ALERT

HEALTH CARE REFORM FOR EMPLOYERS: THE GRANDFATHER PLAN RULES –

PART 2 OF A SERIES

July 13, 2010

The recent landmark health care bill – formally known as the Patient Protection and Affordable Care Act of 2010 ("PPACA") – is bringing monumental changes to our health care system. This new law will affect virtually every employer in the country in one way or another. In our prior Alert, we summarized many of the PPACA's key provisions. Anyone who had an opportunity to read that Alert realizes that we are all in store for quite a bumpy ride.

Some of the changes required by PPACA take effect immediately, while others won't apply until one to seven years from now. In a stated effort to minimize part of the anxiety and disruption that this law will have on employers and employees alike, Congress exempted current plans from a number of the new law's most far-reaching requirements, so long as those plans – commonly called "**grandfathered plans**" – comply with very strict rules. (The details of those rules are explained in the Memorandum that is included with this Alert.)

Some of the exemptions applicable to grandfathered plans are permanent. Others simply allow grandfathered plans to delay the effective dates of various reforms for several years. Congress, though, left it up to federal regulatory agencies to flesh out the details as to what exactly a grandfathered plan is, and what a plan must do (or not do) in order to maintain grandfathered status. Last month, the Departments of Labor, Treasury, and Health & Human Services jointly issued just such guidance in the form of interim final regulations. One thing is clear: these agencies aren't making it easy for employer-sponsored plans to preserve their grandfathered status.

So what is a grandfathered plan? It is basically any fully-insured or self-insured health care plan that was in existence on March 23, 2010 (the date PPACA was signed into law). A grandfathered plan automatically maintains that status until it engages in some act that, under the new regulations, triggers the loss of grandfathered status. Unfortunately, the regulations impose very severe restrictions on a plan wishing to preserve its grandfathered status, and many employers may determine that – from a cost-benefit perspective – complying with those restrictions isn't worth the benefits of such status.

As we indicated in our last Alert, **beginning later this summer, we will be presenting workshops at no cost explaining the "grandfather" rules and other key aspects of health care reform**. We plan to do this in time for insurance renewal season, but after most of the key guidance has finally been issued. Please stay tuned -- we will announce the dates in the near future. In the meantime, we plan to send out another Alert very soon explaining the "age 26" mandate (i.e., the new requirement that medical coverage be offered to a participant's children until they turn 26). As additional guidance is issued, we also plan to send out additional Alerts. We hope these are useful to you as your business prepares for the implementation of this monumental legislation.

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As outlined in greater detail in the accompanying Memorandum, the grandfathered plan regulations specify seven different types of changes that will cause a health care plan to lose its grandfathered status. They are:

(1) **Changing Insurance Carriers or Policies.** If an employer enters into a new policy or contract of insurance with the plan's insurer regarding a specific benefit package option, grandfathered status will be lost for that benefit package option. This also means that if an employer goes from a self-insured plan to an insured plan, the plan will lose its grandfathered status. (A move from an insured plan to a self-insured plan, however, would not affect the plan's grandfathered status.)

(2) **Eliminating Benefits.** Grandfathered status will be lost if the plan eliminates all or substantially all plan benefits used to diagnose or treat a particular condition, even if the condition affects only a tiny number of individuals in the plan, or if it eliminates any benefit necessary to diagnose or treat a particular condition. For example, if a plan covers a mental health condition, the treatment of which requires counseling, the elimination of coverage for counseling will trigger a loss of the plan's grandfathered status.

(3) **Increasing Fixed Amount Cost-Sharing (other than Co-Payments).** If a fixed-amount cost-sharing requirement (such as a deductible or out-of-pocket limit but not a co-payment) is increased by more than the medical rate of inflation plus 15 percentage points, grandfathered status will be lost.

(4) **Increasing Fixed Amount Co-Payments.** If a fixed co-payment is increased, the plan will lose its grandfathered status if the total increase in the co-payment – measured from March 23, 2010 – exceeds the greater of (a) the rate of medical inflation, plus 15%, or (b) $5, increased by the rate of medical inflation (calculated as $5 x the medical rate of inflation, plus $5).

(5) **Increasing Percentage Co-Insurance Requirement.** Any increase in co-insurance that uses a percentage formula to determine the coverage (e.g., increasing co-insurance requirement for in-patient surgery from 25% to 33%) will lead to the loss of the plan's grandfathered status.

(6) **Decreasing the Rate of Employer Contribution Toward Cost of Coverage.** If an employer decreases its contribution toward the cost of any tier of coverage for any class of similarly situated individuals by more than 5% of the contribution rate in place on March 23, 2010, the plan's grandfathered status will be eliminated.

(7) **Changing Annual Limits.** Adjustments to a grandfathered plan's annual benefit limits (i.e., the addition of a previously non-existent annual limit or an increase in the annual limit) will often cause the loss of grandfathered status, subject to very narrow exceptions.

A grandfathered plan designation is very significant because it exempts the plan from many requirements in the new legislation. Please see the Memorandum accompanying this Alert for further details on this topic.

This Alert represents a very brief summary of some very complicated statutory and regulatory provisions. Because of the significant repercussions – both financial and otherwise – of a plan losing its grandfathered status, and the relatively short time-frame for ensuring that your plan is in compliance with the new regulations, ***it is important for you or someone in your organization to read the attached Memorandum.*** If you have any questions regarding the impact of health care reform on employers, please feel free to call Eric Namee, Steven Smith, Ruhe Rutter, or Brad Schlozman at (316) 267-2000.

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MEMORANDUM

HEALTH CARE REFORM FOR EMPLOYERS: SUMMARY OF REGULATORY GUIDANCE ON "GRANDFATHERED PLAN" RULES

July 13, 2010

During the debate leading to the passage of the recent major health care bill – the Patient Protection and Affordable Care Act of 2010 ("PPACA") – the President emphasized that the new law would allow Americans to keep their current health plans if they liked them. The way Congress ultimately addressed this presidential promise was through the adoption of "*grandfather*" rules that delay, or provide a complete exemption from, some of PPACA's most significant changes. Whether or not most employers will actually be able to take advantage of the grandfather rules is yet to be seen. This Memorandum attempts to explain the grandfather rules, as reflected in recently issued government regulations, so that employers can begin to figure out where they stand.

Like many other parts of PPACA, the "grandfather" provisions in the statute itself are little more than broad concepts. The statute offers no details as to what exactly a grandfathered plan is or how a current plan can achieve and maintain grandfathered status. Congress left all of those details to federal regulatory agencies to work out. After several months of anticipation, the feds have finally completed much of their work on this issue. On June 14, 2010, the Departments of Labor, Treasury, and Health & Human Services jointly issued interim final regulations that provide critical guidance on what plans must (and must not) do in order to maintain their grandfathered status.

This Memorandum is intended to explain and make sense of these new regulations ("Grandfather Regulations"). Part I summarizes what a "grandfathered plan" is under PPACA and why such a designation can be beneficial to a health care plan. Part II then explains the limited flexibility that grandfathered plans have to change their terms of coverage and cost to participants if the plans want to retain their grandfathered status. Finally, Part III describes the additional procedural requirements and record-keeping obligations with which a grandfathered plan must comply.

I. – BENEFITS OF GRANDFATHERED STATUS

As outlined in our Alert and Memorandum dated June 16, 2010, PPACA imposes a blizzard of new obligations and restrictions on employer-sponsored group health plans and health insurance carriers. Some of the new requirements kick in right away, while others will not be effective until one to seven years from now. However, nearly all the reforms in PPACA will involve substantial changes in the way that health care plans and policies have traditionally been administered. In an effort to reduce some of the disruption and anxiety flowing from these landmark changes, Congress added provisions to PPACA that allow certain plans – i.e., "grandfathered health plans" – to avoid having to implement (or at least to delay the implementation of) a number of the law's most far-reaching requirements.

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A. – Requirements Avoided by Grandfathered Plans

A grandfathered plan designation under the Grandfather Regulations is very significant because it either permanently exempts the plan from, or delays the normally required implementation date of, each of the following mandates (for as long as the plan retains its grandfathered status):

(1) **Mandatory coverage of preventive services.** Non-grandfathered plans must provide coverage for certain preventive services (e.g., immunizations and screenings) and may not impose any cost-sharing requirements such as co-payments or deductibles on those benefits.

(2) **Mandatory coverage of emergency services coverage.** Non-grandfathered plans that offer coverage for emergency room services are prohibited from (i) limiting such coverage to in-network providers, (ii) imposing higher cost-sharing requirements such as co-payments or deductibles for participants using out-of-network providers, and (iii) requiring pre-authorization.

(3) **Prohibition of pre-authorizations or referrals for OB/GYN services.** Non-grandfathered plans may not require any preauthorization or referrals for OB/GYN services.

(4) **Permissive designation of any primary care physician as the primary care physician under the plan.** Non-grandfathered plans that require or provide for a primary care physician designation must allow participants to designate *any* participating primary care doctor (or pediatrician) who is available.

(5) **Mandatory appeals procedure, including binding external review, for challenging claims denials and adverse coverage determinations.** Non-grandfathered plans must implement an "effective" appeals procedure for challenging coverage and claims denials. The appeals procedure must include procedures for binding external review.

(6) **Prohibition against discriminating in favor of highly compensated individuals in insured plans.** Non-grandfathered plans that utilize insurance products are prohibited from discriminating in favor of highly compensated employees. In other words, the same non-nondiscrimination rules that already apply to self-funded plans will apply to fully insured plans.

(7) **Mandatory coverage of costs from participation in clinical trials.** Non-grandfathered plans may not deny most individuals from participating in certain clinical trials, may not deny coverage of routine patient costs for items and services furnished in connection with the clinical trials, and may not discriminate against individuals who participate in the clinical trials.

(8) **Disclosure obligations on the plan's claims practices.** Sponsors of non-grandfathered plans must annually file public reports regarding their plan benefits, reimbursement structures, and claims denials. The exact type of information subject to disclosure will be determined by regulations (yet-to-be-issued) from the Department of Health and Human Services ("HHS").

(9) **Reporting obligations on the plan's wellness programs.** Sponsors of non-grandfathered plans must annually submit reports to HHS regarding the wellness programs (and effectiveness thereof) that are offered by their plans. The exact type of information subject to disclosure will be determined by regulations (yet-to-be-issued) from HHS.

(10) **Limits on cost-sharing (i.e., co-payments and deductibles).** Beginning January 1, 2014, non-grandfathered plans are prohibited from (a) imposing annual deductibles in excess of $2,000 for self-only coverage or $4,000 for family coverage and (b) imposing total annual out-of-pocket expenses in excess of those that are applicable to a high-deductible health plan for self-only or family coverage (currently $5,950 and $11,900) (as applicable).

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(11) **Coverage of children up to age 26.** Non-grandfathered plans that offer dependent coverage must offer such coverage to all covered participants' children until age 26, *regardless of whether a child has access to other employer-sponsored coverage*. (This coverage obligation kicks in for non-grandfathered for plan years beginning on or after September 23, 2010. By contrast, grandfathered plans do not have to offer coverage – until January 1, 2014 – to any child who has access to other employer-sponsored coverage (other than the employer of the child's parents)).

B. – Definition of a Grandfathered Health Plan

Under the Grandfather Regulations, any fully-insured or self-insured health plan that was in existence on March 23, 2010 (the date that PPACA was signed into law) is, by definition, a grandfathered health plan on that date. The plan will remain grandfathered unless and until it does something to lose such status under the Grandfather Regulations, as described in Part II below.

1. – Grandfather Regulations Apply Separately to Each Benefit Package

The Grandfather Regulations apply separately to each benefit package available under a plan. In other words, changes that result in the loss of grandfathered status for one benefit package do not automatically cause another benefit package in the same plan to lose its grandfathered status. For example, assume that an employer has continuously sponsored a group health plan since March 23, 2010, and that such plan offers participants two alternative coverage options – a PPO option and an HMO option. A change to the PPO option that causes the PPO benefit package to lose its grandfathered status would not cause the separate HMO option to lose its grandfathered status.

2. – Changing Covered Individuals Does Not Cause Plan to Lose Grandfathered Status

As a general rule, a plan does not lose grandfathered status merely because one (or even all) individuals enrolled on March 23, 2010, later drop out of the plan, as long as the plan has continuously covered *someone* (not necessarily the same person) since March 23, 2010. Similarly, as a general rule, adding new employees (either newly hired or newly enrolled) to a plan after March 23, 2010, does *not* cause the plan to lose its grandfathered status. The same rule applies if family members of a covered participant become enrolled in the plan after March 23, 2010.

There are, however, two exceptions to these general rules. In particular, the Grandfather Regulations include two anti-abuse rules designed to prevent employers from circumventing the new regulatory restrictions.

a. – Anti-Abuse Rule Number 1

The first anti-abuse rule provides that a plan will lose its grandfathered status if the sponsoring employer adds new enrollees to the plan through a merger, acquisition, or similar business restructuring, where the principal purpose of the transaction was to cover new individuals under a grandfathered health plan. Regulators adopted this provision to ensure that employers do not buy and sell their plans' grandfathered status as a commodity in the marketplace. Of course, this rule will require that employers carefully document the rationale for a particular transaction, at least when grandfathered health plan status is at issue.

b. – Anti-Abuse Rule Number 2

The second anti-abuse rule is designed to prevent employers from doing indirectly what they cannot do directly. This rule limits an employer's ability to transfer employees between grandfathered plans unless there is a bona fide employment-based reason for the transfer. Therefore, the regulations state that a plan will lose its grandfathered status if all of the following three events occur:

- Employees are transferred from one grandfathered plan (a "transferor plan") to another grandfathered plan (a "transferee plan");

- Treating the transferee plan as if it were an "amendment" of the transferor plan would cause the transferor plan to lose its grandfathered status; and

- There is no bona fide employment-based rationale for the transfer.

Importantly, changing plan terms or concerns over the cost of coverage are *not* bona fide employment reasons.

Although this rule has language that only a government bureaucrat could love, a quick hypothetical will demonstrate how it all works in application:

- Employer sponsors a group health plan that offers two benefit packages on March 23, 2010: Option A and Option B.

- A year later, the employer eliminates Option A because of its high cost and transfers employees covered under Option A to Option B.

- Assume that, if, instead of transferring employees from Option A to Option B, Option A was amended to match the terms of Option B, it would cause Option A to lose its grandfathered status (for any of the reasons described in Part II below).

- Assume that the employer did not have a bona fide employment-based reason to transfer the covered individuals from Option A to Option B.

- Accordingly, Option B would cease to be a grandfathered plan with respect to all of its enrollees.

3. – Retiree-Only Plans and Excepted Benefits

The preamble to the Grandfather Regulations helpfully clarifies that retiree-only plans and HIPAA excepted benefits (e.g., dental-only plans and vision-only plans) are *not* subject to the new health care bill. Therefore, sponsors of plans that currently cover both active employees and retirees may want to consider establishing a separate plan for retirees. By doing so, the separate retiree plan would enjoy much greater flexibility than if it were part of a broader plan that later became subject to PPACA. For instance, it would continue to be able to change its terms and conditions of coverage and/or to continue imposing annual and lifetime benefit limits.

II. – CHANGES THAT CAUSE LOSS OF GRANDFATHERED STATUS

The Grandfather Regulations are surprisingly restrictive and substantially limit the changes that employers can make to their plans if they wish to maintain their plans' grandfathered status. It is thus critical that employers proceed cautiously (and consider consulting with a benefits attorney) before amending their plan.

A. – Changes Triggering Loss of Grandfathered Status

The Grandfather Regulations specify seven different types of changes that will cause a plan to lose its grandfathered status. Those prohibited changes are explained below.

1. – Changing Insurance Carriers or Policies

If an employer enters into a new policy, certificate, or contract of insurance with the plan's insurer regarding a particular benefits package, grandfathered status will be lost for that benefit package option. If, as is ordinarily the case with small and medium-size employers, the plan contracted with a single insurance company to provide all benefits under the plan, the entire plan's grandfathered status will disappear upon the change in insurance carrier or policy. (A special rule applies to collectively bargained plans, as discussed below.)

One question that employers may ask is what impact this restriction will have on their decision to move from a self-insured plan to a fully-insured plan (or vice versa). The answer is that if an employer shifts its plan from a self-insured plan to a fully-insured plan, grandfathered status will be lost. If, on the other hand, the employer shifts from a fully-insured plan to a self-insured plan, the plan's grandfathered status will be unaffected.

2. – Eliminating Benefits

Grandfathered status will be lost if a health care plan eliminates all or substantially all of the plan benefits for the diagnosis or treatment of a particular condition. This is true even if the condition affects only a tiny number of individuals in the plan.

The elimination of plan benefits that are necessary to diagnose or treat a particular condition also will result in a loss of grandfathered status. For example, if a plan covers a particular mental health condition, the treatment of which requires counseling, the elimination of coverage for counseling will trigger a loss of the plan's grandfathered status. (This provision may be tricky to comply with for plans that are evaluating their mental health coverage in the wake of the Mental Health Parity and Addiction Equity Act of 2008.)

3. – Increasing Fixed Amount Cost-Sharing (other than Co-Payments)

If a "fixed-amount cost-sharing requirement" (other than a co-payment) is increased by more than the medical rate of inflation plus 15%, grandfathered status will be lost. Deductibles and out-of-pocket limits are examples of fixed-amount cost-sharing requirements. This rule is designed to ensure that any cost adjustments by the plan are largely in line with the medical rate of inflation.

Importantly, the limit on fixed amount cost-sharing increases is measured from the amount of the cost-sharing in place on March 23, 2010. In other words, the employer cannot annually raise its figures by the medical rate of inflation plus 15%. Instead, the limit is cumulative, with the baseline always remaining March 23, 2010. Once the threshold is crossed, grandfathered status is gone.

For example, assume that on March 23, 2010, the plan has a deductible of $1,000. Assume further that the "medical rate of inflation" is 10% per year. The plan could raise its deductible for 2011 by as much as $250 ([10% + 15% = 25%] x $1,000), for a maximum total deductible in 2011 of $1,250. But if it did so, the plan would have blown its entire discretionary increase. Deductible increases in subsequent years would be limited to the medical rate of inflation (measured from March 23, 2010). Thus, if the plan wanted to raise the deductible again in 2012, the maximum increase would be $110 (assuming a 10% additional increase in medical inflation in 2012, which is on top of the 10% increase in 2011). Therefore, the maximum deductible in 2012 would be $1,360 (which is $110 + $1,250).

4. – Increasing Fixed Amount Co-Payments

Increasing a fixed co-payment can cause a plan to lose its grandfathered status, but only if the total increase in the co-payment – measured from March 23, 2010 – exceeds the greater of (a) the rate of medical inflation, plus 15% or (b) $5, increased by the rate of medical inflation (calculated as $5 times the medical rate of inflation, plus $5).

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As an example, assume that on March 23, 2010, a grandfathered plan requires a co-payment of $10 for routine office visits. The co-payment is later increased to $15 (a 50% increase). Assume further that the medical rate of inflation from March 23, 2010, until the date of the increase is 7.2%. A permissible maximum increase under the regulations would be the greater of: (a) 22.2% (7.2% + 15%), which would be $2.22 in this example or (b) $5.36 ($5 x 7.2%, plus $5). Because the $5 increase is less than $5.36, the plan would not lose its grandfathered status.

5. – Increasing Percentage Co-Insurance Requirement

Any increase in co-insurance that uses a percentage formula to determine the coverage (e.g., increasing co-insurance requirement for in-patient surgery from 25% to 33%) causes a plan to lose its grandfathered status.

One might ask why the Grandfather Regulations treat increases in fixed-amount co-insurance differently from increases in percentage-based co-insurance. The theory is that fixed-amount co-insurance needs to be adjusted periodically to keep pace with the medical rate of inflation. However, co-insurance that uses a percentage formula to determine cost-sharing automatically rises with any increase in medical inflation. For instance, the total payment arising out of a participant's 20% co-insurance obligation will necessarily increase when medical inflation rises, because the cost of the medical service against which the 20% co-payment is measured has increased due to medical inflation. To use real numbers, assume that a participant has a 20% co-insurance requirement on a $100 medical procedure (i.e., $20). The following year, the medical rate of inflation increases 10%, and the medical procedure thus now costs $110. The participant's co-insurance obligation will likewise increase to $22, even though the co-insurance percentage has remained constant.

6. – Decreasing the Rate of Employer Contribution Toward Cost of Coverage

Decreasing the employer's contribution toward the cost of any tier of coverage for any class of similarly situated individuals by more than 5% of the contribution rate in place on March 23, 2010, causes a plan to lose its grandfathered status. In general, the employer contribution rate is the amount of contribution made by the employer compared to the total cost of coverage, as determined under the COBRA valuation rules. In the case of a self-insured plan, contributions by the employer are equal to the total cost of coverage minus the employee contributions toward the total cost of coverage. (Pre-tax salary reduction contributions are considered employee contributions for this purpose.)

Some questions still remain with regard to employer contributions, even in the wake of the Grandfather Regulations. For instance, will employer reductions of wellness incentives be considered a decrease in its contribution rate? Similarly, if an employer provides its employees flex dollars as part of a cafeteria plan and allows such flex dollars to be used towards employee premiums in a health care plan, will a reduction in the amount of flex dollars provided constitute a decrease in the employer's contribution rate? No doubt, more guidance will be forthcoming in the months and years ahead.

7. – Changing Annual Limits

Adjustments to a grandfathered plan's annual benefit limits will cause the loss of grandfathered status in any of the following circumstances:

- An annual benefit limit is added to a plan that did not have either an annual limit or a lifetime limit on benefits as of March 23, 2010;
- An annual benefit limit is added to a plan that did have a lifetime limit (but not an annual limit) on benefits as of March 23, 2010, and the new annual limit is less than the old lifetime limit; and/or
- The annual benefit limit that was in effect on March 23, 2010, is decreased.

B. – <u>Special Rules for Fully-Insured Collectively Bargained Plans</u>

The Grandfather Regulations treat any health care plan that is established pursuant to a collective bargain agreement ("CBA") in much the same way as every other type of plan. Most importantly, the regulations contain no delayed effective date for collectively bargained plans, regardless of when the CBA expires. The fact that the agreement may be in the middle of its term is irrelevant.

There is, however, a special rule that applies to *fully-insured* (but not self-insured) collectively bargained plans. Specifically, if changes are made to a fully-insured collectively bargained plan that would otherwise cause such plan to lose its grandfathered status, the fully-insured collectively bargained plan will be permitted to retain its status as a grandfathered plan until the termination of the last CBA in effect on March 23, 2010. Once the CBA that was in effect on that date ends, however, the plan will lose its grandfathered status.

III. – PROCEDURAL STEPS TO RETAIN GRANDFATHERED STATUS

In addition to satisfying all the substantive requirements detailed above, a plan that wishes to maintain its grandfathered status also must comply with a variety of documentation and notice obligations. These include the following:

- Any materials provided to participants or beneficiaries that describe the benefits under the plan (including a summary plan description) must include (a) a specific statement that the plan believes it is a grandfathered plan within the meaning of federal law, and (b) contact information for questions or complaints; and

- For as long as the plan remains grandfathered, it must retain (a) records documenting the terms of the plan or health insurance coverage in effect on March 23, 2010, and (b) any documents necessary to verify its status as a grandfathered plan. These records must be made available for examination by participants, beneficiaries, and government agencies with jurisdiction over the plan.

IV. – CONCLUSION

As you can see, the Grandfather Regulations do not offer employers much latitude in adjusting the coverage of their health care plans or in imposing additional cost-sharing burdens on participants. The agencies drafting the regulations estimate that many employers will be unable or unwilling to adhere to these restrictions, causing approximately 50% of all employer plans to lose their grandfathered status by the end of 2013. Other experts suggest the figure could be as high as 69%. Whatever the numbers are in reality, employers are going to need to consider whether the limited flexibility and additional administrative burdens associated with grandfathered plans are worth maintaining such status.

If you have any questions regarding the impact of health care reform on employers, please feel free to call Eric Namee, Steven Smith, Ruhe Rutter, or Brad Schlozman at (316) 267-2000.

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