HUNTON& WILLIAMS

CLIENT ALERT

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Health Care Reform — Grandfathered Plan Regulations Issued

On June 14, 2010, the Departments of Treasury, Labor and Health & Human Services published interim regulations addressing "grandfathered plan" status under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (collectively, the "Health Care Reform Law"). As was discussed in our April 2010 client alert "Health Care Reform — What Employers Need to Know Now," the Health Care Reform Law creates a number of new design and coverage mandates for group health plans. However, the new law also provides that some of these new requirements will not apply to, or will have a delayed effective date for, "grandfathered plans" — generally, both insured and self-insured group health plans in effect on March 23, 2010 (the date of the law's enactment). See April 2010 alert (at pages 2–3) for a description of these requirements.

In general, a loss of grandfathered status would cause a plan to become subject to all the Health Care Reform Law mandates applicable to group health plans, which could result in significant cost increases. The statute, however, does not directly address what benefit or other changes could cause a plan to lose grandfathered status. Because many employers are currently in the process of considering potential group health plan design changes for the upcoming plan year, there has been considerable concern and confusion over what types of changes might result in a loss of grandfathered status. The interim regulations, which are generally effective June 17, 2010, shed light on this question. The regulations also clarify that HIPAA-excepted benefits and retiree-only programs are not subject to the group health plan mandates contained in the Health Care Reform Law.

Set out below is a brief description of what the regulations provide regarding (i) the benefit and other changes that could affect continued grandfathered status of a group health plan and (ii) the applicability of the group health plan reforms to HIPAA-excepted benefits and retiree-only programs.

Application of Grandfathered Rules

Scope

The regulations provide that the grandfathered rules apply separately to each benefit option offered under a group health plan (e.g., PPO, HMO and high-deductible plan options). For example, the determination of grandfathered status for a plan that offers both an indemnity and an HMO option must be made for each option.

Thus, a disqualifying change to one option would not, by itself, cause the entire plan to cease to be grandfathered. Instead, only that option would lose grandfathered status.

Disqualifying Changes

The interim regulations provide that the following types of changes to a group health plan option will result in the loss of grandfathered status.[1]

For insured options:

- Entering into a new policy, certificate or insurance with the plan's current insurer; or
- Changing insurers.

For all options:

- Eliminating all or substantially all benefits to diagnose or treat a particular condition, or eliminating benefits for any necessary element to diagnose or treat a condition;
- Increasing a *percentage* cost-sharing requirement (such as a 20 percent coinsurance requirement);
- Increasing a *fixed-amount* cost-sharing requirements (other than copayments), such as a $500 deductible or a $2,500 out-of-pocket limit, by a total percentage that is more than the sum of medical inflation (expressed as a percentage) and 15 percentage points;
- Increasing a *fixed-amount* copayment by an amount that exceeds the greater of: (i) a total percentage that is more than the sum of medical inflation plus 15 percentage points or (ii) a $5 increase by medical inflation; or
- Decreasing the employer contribution rate for any tier of coverage (e.g., family or single coverage) by more than 5 percentage points.

In addition, the regulations provide that the following changes to an option's annual limits in effect on March 23, 2010, will also cause the option to lose grandfathered status.

- Imposing, for the first time, an annual limit on the dollar value of benefits (unless, in the case of an option that has a lifetime limit, the new annual limit is at least as high as the lifetime limit); or
- Decreasing the dollar value of the annual limit (regardless of whether the plan or health insurance coverage also imposes an overall lifetime limit on the dollar value of all benefits).

Permitted Changes — Special Rules

The regulations provide that the following post-March 23, 2010, changes will not cause a benefit option to lose grandfathered status:

- Changes made pursuant to a legally binding agreement entered into, a state insurance filing filed or an amendment adopted, prior to March 23, 2010;
- Changes made to comply with (or voluntarily follow) the Health Care Reform Law mandates; and
- Any other changes that were adopted prior to June 17, 2010 (the date the regulations were published), but only if those changes are reversed by the first plan year beginning on or after September 23, 2010 (e.g., January 1, 2011, for calendar year plans).

Disclosure/Documentation Requirements

In order to maintain grandfathered status, a group health plan must include a statement in any plan materials provided to participants or beneficiaries that describes the plan's benefits (e.g., open enrollment materials, summary plan description, etc.) that are grandfathered and lists contact information for participant questions. The interim regulations provide model language for satisfying this disclosure requirement.

Plans must also maintain records, subject to inspection by plan participants and government agency officials, documenting the terms of the plan in effect on March 23, 2010, which evidence its grandfathered status. In general, this documentation would include plan documents, health insurance policies, certificates of insurance, SPDs, premium rates, plan costs and employee contribution rates.

Special Rules for Collectively Bargained Plans

In general, the regulations provide that *insured* group health plans maintained pursuant to one or more collectively bargained agreements in effect on March 23, 2010, will be able to maintain their grandfathered status through the date that the last agreement expires, even if the plan changes

[1] Note that the determination of whether an impermissible change has been made is based on the benefit programs in place on, and (where relevant) medical inflation since, March 23, 2010.

insurers prior to expiration. However, upon expiration of the last agreement, the insured plan will be fully subject to the rules above, taking into account any changes prior to expiration. Thus, if a disqualifying change was made prior to expiration of the collective bargaining agreement, the applicable insured plan option will cease to be grandfathered upon the expiration of the collective bargaining agreement.

As for collective bargaining *self-insured* group health plans, the regulations provide that these plans are fully subject to the rules outlined above and, hence, have no special transition period.

Group Health Plan Reforms Applicable to Grandfathered Plans

As was pointed out in our April 2010 alert, even group health plan options that have, and continue to maintain, grandfathered status are subject to certain Health Care Reform Law mandates, including the following:

- The prohibition of preexisting condition exclusions.
- The limits on waiting periods.
- The prohibition of rescissions.
- The extension of adult child coverage until age 26.
- The prohibition of lifetime limits and the restriction of annual limits.
- The development and use of uniform explanation of coverage documents and standardized definitions.

Treatment of HIPAA-Excepted Benefits and Retiree-Only Programs

The agencies also addressed (in the preamble to the regulations) the treatment of HIPAA-excepted benefits[2] and retiree-only programs under the Health Care Reform Law, concluding that the group health plan reforms do *not* apply to these programs. Thus, employers will not need to revise these programs to comply with those reforms.

As you work through future health care plan design alternatives, it will be critical to understand whether any proposed changes will result in a loss of grandfathered status. We welcome the opportunity to assist you in this process or answer any questions you may have regarding the new regulations, including the exclusion of HIPAA-excepted benefits and retiree-only programs.

[2] In general, "excepted benefits" include most health care flexible spending accounts, dental-only and vision-only plans, Medigap policies and accident and disability programs.