

HUMAN CAPITAL PRACTICE

ALERT: HEALTH CARE REFORM BILL

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REGULATIONS ON GRANDFATHERED PLANS

As the dust settled following enactment of the health care reform law last March, many employers found that the law's grandfather provisions didn't provide as much protection as they had hoped. They were further disappointed when the interim final regulations interpreting the grandfather provisions were issued on June 14, 2010. The regulations make clear that:

- Grandfathered plans are exempted from some – but not all – of the insurance reform provisions of the health care reform law, making grandfathered status less valuable than many had hoped.
- A variety of plan changes cause medical plans to lose grandfathered status.
- There is no delayed effective date for collectively bargained plans – only a period during which grandfathered plan status is assured regardless of plan changes.
- Exemptions are available for retiree-only plans and so-called excepted benefits, and those exemptions may be more valuable than the exemption for grandfathered plans.

BACKGROUND: THE INSURANCE REFORM PROVISIONS OF THE HEALTH CARE REFORM LAW

The health care reform law includes a number of provisions that are called “insurance reforms.” Despite that name, many of these provisions apply to both insured and self-insured employer-sponsored health plans, as well as to several other types of plans. They include a ban on lifetime limits on benefits available under a plan and a requirement to cover preventive care with no cost sharing. The Department of Labor has posted a **chart of the insurance reform provisions** in which each provision's applicability to grandfathered plans is noted.

NOTE The health care reform law includes a variety of provisions other than the insurance reforms. For example, the employer “pay-or-play” mandate and the individual mandate, as well as the insurance exchanges, are prominent features of the health care reform law, but are not considered part of the insurance reforms.

GRANDFATHERED PLANS ARE EXEMPT FROM SOME (BUT NOT ALL) INSURANCE REFORM PROVISIONS

Many employers and benefits professionals had hoped that grandfathered plans would be completely exempt from the health care reform law, but it was clear at enactment that the new law did not provide such broad protection. To the extent it applies, the grandfather rule makes some of the insurance reform provisions noted above inapplicable to a grandfathered plan for as long as it remains grandfathered. The grandfather rule does not:

- Provide any exemption from health care reform compliance obligations other than the insurance reforms (other compliance obligations include the automatic enrollment requirement, the employer pay-or-play mandate, the per-capita fee to fund comparative effectiveness research and the “Cadillac” plan excise tax)
- Delay the effective date of any provision of the health care reform law for a grandfathered plan; provisions affected by the grandfather rule are simply inapplicable for as long as the plan remains grandfathered (except that, until the 2014 plan year, the ban on dependent age limitations lower than 26 allows grandfathered plans to exclude certain children based on other coverage)
- Discrimination against health care providers prohibited as long as they act within the scope of their licenses
- Out-of-pocket maximum can be no greater than that allowed for a high-deductible health plan offered in connection with a health savings account
- Deductibles can be no greater than \$2,000 for single coverage and \$4,000 for family coverage (guidance is needed on the extent to which this limit applies to employment-based plans)
- Limits on plans’ wellness incentives increased to 30% of individual COBRA rate (federal agencies may allow additional increases up to 50%)
- Annual reports to enrollees and the Department of Health & Human Services (HHS) on plan benefits that improve health outcomes
- “Transparency” reports on such matters as claim payment policies and practices, finances, enrollment, disenrollment, claim denials, rating practices, cost sharing and enrollees’ rights, which plans are to send to HHS and make publicly available
- For certain insured plans, the insurer must comply with rating limitations, as well as guaranteed issue, guaranteed renewability, essential benefits coverage and certain other requirements

THE DIFFERENCES BETWEEN GRANDFATHERED PLANS AND NON-GRANDFATHERED PLANS

The limitations of the grandfather rule as it applies to employer-sponsored group health plans mean that grandfathered plans mostly have the same compliance obligations as non-grandfathered plans. The only differences in their compliance obligations are that non-grandfathered plans must adhere to the following provisions:

- Requirement for coverage of certain preventive health services and immunizations without cost sharing
- No discrimination by insured plans in favor of higher-wage employees (self-insured plans continue to be subject to current nondiscrimination rules)
- Requirements to provide patient protections regarding emergency services, choice of primary care provider and access to gynecological/obstetric services
- Internal and external appeals processes must meet certain requirements
- Requirement to cover routine patient costs for care in connection with clinical trials

One additional compliance break for grandfathered plans allows them, when complying with the requirement that plan coverage be available for children until they reach age 26, to exclude children eligible for other employment-based health coverage (other than a parent’s plan), but only until the 2014 plan year. In addition, coverage under a grandfathered plan automatically qualifies as the coverage required for an individual to comply with the individual mandate and avoid the penalty that applies starting in 2014 to those who do not have such coverage. (Of course, technically, this is not a compliance obligation for an employer-sponsored plan, but it is likely to become an employee relations issue if coverage under an employer’s plan does not meet this requirement.)

If a grandfathered plan loses that status, the provisions listed above become applicable to the plan on the date of the loss or, if later, the effective date that would otherwise apply. (See the discussion below of the circumstances under which a plan will lose grandfathered status.) Given the limited differences between the compliance obligations for grandfathered and non-grandfathered plans, many employers have questioned whether they should simply forego grandfathered plan status. It is not possible to foresee all of the possible consequences of relinquishing grandfathered status when so much regulatory guidance remains to be issued. For example, we do not know the full scope of the preventive expenses that must be covered without cost sharing or the routine patient expenses that must be covered in connection with clinical trials. We also do not know how burdensome the reporting and disclosure requirements will be.

BECOMING A GRANDFATHERED PLAN - EASY

A grandfathered plan is a group health plan that was in existence on March 23, 2010 and covered at least one individual. (March 23, 2010 was the date that the largest part of the health care reform legislation was signed into law.)

REMAINING A GRANDFATHERED PLAN - HARD

Although grandfathered plans may remain grandfathered for an unlimited time, there are several ways that grandfathered status can be lost:

- Entering into a new insurance contract
- Making certain changes in the individuals covered by the plan
- Making certain changes in the benefits provided by the plan
- Making certain changes in the employer's contributions toward plan coverage
- Failing to notify participants that the plan is grandfathered or failing to retain records that document grandfathered status

APPLYING THE RULES

SEPARATE APPLICATION TO EACH BENEFIT PACKAGE The interim final regulations specify that they are to be applied separately to each "benefit package" under a plan. Although the rules do not define what a benefit package is, it appears that each separate benefit option under a plan will be treated as a benefit package. For example, a plan that offers participants a choice of HMO or PPO coverage would have two separate benefit packages, and the rules would apply to each separately. Therefore, if a change to the HMO benefit package causes it to lose grandfathered status, the PPO would not lose grandfathered status simply because it is part of the same plan as the non-grandfathered HMO benefit package. In the sections that follow, when we use the word "plan," it generally should be read as referring to a benefit package under a plan.

TRANSITION RULES All of the changes that can result in loss of grandfathered status refer to differences from the plan's situation on March 23, 2010. In determining what was in effect, changes that become effective after March 23, 2010 are treated as if they were in effect on March 23 if the changes are made:

- Pursuant to a legally binding contract entered into on or before March 23, 2010
- Pursuant to a filing on or before March 23, 2010 with a state insurance department
- Pursuant to written amendments to a plan that were adopted on or before March 23, 2010

The transition rules also allow for avoiding loss of grandfather status due to changes that are effective before June 14, 2010 or that are memorialized in one of the three ways noted above after March 23, 2010 and before June 14, 2010. (June 14, 2010 was the release date of the interim final regulations.) This second group of changes is not treated as occurring on or before March 23, 2010. Instead, the plan is given an opportunity to retain grandfathering by reversing or modifying those changes so that, effective no later than the first day of the first plan year starting on or after September 23, 2010, the plan has not had any changes that would result in loss of grandfathered status.

ENTERING INTO A NEW INSURANCE CONTRACT

Except as noted below for fully insured collectively bargained plans, if an employer or employee organization enters into a new policy, certificate or contract of insurance after March 23, 2010 (because, for example, any previous policy, certificate or contract of insurance is not being renewed), then that policy, certificate or contract of insurance is not grandfathered. It is clear that this rule will cause loss of grandfathered status 1) in the event of a change of insurers, even if the new policy provides coverage that is identical to the previous policy, or 2) if a plan goes from being self-insured to being fully insured.

A simple renewal of an existing policy should not cause loss of grandfathered status, provided there are no coverage, benefits or contribution changes that would cause the loss. In the case of a renewal, it might be a good idea to ask the insurer to provide a letter confirming that the renewal will not result in issuance of a new policy, certificate or contract of insurance.

Unfortunately, we do not know definitively from the regulations whether a change of stop-loss insurers with respect to a self-insured plan falls within this provision. We believe that the agencies should conclude that stop-loss coverage – to the extent that it insures the employer and is paid for out of the employer’s general assets – is not part of the “plan” being offered to employees. If it is not part of the plan, an employer should be able to change the stop-loss insurer without losing the plan’s grandfathered status.

According to the preamble to the interim final regulations, self-insured plans can change TPAs without jeopardizing their grandfathered status.

CHANGING THE INDIVIDUALS COVERED

Grandfathered status generally applies to a plan – not to the individuals enrolled in the plan. A plan can remain grandfathered even if it no longer covers any of the individuals that it covered on March 23, 2010, so long as at least one individual is covered at all times. Grandfather protections also are not lost if a group health plan allows enrollment of new family members, so long as the plan provided for enrollment of family members on March 23, 2010. As a result, a plan sponsor maintaining a grandfathered plan generally can allow participants to make personal and dependent coverage changes (e.g., at annual enrollment periods) without risking termination of the plan’s grandfather protection.

These rules on allowable changes indicate that the following changes in the individuals covered by a plan will cause loss of grandfathered status:

- Failing to cover at least one individual (which need not be the same individual) at all times from and after March 23, 2010
- Allowing enrollment of participants’ family members if the plan did not provide for coverage of dependents on March 23, 2010

In addition, transferring groups of employees among plans may cause loss of grandfathered status. Specifically, if a group of employees are transferred to a grandfathered health plan from the plan under which they were covered on March 23, 2010, the receiving plan will lose grandfathered plan status if both of the following are true:

- The transfer results in changes that, if made by changing the plan under which the employees had coverage on March 23, 2010 (instead of by transferring the employees to the new plan), would cause loss of grandfathered status

- There is no bona fide employment-based reason for the transfer (changing the terms or cost of coverage is not a bona fide employment-based reason)

The regulations note that an event like closing a location is a bona fide employment-based reason for transferring employees to another plan. Termination of a plan that has become too expensive is not a bona fide employment-based reason for transferring a group of employees to another plan. The regulations do not address the situation in which an employer discontinues one medical option while allowing employees to choose among two or more remaining options. It is not clear whether the group of employees previously covered by the discontinued option would be considered transferred to the other options for this purpose.

The regulations also provide that, if the principal purpose of a merger, acquisition or similar business restructuring is to cover new individuals under a grandfathered health plan, that plan ceases to be a grandfathered health plan.

CHANGING THE PLAN'S BENEFITS

The interim final regulations explain that certain benefits changes result in loss of grandfathered status. These are:

- Elimination of all or substantially all benefits to diagnose or treat a particular condition (or elimination of benefits for any item that is needed to diagnose or treat a particular condition) causes a plan to cease to be a grandfathered plan.
- Any increase, measured from March 23, 2010, in a percentage cost-sharing requirement (such as an individual’s coinsurance requirement) causes loss of grandfathered health plan status. An example in the regulations notes that increasing a coinsurance

requirement from 20% to 25% causes loss of grandfathered status.

- An increase in any fixed-amount cost-sharing requirement (e.g., a copayment, deductible or out-of-pocket limit) causes coverage to cease to be grandfathered if the total percentage increase in the amount when compared to the amount in effect on March 23, 2010 exceeds 15% increased by the number of percentage points that represent medical inflation since March 23, 2010 (determined according to the regulations). In the case of a copayment increase, loss of grandfathered status will not occur unless the dollar amount of the increase is also greater than \$5 increased by medical inflation since March 23, 2010 (determined according to the regulations). Because of this two-part test for copayment increases, it would be possible to introduce a new copayment without losing grandfathered status, so long as the new copayment never exceeded \$5 increased by medical inflation since March 23, 2010 (determined according to the regulations). The same is not true of a new deductible, which will apparently cause loss of grandfathered status.

EXAMPLE On March 23, 2010, Employer A's plan has a copayment of \$30 per specialist physician visit. The plan increases this copayment by 33% to \$40 effective January 1, 2013. Medical inflation for the period between March 23, 2010 and January 1, 2013, calculated according to the regulations' formula, is 22%. Because 33% is less than 37% (15% + 22% medical inflation since March 23, 2010), the plan will not cease to be a grandfathered plan because of this change. Under this rule, so long as the percentage increase in the amount is no greater than 15%, the increase will not affect grandfather status. If the percentage increase is greater than 15%, medical inflation since March 2010 may be taken into account and may make a greater increase consistent with retaining grandfathered status.

- A plan that had no overall annual or lifetime limit on the dollar value of all benefits on March 23, 2010 ceases to be a grandfathered health plan if it imposes an overall annual limit on the dollar value of benefits.
- Coverage that had an overall lifetime limit on the dollar value of all benefits on March 23, 2010 but had no overall annual limit on the dollar value of all benefits, ceases to be grandfathered if an overall annual dollar limit is adopted that is lower than the lifetime dollar limit in effect on March 23, 2010.

- Coverage that had an overall annual limit on the dollar value of all benefits on March 23, 2010, ceases to be grandfathered if the amount of the annual limit decreases.

CHANGING THE EMPLOYER'S CONTRIBUTIONS

If the employer or employee organization decreases its rate of contribution towards the cost of any tier of coverage for any class of similarly situated individuals by more than five percentage points below the contribution rate for the coverage period that includes March 23, 2010, the plan will lose its grandfathered status. This means that a plan will not lose grandfathered status if employees' required contributions increase, so long as the percentage split of the cost of coverage between the employer and employees for each tier of coverage remains within the limit.

EXAMPLE On March 23, 2010, Employer A contributed 80% of the cost of employee-only coverage (based on COBRA rates less the 2% add-on) and 60% for family coverage. If the employer reduces its contributions for the family tier to 50% (a 10-percentage-point decrease), the plan loses its grandfathered status, even if the employer's contribution rate for employee-only coverage remains the same or increases.

A special rule applies in the case of contributions based on a formula, such as hours worked or units produced, to determine whether a change in contributions causes loss of grandfather status.

FAILING TO NOTIFY PARTICIPANTS AND KEEP RECORDS

A plan will lose grandfathered status if it provides a description of the benefits provided under the plan to participants that does not include a statement that the plan believes that it is a grandfathered health plan and contact information for questions and complaints. The regulations provide **model language** for this notice.

A plan will lose grandfathered status if it fails to maintain (and make available for examination by participants, beneficiaries and state and federal regulators) records documenting the terms of the plan in effect on March 23, 2010, as well as any other documentation necessary to verify, explain or clarify why the plan qualifies for grandfathered status. The preamble to the regulations notes that such documents could include plan documents and amendments, health insurance policies, certificates and riders, summary plan descriptions, and documentation of the cost of coverage as well as employee and employer contribution rates.

NO DELAYED EFFECTIVE DATE FOR COLLECTIVELY BARGAINED PLANS

The interim final regulations clarify the interaction of the grandfather rule with what many had read as a delayed effective date provision for collectively bargained plans. The rules make clear that there is no delayed effective date for collectively bargained plans. The health care reform law's provisions apply to collectively bargained plans on the same dates that they are effective for non-collectively bargained plans.

APPLYING THE GRANDFATHER REGULATIONS TO COLLECTIVELY BARGAINED PLANS

Under the regulations, collectively bargained plans that were in existence and covering at least one individual on March 23, 2010 generally have the benefit of the grandfather rule to the same extent as non-collectively bargained plans that meet those conditions. That is, the grandfather rule will exempt qualifying collectively bargained plans from some, but not all, insurance reform provisions, will provide that exemption until grandfathered status is lost, and will cease to apply to a plan for the same reasons. The only special rule for collectively bargained plans under the grandfather rule applies to *fully insured* plans that are subject to one or more collective bargaining agreements ratified before March 23, 2010. This means that the grandfather rule – as well as the insurance reforms affected by that rule – applies to *self-insured* collectively bargained plans the same way that it applies to non-collectively bargained plans. The same is true for an insured collectively bargained plan if all of the collective bargaining agreements governing the plan were ratified on or after March 23, 2010.

SPECIAL RULES FOR FULLY INSURED COLLECTIVELY BARGAINED PLANS

For *fully insured* collectively bargained plans that are subject to one or more collective bargaining agreements ratified before March 23, 2010, there is a variation in how the grandfather rules apply. Specifically, until the last of the pre-March 23, 2010 collective bargaining agreements governing such a plan terminates, any changes to the plan will not result in loss of grandfathered status even if such changes would have caused a non-collectively bargained plan to lose grandfathered status. (See the discussion above regarding plan changes that result in loss of grandfathered status.)

In effect, this is a timing rule. An insured collectively bargained plan that makes any such change during this period would not lose its grandfathered status due to that change until the last pre-March 23, 2010 collective bargaining agreement relating to the plan terminated. If the insured collectively bargained plan remained grandfathered after the last collective bargaining agreement relating to the plan terminated, the grandfather rule would then apply to that plan in the same way that it applies to other plans. There is an exception to this timing rule for a new policy, certificate, or contract of insurance entered into during this period. Assuming that the new insurance contract does not entail any of the benefit or contribution changes that would cause loss of grandfathered status independent of the insurance change, that new insurance contract will not cause loss of grandfathered status at the end of the last pre-March 23, 2010 collective bargaining agreement or otherwise.

MANY RETIREE-ONLY PLANS ARE EXEMPT

The preamble to the grandfather rules confirmed that self-funded retiree-only ERISA plans are exempt from all insurance reform provisions, including those insurance reforms that apply to grandfathered plans (e.g., requirement to cover adult children and ban on lifetime and annual dollar limits). The exemption applies regardless of whether the retiree-only plan is grandfathered. It also applies even if a plan was not in existence or was not a retiree-only plan on March 23, 2010.

A retiree-only plan is one that covers fewer than two participants who are current employees. That is, no one who is a current employee should be included in the plan if this exemption is going to apply. Because of this requirement, most experts recommend keeping the retiree plan strictly separate from the active plan. That is, making sure that it is a separate ERISA plan with its own plan document, SPD and plan number, and that it also files its own Form 5500, if required. Keeping that retiree-only plan's funding and administration entirely separate from that of any plan that covers current employees would also be important.

An oddity in the health care reform law's language makes the insurance reforms (as set out in the Public Health Service Act or as adopted by states) applicable to retiree-only plans that are insured or are not subject to ERISA. These provisions do not apply with respect to self-insured ERISA plans, but do apply to insurance provided under an employer plan and to nonfederal governmental plans, among others. HHS stated in the preamble to the grandfather regulations, however, that it will not enforce insurance reforms against retiree-only plans. It also urged states not to enforce insurance reforms against retiree-only plans.

EXCEPTED BENEFITS ARE NOT SUBJECT TO INSURANCE REFORMS

Although there is a glitch in the health care reform law's language, it appears that excepted benefits are exempt from all of the insurance reforms. As with the retiree-only exemption, excepted benefits are exempt even from the insurance reforms that apply to grandfathered plans, and the exemption applies whether or not the excepted benefits qualify for the grandfather rule. Similarly, the excepted benefits exemption applies even if a plan was not in existence on March 23, 2010.

Excepted benefits were initially defined for purposes of the HIPAA portability provisions, and that definition now applies to determine which benefits are exempted from the insurance reforms. Excepted benefits generally include stand-alone dental and vision coverage, most health flexible spending arrangements, on-site medical clinics, long-term care benefits, and accidental death and dismemberment coverage. In addition, hospital or other fixed indemnity coverage is an excepted benefit if it is provided under a separate policy, certificate or contract of insurance, and pays a specified dollar amount for each day (or other period) that a covered individual is hospitalized or ill, regardless of whether or how much the individual incurs for care while hospitalized or ill and regardless of whether or how much any other plan of the employer pays.

For more information on excepted benefits, see Chapter 9 of Willis' online *Compliance Manual*.

CONCLUSION

Before the interim final regulations were issued, employers considering compliance issues under the health care reform law were unsure how much they could rely on the exemption for grandfathered plans. The regulations have now answered that question, clarifying some of the changes that will cause loss of grandfathered status. Employers weighing those changes will need to balance the cost of losing grandfathered status against the cost of foregoing such plan changes. Many appear to be concluding that grandfather status is not sufficiently valuable to justify the measures needed to keep it. The exemptions for retiree-only plans and excepted benefits are more durable and may prove to be more valuable for employers.

KEY CONTACTS

US BENEFITS OFFICE LOCATIONS

NEW ENGLAND

Auburn, ME
207 783 2211

Bangor, ME
207 942 4671

Boston, MA
617 437 6900

Hartford, CT
860 756 7365

Manchester, NH
603 627 9583

Portland, ME
207 553 2131

Shelton, CT
203 924 2994

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Buffalo, NY
716 856 1100

Cranford, NJ
908 931 3005

Florham Park, NJ
973 410 4622

Morristown, NJ
973 829 6374
973 829 6465

New York, NY
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Norwalk, CT
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Radnor, PA
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901 248 3103

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Gainesville, FL
352 378 2511

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704 344 4856

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904 355 4600

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770 425 6700

Miami, FL
305 421 6208

Mobile, AL
251 544 0212

Orlando, FL
352 378 2511

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312 621 4843
312 348 7678

Cleveland, OH
216 357 5921

Columbus, OH
614 326 4788

East Lansing, MI
517 349 3226

Grand Rapids, MI
248 735 7249

Green Bay, WI

414 259 8837

Milwaukee, WI

414 203 5248

414 259 8837

Minneapolis, MN

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763 302 7209

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713 625 1082

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Mills, WY

307 266 6568

New Orleans, LA

504 581 6151

Oklahoma City, OK

405 232 0651

Overland Park, KS

913 339 0800

San Antonio, TX

210 979 7470

Wichita, KS

316 263 3211

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Irvine, CA

949 885 1200

Las Vegas, NV

602 787 6235

602 787 6078

Los Angeles, CA

213 607 6300

Novato, CA

415 493 5210

Phoenix, AZ

602 787 6235

602 787 6078

Portland, OR

503 274 6224

Rancho/Irvine, CA

562 435 2259

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858 678 2000

858 678 2132

San Francisco, CA

415 291 1567

San Jose, CA

408 436 7000

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800 456 1415

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