implement further procedures or rules under PPACA. The new items, which are described in further detail below, include:

- FAQs – providing three sets of Frequently Asked Questions relating to PPACA implementation for group health plans, which were released on September 20, October 8, and October 13.
- DOL Technical Release 2010-02 – providing a grace period for implementing new claims and appeals procedures for non-grandfathered plans.
- IRS Notice 2010-63 – explaining the penalties that apply to a discriminatory fully-insured health plan.
- Revised Model Notice of Adverse Benefit Determination.
- Revenue Ruling 2010-23 – confirming expenses for most over the counter drugs cannot be reimbursed under cafeteria plans, HRAs or HSAs beginning January 1, 2011.
- IRS Notice 2010-69 – making reporting of health plan costs on Form W-2 optional for 2011.
- Early Retiree Reimbursement Guidance – providing several items to assist plan sponsors in requesting reimbursements under the program.

FAQs and Technical Release 2010-02

The three sets of FAQs clarify a number of issues relating to grandfather plan status, the coverage of children up to age 26, the application of PPACA to excepted benefits, permissible rescissions of coverage, and other matters.

Grandfathering

The interim final rules regarding grandfathered plans issued in June provide that a plan will lose its grandfathered status if the employer reduces its contribution rate by more than 5%. In response to concerns that insurers may not know if an employer changes its contribution rates, the September FAQs provide that even if an employer elects to reduce its contribution rate by more than 5%, the policy issuer will not be required to treat the plan as non-grandfathered until the issuer is notified of the increase, as long as the issuer: (1) requires the plan sponsor, upon renewal, to disclose both its contribution rate as of March 23, 2010 and its current contribution rate, and (2) includes language in the policy requiring the plan sponsor to notify the issuer of any rate changes made during the year. The contract must be amended to include the required disclosure and notification language by January 1, 2011 for policies renewed before January 1, 2011 (and, presumably, as of the renewal date for policies renewed thereafter). Note, however, that the grace period is only applicable until final regulations on grandfathered health plans are issued.

[1] These agencies include the Internal Revenue Service (IRS), the Department of Treasury, the Department of Labor (DOL), and the Department of Health and Human Services (HHS).

The October 8 FAQs provide more substantive guidance on the loss of grandfathered status and develop clearer rules regarding loss of grandfathering. The October 8 FAQs clarify that only the six specific plan or policy changes described in the interim final regulations will result in the loss of the grandfathered status. The six prohibited changes are: (1) the elimination of all or substantially all benefits to diagnose or treat a condition; (2) an increase in a percentage cost-sharing requirement, such as coinsurance; (3) an increase in a deductible or out-of-pocket maximum by an amount that is more than 15 percentage points greater than medical inflation; (4) an increase in a copayment by an amount that exceeds the greater of medical inflation plus 15 percentage points or medical inflation plus $5; (5) a decrease in an employer's contribution rate of more than 5%; or (6) the imposition of certain new annual limits. According to the October 8 FAQs, until further guidance is issued, a plan continuing the same insurance policy may make changes to the plan other than the six changes described above without losing grandfathered status, and it appears this rule also applies to self-insured plans. The October 8 FAQs also confirm that:

- *Grandfathered status is examined on a benefit-package-by-benefit-package, not plan-by-plan, basis*. Thus, a plan may relinquish grandfathered status for one benefit option under the plan (for instance, an HMO) and maintain grandfathered status for the remaining options (such as a PPO or a POS arrangement).
- *Restructuring the plan's coverage tiers will not automatically jeopardize grandfathered status.* A plan or benefit package will not lose its grandfathered status if the tiers of coverage in effect on March 23, 2010 are modified, provided that the employer contribution toward the new level of coverage is within 5 percentage points of the contribution for the prior corresponding tier. For example, if the plan offered the choice between employee-only or family coverage in March 2010, it could be amended to offer employee-only, employee-plus-one and family coverage tiers, as long as the employer contribution for the new employee-plus-one tier is within 5 percentage points of the March 2010 employer contribution rate for family coverage. However, if a plan simply adds new coverage levels (for example, it offers family coverage in addition to an existing individual coverage option), the plan will not lose its grandfathered status regardless of the rate of employer contributions for the new tier.
- *Individual cost-sharing increases may jeopardize grandfathered status.* An increase in the cost-sharing requirement for any category of services (for example, outpatient care) is treated as an increase that may jeopardize the grandfather status of the entire plan or package even if the cost-sharing requirement is not increased for other categories of services.
- *Wellness program penalties should be examined to determine if the penalty could cause the plan to lose grandfathered status.* Changes to an individual participant's cost-sharing as a result of wellness initiatives (for example, a cost-sharing surcharge for employees who decline participation in a wellness program) are subject to the rules providing that any increase in percentage cost-sharing will cause the loss of grandfathering.

Claims Review Procedures for Non-Grandfathered Plans

The September FAQs address the application of new external claims review procedures to certain self-insured plans. Under new Public Health Services Act (PHSA) section 2719, non-grandfathered self-insured health plans are required to comply with certain external claims review procedures. DOL Technical Release 2010-01 issued in August, sets forth an interim enforcement safe harbor under which these self-insured plans can meet the external review requirement. If the plan complies with one of the methods set forth in the release, the DOL and the IRS will not take any enforcement action with respect to the new external claims review procedures for plan years beginning on or after September 23, 2010 until future guidance is issued on the Federal external review process.

The September FAQs address instances in which a non-grandfathered self-insured plan's external review procedures do not comply with the safe harbor provisions of Technical Release 2010-01. According to the FAQs, in such situations, compliance will be determined on a case-by-case basis under a facts and circumstances analysis. Thus, a plan that does not satisfy all of the standards of the safe harbor may, in some circumstances, be considered to be in compliance with PHSA section 2719 if the plan otherwise ensures that its external review process is independent and without bias.

Under Technical Release 2010-2, issued in conjunction with the September FAQs, non-grandfathered self-insured and fully-insured plans have a grace period until July 1, 2011 to comply with certain claims-related standards under PPACA (such as the new standards for urgent care claims decisions and new content requirements for adverse benefit determinations). The Technical Release provides that the grace period does not extend to three new rules: (1) any decision regarding a rescission of coverage must be treated as a benefit denial eligible for review under the claim procedures; (2) any new evidence considered by a plan or new rationale for a claim denial must be disclosed to the claimant, and he or she must have time to respond; and (3) decisions by claims adjudicators and medical experts must be free from conflicts of interest. The September FAQs clarify that, during this grace period, notices regarding claims decisions must comply with the DOL claims regulations issued November 21, 2000. The FAQs also clarify that, while the interim final claims regulations shorten the times for making initial determinations with respect to urgent care claims (from 72 hours to 24 hours), the time for making decisions on internal appeals (a maximum of 72 hours for an urgent claim) remains unchanged. The revised model notice of adverse benefit determination issued by DOL reflects this clarification.

Dependent Coverage of Children up to Age 26

The September FAQs clarify that continued coverage of children up to age 26 is required only for children as defined under Code section 152(f)(1), which include only sons, daughters, stepchildren, adopted children (including children placed for adoption), and foster children. Specifically, plans providing for coverage of "children" other than as defined under section 152(f)(1) may continue to condition coverage for those children (such as a grandchild or niece) on support, residency, or other dependency factors, even though the plan may not condition coverage of children as defined under the section 152(f)(1) based on those factors. In addition, the FAQs provide that plans are not required under PPACA to extend coverage until age 26 for children not included under section 152(f)(1), even if these children are otherwise treated as dependents under the plan.

Out-of-Network Emergency Services under Non-Grandfathered Plans

The September FAQs address open issues regarding state laws that prevent providers from billing patients for the difference between the cost of hospital emergency services and the amount paid to the provider by a plan or an insurer. Under the interim final rules on emergency services issued in June 2010, if a non-grandfathered health plan provides any benefits for emergency services in an emergency department of a hospital, any copayments or coinsurance imposed for out-of-network emergency services cannot exceed the cost-sharing requirements that would be imposed if the services were provided in-network, and the amount paid to the hospital must meet certain minimum standards. The September FAQs clarify that plans are not required to comply with the minimum payment standards in states that prohibit providers from "balance billing" patients, or if the plan or issuer is contractually responsible for any amounts that are "balance billed" by a provider.

Excepted Benefits

Although HIPAA-excepted benefits (*e.g.*, stand-alone vision and dental plans) are exempt from the insurance reform mandates of PPACA pursuant to the interim final rules for grandfathered plans, the application of the PPACA rules to dental and vision benefits has been a "grey-area." The October 8 FAQs attempt to provide some clarity, confirming that if such benefits are offered under a separate policy, certificate, or contract of insurance, or if the benefits are not integral to the plan because participants may opt-out of the coverage and are required to pay an additional premium for the coverage, the benefits are excluded from PPACA's insurance reform mandates. The FAQs specifically say that vision or dental plans that require a separate election and at least nominal employee contributions are not subject to the PPACA mandates, including the requirement to cover children up to age 26 and first-dollar preventive care. In addition, the October 13 FAQs reiterate that HIPAA-excepted plans with "less than two participants who are active employees" (such as retiree-only plans) are exempt from PPACA's insurance reform mandates. However, the agencies declined to issue guidance on whether plans that cover both retirees and non-active employees on long-term disability remain exempt from HIPAA and, by extension, PPACA's insurance reform mandates. The agencies indicated that they will soon issue a request for information on these issues and that they intend to issue further guidance in 2011. Until then, plans covering only these two groups of individuals will be treated as exempt from the insurance reform mandates.

Rescissions

The October 8 FAQs clarify several points regarding rescissions, defined as retroactive terminations of health coverage:

- Generally a plan may retroactively terminate coverage only as a result of any fraudulent or intentional misrepresentation by the participant, but it is not relevant whether the fraud or misrepresentation is related to a covered person's prior medical history or any other matter.
- If an employer mistakenly covers an employee, for example, a part-time employee who is not eligible under the plan, the coverage can be cancelled only prospectively after the error is discovered unless the employee obtained the coverage through fraud or an intentional misrepresentation.
- Plans may, however, retroactively eliminate coverage beginning on the date of an employee's termination of employment if the delay in cancelling coverage is for administrative reasons, for example, because the employer reconciles lists of eligible individuals with the plan's participant list only once per month.
- Similarly, a plan may cancel coverage of a former spouse retroactive to the date of a divorce after the plan is notified of the divorce.

Preventive Health Services

The October 8 FAQs also provide guidance with respect to the plan's ability to limit preventive health treatment based on guidelines of the United States Preventive Services Task Force (USPTF), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) and the Health Resources and Services Administration (HRSA). The interim final regulations on preventive care services provide that a plan may rely on "reasonable medical management techniques" in order to limit the frequency, method, treatment, or setting for preventive care services if such details are not provided by USPTF, the Advisory Committee, or HRSA. The October 8 FAQs clarify

that appropriate reasonable medical management techniques include medical necessity or medical appropriateness determinations based on prior authorization requirements or concurrent review or similar practices. Thus, a plan may deny participant requests for additional preventive care services if, for example, the plan can demonstrate that based on prior medical authorizations, additional services were not deemed medically necessary.

Nondiscrimination Rules for Non-Grandfathered Fully-Insured Plans

Under Code section 105(h)(1), highly compensated individuals covered under a discriminatory self-insured health plan are subject to taxation on the benefits provided under the plan. PPACA extended these nondiscrimination rules to fully-insured health plans but did not make clear what penalties would apply if a fully-insured plan violated the rules for a plan year beginning on or after September 23, 2010. In Notice 2010-63, IRS and Treasury have said that highly-compensated individuals covered under a discriminatory fully-insured plan are not subject to tax on the plan benefits. Instead, discriminatory fully-insured plans are subject to a civil action to compel the plan to provide nondiscriminatory benefits, and the plan or plan sponsor is subject to an excise tax or civil penalty of $100 per day per individual discriminated against. The Notice includes a reminder that the interim final rules on grandfathered plans provide that the nondiscrimination rules do not apply to grandfathered insured plans. In the Notice, Treasury and the IRS have also requested comments on the application of the Code section 105(h)(2) nondiscrimination standards to insured group health plans.

Reimbursement of Over the Counter Drugs No Longer Permitted

The IRS has issued Revenue Ruling 2010-23, which provides that over the counter drugs can no longer be reimbursed from health flexible spending accounts (health FSAs) under cafeteria plans, health reimbursement arrangements (HRAs), Health Savings Accounts (HSAs), or Archer Medical Savings Accounts (MSAs) after December 31, 2010 unless the drugs have been prescribed. This revenue ruling supersedes a 2003 ruling, which had permitted the reimbursement of drugs without a prescription from these types of plans. The 2010 ruling was issued to implement a provision in PPACA that changes the definition of medical expenses for health FSAs, HRAs, HSAs and MSAs to exclude non-prescription drugs after December 31, 2010.

Reporting Health Plan Cost on W-2 Optional for 2011

In Notice 2010-69, the IRS has said that employers will not be required to report the cost of group health plan coverage on Form W-2 for 2011. While PPACA generally provides that the cost of health coverage, as determined under rules similar to the rules for determining the cost of COBRA coverage, must be reported on W-2s beginning for 2011, the IRS determined that it was appropriate to allow employers additional time to make changes to payroll systems and procedures to implement this reporting requirement. The Notice also says that the IRS expects to issue further guidance regarding the reporting requirement before the end of 2010.

Additional Guidance on the Retiree Reimbursement Program

HHS has announced that over 3,000 employers have been approved for participation in its early retiree reinsurance program (ERRP) and has released additional information to assist employers in requesting reimbursements, including:

- *Clarification of Reimbursable Amounts*. The regulations issued by HHS generally provide that employers may request reimbursement for health benefits, defined as medical, surgical, hospital, prescription drug or other benefits, as determined by HHS, for the diagnosis, cure, mitigation or prevention of physical or mental disease. To clarify this rule, HHS previously posted an FAQ that says the benefits that are reimbursable under the ERRP are the items and services generally covered by Medicare. The latest clarification from HHS lists 12 specific items and services not covered by Medicare that are not eligible for reimbursement under the ERRP and will not be credited to the $15,000 cost threshold for reimbursement of an individual's medical claims, including routine vision services, glasses and lenses; routine dental services; custodial care; and items and services provided outside the U.S. HHS also said, however, that Medicare frequency or maximum limits on amount, duration, or scope of covered items, such as home health services and skilled nursing care, will not be applied to limit reimbursements for these claims or the credit for these claims towards the cost threshold. In addition, HHS will not apply Medicare medical necessity determinations, impose restrictions such as a requirement that a covered person must have been in the hospital before being admitted to a skilled nursing facility, or impose restrictions on the site or circumstances of care (except as per the list of 12 specific items), such as prohibiting reimbursement for services of providers not participating in Medicare. The guidance further notes that the list of exclusions is not exhaustive, says a detailed list of codes corresponding to the exclusions will be posted in October, and says questions relating to the exclusions can be submitted by email.
- *Reimbursement Preparation Features Announced*. HHS announced that employers and their account managers may now use the ERRP Website to complete a number of processes in preparation for reimbursement, including:

    - Assign and manage designees to assist with requesting reimbursement and related tasks. Assigned designees will receive an email inviting them to register for the Website.
    - Update banking information, including a required one-time confirmation of information submitted in the employer's application.
    - Complete early retiree list setup, including specifying the methods for submitting lists and receiving responses. A training presentation on this process is available.
    - Submit the early retiree list, which is required prior to requesting reimbursement. The list must be specific to a plan year. HHS has posted information on identifying who should be on the list, the required format for lists, the methods for submitting lists and step-by-step instructions.
    - Receive responses to early retiree lists, which will specify the period for which reimbursement can be requested for each individual. HHS has posted six FAQs with information on processing these response files.
    - Manage early retiree information, including viewing both the list submitted and the count of those approved.
    - Assign account manager reimbursement request privileges, since the same individual may not report costs and request reimbursement.

The guidance notes that the Website will be further updated in October to allow employers to submit cost data and reimbursement requests.

■ ■ ■

If you have any questions regarding this Legal Alert, please feel free to contact the attorneys listed below or the Sutherland attorney with whom you regularly work.

Daniel M. Buchner	202.383.0869	daniel.buchner@sutherland.com
Adam B. Cohen	202.383.0167	adam.cohen@sutherland.com
Jamey A. Medlin	404.853.8198	jamey.medlin@sutherland.com
Alice Murtos	404.853.8410	alice.murtos@sutherland.com
Joanna G. Myers	202.383.0237	joanna.myers@sutherland.com
Robert J. Neis	404.853.8270	robert.neis@sutherland.com
Vanessa A. Scott	202.383.0215	vanessa.scott@sutherland.com
W. Mark Smith	202.383.0221	mark.smith@sutherland.com
William J. Walderman	202.383.0243	william.walderman@sutherland.com
Carol A. Weiser	202.383.0728	carol.weiser@sutherland.com