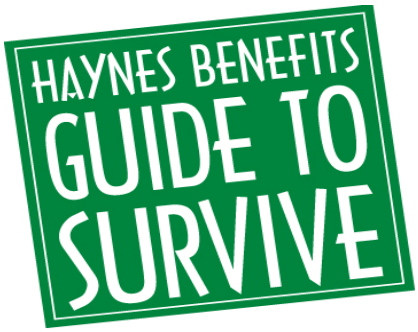

. . . Health Care Reform 2010

Grandfathered Plans Rules Guide Current Benefit Decisions

On June 17, 2010, the Department of Treasury ("Treasury"), the Department of Labor ("DOL") and the Department of Health and Human Services ("HHS") jointly issued Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act (the "rules").

The grandfathered plan rules will guide the actions of plans in the weeks and months ahead. Due to the importance of these rules, we have interjected this report ahead of our next alert on the revenue provisions under the Act.

> *The rules clarify many important issues, but still leave certain key issues unanswered. For this reason, we repeat our mantra—plan sponsors and plans should not make changes without guidance from a respected benefits professional as to the effect of any proposed changes on maintaining or losing grandfathered plan status.*
>
> *These email alerts provide a summary of the Act and our comments, which are in italics.*

Effective date. The rules are effective for plan years beginning on or after September 23, 2010 (January 1 for calendar year plans).

Grandfathered plan definition. A "grandfathered health plan" is any group health plan or health insurance coverage in which an individual was enrolled and that was in effect on the date of the enactment of the Act (March 23, 2010). The rules add that a plan does not lose grandfathered plan status if individuals covered on that date cease coverage, so long as the plan has continuously covered someone (not necessarily the same person).

The rules amplify that the determination of grandfathered status is to be made separately with respect to each "benefit package" made under a plan.

> *Thus, an employer may make changes to an HDHP option, thereby losing grandfathered status with respect to that option, without affecting other plan options.*

Adding new employees and family members. The Act provided that the enrollment of new employees and new family members of individuals will not cause the plan to lose its grandfathered status. The rules add two anti-abuse provisions. Grandfathered plan status will be lost when the principal purpose of a merger or acquisition is to cover new individuals under a grandfathered health plan, and when employees are transferred to a different plan for no bona fide employment based reason.

> *This anti-abuse rules will have far reaching effects. Plan sponsors should review carefully any merger or transfer options.*

Changing insurance policy. If an employer enters into a new insurance policy after March 23, 2010, that new policy is not a grandfathered plan.

> *Any new insurance policies must comply with and bear the cost of the Act's mandates. Separate provisions address insurance policies in collectively bargained plans, discussed below.*

Changing TPAs. A change in TPA by a self funded plan will not cause a loss of grandfathered plan status.

> *We are glad to see that the rules recognize that a plan can change TPAs without changing the plan/benefits at all. Presumably, this rule also should protect the change of administrator under an ASO arrangement.*

Changing benefits. The rules specify 6 changes to benefits that cause loss of grandfathered status.

- Elimination of benefits to diagnose or treat a particular condition.
- Increase in a percentage based cost-sharing provision such as coinsurance or copercentage.
- Increase in a fixed amount cost sharing requirement such as a deductible or out of pocket limit, if the total percentage increase is more than medical inflation plus 15 percentage points.
- Increase in a fixed amount copayment by the greater of $5 increased by medical inflation, or medical inflation plus 15 percentage points.
- Decrease in the employer contribution rate by more than 5 percentage points.
- Change in annual limits, including the addition of an annual limit, the decrease in limit for a plan with only a lifetime limit, or the decrease in limit for a plan with an annual limit.

In some respects, the inflationary provisions are surprisingly generous, by allowing inflationary adjustments, measured as of March 23, 2010. However, the preamble expressly rejects the option of an annual change allowance, thereby expecting plans eventually to lose grandfathered status prior to the implementation of the 2014 rules. The application of the inflationary provisions is quite complex, as is evidenced by the examples in the rules.

Collectively bargained plans. The rules clarify that any health insurance coverage under a collectively bargained agreement ratified before March 23, 2010 is a grandfathered health plan even if there is a change in insurers. The preamble also states that this rule applies only to insured plans, not self funded plans. Finally, the rules provide that both insured and self funded collectively bargained plans must comply with all the reforms under the Act that apply to grandfathered plans by the effective dates applicable to other plans.

These interpretations are surprisingly narrow, and do not favor collectively bargained plans.

Notice and recordkeeping requirements. The rules require grandfathered plans to include a statement in any plan materials that the plan believes that it is a grandfathered plan. The rules provide model language for this purpose. In addition, the plan must maintain records documenting its coverage as of March 23, 2010, and any other documents necessary to clarify its status.

Timing issues. Changes made to a plan on or before March 23, 2010 but not effective until later will not cause loss of grandfathered plan status. Additionally, changes made to a plan after March 23, 2010 and adopted prior to issuance of regulations will not cause loss of grandfathered plan status if the changes are revoked or modified as of the first day of the plan year beginning on or after September 23, 2010 and the modified terms would not cause loss of such status.

No preemption. The preamble states that the Act does not preempt state laws relating to insurers that are more strict than the Act.

Outstanding issues. The rules specifically leave unanswered, and invite comments on, whether the following changes lead to loss of grandfathered plan status:

- Changes to a plan structure, such as from a fully insured plan to a self funded plan.
- Changes (or the magnitude of changes) to a plan's provider network.
- Changes (or the magnitude of changes) to a plan's prescription drug formulary.
- Any other substantial change to the overall benefit design.

We can think of a few other items not addressed. The issue of whether a plan can switch from fully insured to self funded remains a critical issue, as many plan

sponsors might desire to change funding mechanisms in order to avoid the provisions specifically directed at insured plans such as the cost reporting and rebate rules (also known as medical loss ratio rules).

Definition of group health plan. The preamble clarifies some issues raised by imprecise language in the Act. The preamble states that the Act does not apply to plans with less than 2 employees, retiree only plans and excepted benefits under the HIPAA portability rules. The preamble further states that HHS will not enforce these provisions against retiree only plans or excepted benefits offered by nonfederal governmental plans, and that states have the primary authority to enforce the provisions with respect to individual and group market insurers.

Dated: July 6, 2010