A Timely Analysis of Legal Developments

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Among the numerous changes to health care laws under the Patient Protection and Affordable Care Act (PPACA), several require group health plan amendments in 2011. For example, plans involving certain tax-favored vehicles that pay for over-the-counter medicines and drugs, such as health flexible spending arrangements, health reimbursement arrangements, and health savings accounts, must be amended by the deadline of June 30, 2011, to exclude those charges effective as of the first day of the plan year.

2011 Deadlines Loom for Plan Amendments for Health FSA Over-the-Counter Medication and Other Health Care Reform Requirements

By Russell Chapman and Adam J. Peters

Among the numerous changes to health care laws under the Patient Protection and Affordable Care Act (PPACA), several require group health plan amendments in 2011, with the next deadline being June 30, 2011. The PPACA revised the definition of "medical expenses" for employer-provided accident and health plans, including health flexible spending arrangements (health FSAs) and health reimbursement arrangements (HRAs) to limit an employer's ability to reimburse for certain over-the-counter medications. The PPACA also revised the definition of "qualified medical expenses" under health savings accounts (HSAs) and Archer medical savings accounts (Archer MSAs) to similar effect. FSAs, HRAs, HSAs and Archer MSAs are sometimes referred to as "account-based health programs."

As of January 1, 2011, an account-based health program may not reimburse a participant for the purchase of over-the-counter medicines and drugs (other than insulin) unless the participant obtains a prescription. Because debit cards used for account-based health programs operate through systems not capable of differentiating between medications purchased with or without a prescription, as of January 1, 2011, debit cards cannot be used to purchase over-the-counter medicines and drugs with or without a prescription. Medical supplies, however — such as crutches, bandages, or blood sugar test kits — are not affected by the new rules. These items may still qualify as medical care under Internal Revenue Code section 213(d)(1), which covers expenses for the "diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body."

Account-based health programs that previously provided for reimbursement of over-the-counter medications must be amended to conform to the new over-the-counter medicine and drug requirements. Although the IRS acknowledges that plan amendments to a cafeteria plan may generally be made only on a prospective basis, for expenses incurred after December 31, 2010, the IRS allows plan amendments incorporating the new rules to be adopted up to **June 30, 2011**. In any case, the plan must be operated in conformity with the new rules until the formal amendment is in place.

Other Upcoming Amendment Deadlines

- **Effective for Group Health Plan Years Beginning on or after September 23, 2010 (generally, effective January 1, 2011 for calendar year plans):**

- Extension of Dependent Coverage up to Age 26. Group health plans and insurers that provide health coverage to dependent children must extend that coverage to dependent children up to age 26, even if the dependent child is married.
- Prohibition on Rescissions. Group health plans and insurers are prohibited from rescinding (terminating retroactively) health coverage of a participant, except in the case of fraud or intentional misrepresentation of material fact.
- Prohibition on Pre-existing Condition Exclusions. Group health plans and insurers are prohibited from imposing pre-existing condition exclusions for any participant under the age of 19 (note that this prohibition applies to both covered employees as well as dependent children). Beginning in 2014, pre-existing condition exclusions are prohibited for any participant regardless of age.
- Prohibition on Lifetime Benefit Limits. Group health plans and insurers are prohibited from imposing a lifetime dollar limit on essential health benefits.
- Restriction on Annual Benefit Limits. Group health plans may only impose annual limits on the dollar value of essential health benefits of $750,000 in 2011 and $1.25 million in 2012. Beginning in 2014, annual dollar limits are prohibited for all essential health benefits.
- Preventative Care. Non-grandfathered group health plans and insurers must cover certain preventative care services without cost-sharing, including recommended immunizations, preventative care and screenings for infants, children, and adolescents, and additional preventative care and screenings for women. For an explanation of "grandfathered" and "non-grandfathered" group health plans under PPACA, see the Littler ASAP: "Healthcare Reform: Long-Awaited 'Grandfathered' Regulations Released – What Do Employers Need to Know?" — June 2010.
- Appeals Process. For non-grandfathered plans, a new appeals process for participants is required, including both internal and external reviews and strict compliance with the claim procedures.
- Nondiscrimination in Favor of Highly Compensated Employees. Non-grandfathered, fully insured plans are now subject to Internal Revenue Code section 105(h) nondiscrimination rules; however, implementation of the new rules has been postponed until after regulations are issued.
- Emergency Services. Non-grandfathered group health plans and insurers must cover emergency services without prior authorization or in-network requirements.
- Physician Selection. Non-grandfathered group health plans and insurers providing for or requiring the designation of a primary care provider must permit each participant to designate any participating primary care provider available. The plan must also permit a participant to designate a pediatrician as the primary care provider for a child. Plans are prohibited from requiring authorizations or referrals for an OB-GYN.

Plan sponsors must take care to make sure they are in compliance with the new requirements, and that required amendments are made on time.

What to Do Now

- Review all group health plan documents to make sure all are in compliance with ERISA and PPACA requirements.
- Contact insurers to assure administrative and document compliance.
- Plan sponsors also should take immediate action to assure that the any account-based health plan documents (such as health FSAs or HRAs) are in compliance with the exclusion for over-the-counter medications without a prescription.

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