



THE KULLMAN FIRM

A PROFESSIONAL LAW CORPORATION

CLIENT E-NEWSLETTER

SPECIAL BULLETIN

HEALTH CARE REFORM -- GRANDFATHERED PLAN REGULATIONS

President Obama signed the Patient Protection and Affordable Care Act ("PPACA") into law March 23, 2010. Many employers' first question was the extent to which the new law will affect their group health plan. Plans that were in effect on March 23, 2010, are exempt from complying with many of the PPACA's requirements. They are referred to as "grandfathered plans." Under the new law, it was not clear whether a plan could lose its grandfather status and, if so, what would make it lose that status. Would plan amendments, premium changes, or changes in carrier affect

grandfather status?

On June 14, 2010, the Departments of Health and Human Services, Labor, and Treasury released interim final regulations to answer many of these questions. The regulations define a grandfathered plan as one that had at least one person enrolled on March 23, 2010, and has continuously covered someone since then (even if not the same person). These regulations give circumstances that would cause a plan to lose grandfathered status.

Requirements from Which Grandfathered Plans are Exempt

PPACA requires that group health plans make quite a number of changes over the next few years. Grandfathered plans, however, are exempt from complying with several of PPACA's requirements. Here are some of the requirements from which grandfathered plans are exempt:

- Preventative care (first dollar coverage);
- Emergency services (precludes prior authorization and additional cost sharing, even if non-network);
- Primary care professional (the covered individual may select any participating primary care provider or pediatrician);
- Ob-gyn (plans may not require authorization or referral to an obstetrical and gynecological care professional);
- Nondiscrimination rules (the Internal Revenue Code section 105(h) nondiscrimination rules that previously applied only to self-funded plans will also apply to fully insured plans);
- Appeals process (including the requirement of binding external reviews);
- Group health plan transparency disclosure requirements;
- Cost-sharing (any annual cost-sharing imposed under the plan may not exceed the limitations provided for under the essential health benefits package);
- Clinical trials (must cover clinical trials, i.e., experimental treatments for cancer or other life-threatening diseases for benefits that would otherwise be covered);
- Non-discrimination against providers;
- HIPAA wellness rules;
- Wellness programs and firearms; and
- Covering adult children through age 26 if they are eligible for other employer health coverage (exemption applies only until 2014).

Effect of Changes on Grandfathered Status

Changes that will Result in Loss of Grandfathered Status. Here is a summary of changes that can cause a plan to lose grandfathered status.

Changing Carriers. Grandfathered status will be lost if a fully insured plan changes insurance carriers or if a self-funded plan becomes fully insured. Any insurance policy that is sold after March 23, 2010, will not be grandfathered, even if the product was available before that date. The regulations contain special rules for fully insured multiemployer plans.

Mergers and Acquisitions. If the principal purpose of a merger, acquisition, or similar business restructuring is to cover new individuals under a grandfathered plan, the plan will lose grandfathered status.

Eligibility Changes. Employees can move between coverage options at open enrollment without jeopardizing grandfathered status. Employees can also be transferred from one plan to another without jeopardizing grandfathered status if there is a bona fide employment-based reason for the transfer. However, a plan into which employees are transferred will lose grandfathered status under certain circumstances if there is no employment-based reason for the transfer other than to change the terms of coverage.

Elimination of Benefits. Eliminating all or substantially all benefits to diagnose or treat a particular condition causes a plan to lose grandfathered status. This includes eliminating any necessary element to diagnose or treat a condition. For example, if a plan covered mental health benefits, which included prescription drugs and counseling, and then eliminates counseling benefits, the plan would lose its grandfathered status. The regulation reasons that counseling is an element that is necessary to treat the condition.

Increase in Percentage Cost Sharing. Any increase in a percentage cost sharing (such as a coinsurance requirement) will cause a plan to lose grandfathered status.

Changes that will not Affect Grandfathered Status. Here is a summary of changes that will not by themselves cause a plan to lose grandfathered status.

Changing Third Party Administrators. A self-funded plan's changing third party administrators by itself will not cause the plan to lose grandfathered status.

Increase in Deductibles and Out-of-Pocket Limits. A plan loses grandfathered status if it increases any fixed amount cost-sharing requirement other than a copayment (such as a deductible or out-of-pocket limit) by more than medical inflation plus 15 percentage points measured from March 23, 2010.

Increase in Fixed Amount Copayments. A plan loses grandfathered status if it increases the copayment for any service by more than the greater of: (1) \$5 adjusted for medical inflation or (2) medical inflation plus 15 percentage points, both measured from March 23, 2010. The regulations contain examples of these sometimes complicated calculations.

Decrease in Employer Contribution Rate. A plan loses grandfathered status if the employer decreases its contribution rate towards the cost of any tier of coverage (e.g., single or family) for any class of similarly situated individuals by more than 5 percentage points below the contribution rate on March 23, 2010.

Annual Limits on the Dollar Value of all Benefits. A plan loses grandfathered status if:

- On March 23, 2010, it had no annual or lifetime limit on the dollar value of all benefits and it subsequently imposes an annual limit on the dollar value of benefits.
- On March 23, 2010, it had a lifetime limit on the dollar value of all benefits but no annual limit on the dollar value of all benefits and it then imposes an annual limit that is more than that lifetime limit.
- It had an annual limit on the dollar value of all benefits on March 23, 2010 and it thereafter decreases that limit.

Presumably, changing reinsurance carriers also will not jeopardize a self-funded plan's grandfathered status.

Complying with Federal or State Law. Changes to comply with federal or state law will not cause a plan to lose grandfathered status. For example, a plan can be amended to comply with the Mental Health Parity and Addiction Equity Act and to comply with Michelle's Law without losing grandfathered status.

Voluntarily Complying with PPACA. A plan will not lose grandfathered status if it makes changes voluntarily to comply with PPACA. Thus, a grandfathered plan may adopt a PPACA change it is not required to make. A plan may adopt a PPACA required change early. For example, before the PPACA effective date, some plans and insurance carriers are allowing children under age 26 to remain covered after they lose student status.

New Employees and Dependents. New employees (whether newly hired or newly enrolled) and their dependents can be added to a grandfathered plan without losing grandfathered status.

Changes Made Before March 23, 2010. Changes made before March 23, 2010, that became effective after that date, will not cause a plan to lose grandfathered status if they were made pursuant to: (1) a legally binding contract entered into on or before

March 23, 2010, (2) a filing on or before March 23, 2010, with a state insurance department, or (3) written amendments to a plan adopted on or before March 23, 2010.

Changes Made After March 23, 2010. Changes made after March 23, 2010, but before June 14, 2010, will not cause a plan to lose grandfathered status if the changes are revoked or modified effective as of the first day of the first plan year beginning on or after September 23, 2010, and the terms of the plan on that date, as modified, would not cause the plan to cease to be a grandfathered plan under the regulations.

Good Faith Compliance. The preamble to the regulations recognized that plans often make routine changes from year to year, and some plans may have needed to implement such changes before the regulations were issued. The Departments said that, for enforcement purposes, they will take into account good faith efforts to comply with a reasonable interpretation of the statutory requirements and may disregard plan changes that only modestly exceed those changes permitted by the regulations and that were adopted before June 14, 2010.

Effect on Grandfathered Status Unclear. It is not clear if the following changes will cause a plan to lose grandfathered status. The agencies requested comments on the following changes.

Plan Structure. Changes to a plan's structure, such as switching from a health reimbursement arrangement to major medical coverage or from an insured to a self-funded arrangement.

Provider Network. Changes to a plan's provider network, and if so, what magnitude of changes would have to be made.

Prescription Drug Formulary. Changes to a plan's prescription drug formulary, and if so, what magnitude of changes would have to be made.

Other Changes. Other substantial changes to the overall benefit design.

Administrative Requirements

A plan must include a statement disclosing that it regards itself as a grandfathered plan. It must also include a plan contact for questions and complaints and contact information for the Department of Labor or Department of Health and Human Services (for non-ERISA plans). The regulations include a model

notice. Plans must maintain records documenting plan terms as of March 23, 2010, and other records necessary to verify its grandfathered status. Those documents must be available on request to participants and state and federal government agencies.

Retiree-Only Plans and Excepted Benefits

The preamble to the regulations clarified that PPACA's requirements do not apply to plans sponsored by employers subject to ERISA with fewer than two participants who are current employees (including retiree-only plans that cover fewer than two participants who are current employees). They also do not apply to excepted benefits (such as separate limited scope dental and vision coverage, accidental

death and dismemberment coverage, and limited disease-only coverage). The Department of Health and Human Services said it does not intend to use its resources to enforce the requirements of HIPAA or PPACA with respect to nonfederal governmental retiree-only plans or with respect to excepted benefits provided by nonfederal governmental plans.

If you have any questions please call The Kullman Firm attorney with whom you normally work.



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