

MEMORANDUM

June 15, 2010

RE: Grandfather" Status Under PPACA—Interim Final Rule

On June 14, 2010, the Department of Health and Human Services ("HHS"), the Department of Labor ("DOL"), and the Internal Revenue Service ("IRS"), jointly released their highly-anticipated "Interim Final Rule for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Plan under the Patient Protection and Affordable Care Act" (the "Rule" or the "IFR"). The Rule addresses what changes an insurer or plan sponsor may make to health insurance coverage or a group health plan without loss of its "grandfather" status under the Patient Protection and Affordable Care Act ("PPACA") and what administrative steps a plan must take to maintain grandfather status. The Rule also describes the manner in which the special rule for collectively bargained plans under PPACA interacts with the grandfather provisions. Finally, the Preamble to the Rule also clarifies that retiree-only plans and plans that provide HIPAA excepted benefits are not subject to the insurance market reforms of the PPACA. These rules are summarized below.

The Rule will be published in the Federal Register on June 17, 2010 and is effective immediately. Comments on the Rule are due 60 days after publication in the Federal Register.

I. Background

PPACA requires that insurers and plan sponsors modify their coverage to comply with significant new insurance market reforms, many of which are effective the first plan year on or after September 23, 2010 (*i.e.*, January 1, 2011 for calendar year plans). However, PPACA "grandfathers" certain plans that were in existence on the date of enactment from some of the insurance market reform requirements. Generally, a grandfathered plan will be exempt from certain insurance market reform provisions of PPACA, including requirements related to preventive care, internal and external review, nondiscrimination based on income, choice of providers, emergency care, clinical trials, cost sharing and deductibles, guaranteed issue/renewal, and rating restrictions. Grandfathered plans are not exempt from requirements related to annual and lifetime limits, dependent coverage to age 26, rescission, pre-existing condition exclusions, waiting periods, employer mandates, and tax provisions.

Specifically, PPACA contains a "grandfather" provision that provides, in pertinent part that:

with respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act [March 23, 2010] . . . [Subtitles A and C of the insurance market reform title] shall *not* apply to such plan or coverage, regardless of whether an individual renews coverage after such date of enactment.

The statute allows new employees and family members to be added to coverage, but, notably, does not address whether an insurer or plan sponsor may make changes to a

grandfathered policy or plan without loss of grandfather status. Given PPACA's silence and the considerable interest in this issue by insurers and plan sponsors, HHS, DOL, and the IRS issued the Interim Final Rule.

II. Grandfather Rule Application

A. Definition of a "Grandfathered Plan"

To be a grandfathered plan, the policy or group health plan must have had at least one individual enrolled in coverage on March 23, 2010, and the policy or plan must have continuously covered someone since March 23, 2010 (even if not the same individuals). Any new policy, certificate, or contract of insurance (versus renewal) issued after March 23, 2010 is not grandfathered.

Example: A plan moves from Insurer X to Insurer Z (for insured benefits) after March 23, 2010– the Plan is no longer grandfathered.

Under the Rule, grandfathered status applies separately to each benefit package offered under a policy or plan.

Example: A plan offers three options: Option F (self-funded), Option G (insured), Option H (insured). The Plan replaces the insurance issuer for Option H. Option H is no longer grandfathered, but Option F and G still are grandfathered (subject to the other grandfather rules).

The Preamble to the Rule states that any insurance policy sold to new entities or individuals after March 23, 2010 will *not* be grandfathered, even if the product was offered in the group or individual market before March 23, 2010.

B. Permissible Changes (No Loss of Grandfather Status)

The Preamble to the Rule provides the following examples of changes that, on their own, would not cause a plan to lose grandfather status (if these changes are combined with other types of changes, grandfather status could be impacted.):

- Changes to a policy or plan's premium;
- Changes required to comply with federal or state law;

Note that the Preamble does not provide examples of what changes can be made to comply with federal or state law without loss of grandfather status. Some laws, such as the Mental Health Parity and Addiction Equity Act, permit insurers and plans to place restrictions on benefits which might run afoul of the IFR's rules described above.

- Changes to voluntarily comply with provisions of PPACA or to increase benefits;
- Changes to a plan's third party administrator.

The agencies also ask for comments on whether the following changes should impact grandfather status (indicating that the agencies may view these as currently permissible changes):

- Changes to plan structure, *e.g.*, switching from a health reimbursement arrangement to major medical coverage, or from insured to self-funded coverage;
- Changes to a provider network; and
- Changes to a prescription drug formulary.

C. **Impermissible Changes (Will Cause the Loss of Grandfather Status)**

The Rule provides that the following changes *will* cause a policy or plan to lose its grandfathered status:

- **Elimination of Particular Benefit:** A policy or plan will lose its grandfathered status if it eliminates all or substantially all benefits to diagnose or treat a particular condition (including a necessary element to diagnose or treat a condition).

Example: A plan covers mental health benefits, which include counseling and prescription drug benefits. The plan eliminates the counseling benefit. According to the Rule, the plan has eliminated "an element that is necessary to treat the condition," and therefore has eliminated substantially all benefits to treat a condition. Accordingly, the plan loses its grandfather status.

- **Increase in Coinsurance:** A policy or plan will lose grandfather status if it increases its coinsurance percentage by any amount above the level at which it was set on 3/23/10.
- **Increase in Deductible or Out-of-Pocket Maximum:** A policy or plan will lose its grandfather status if it increases a deductible or out-of-pocket maximum by more than medical inflation plus 15%, as measured from 3/23/10.
- **Increase in Copayment:** A policy or plan will lose its grandfather status if it increases a copayment for any service by more than greater of: (1) \$5 (adjusted for medical inflation), or (2) medical inflation plus 15%, as measured from 3/23/10. The Rule contains a complex formula and examples that illustrate how to apply this requirement.
- **Decrease in Employer Contribution:** A policy or plan will lose grandfather status if an employer (or employee association) decreases its contribution rate toward the cost of any tier of coverage (*e.g.*, self or family) by more than 5 percent below the contribution rate on March 23, 2010.

- **Changes in Annual Limits:**
 - **No Previous Limits:** A policy or plan that did not impose an overall annual or lifetime limit on the dollar amount of all benefits on March 23, 2010 will lose grandfather status if the policy or plan thereafter imposes an overall annual limit on the dollar value of benefits.
 - **Previous Lifetime Limits:** A policy or plan that imposed an overall lifetime limit on the dollar amount of all benefits, but no annual limit, will lose grandfather status if the policy or plan thereafter imposes an overall annual limit on the dollar value of benefits that is lower than the dollar value of the lifetime limit on March 23, 2010.
 - **Previous Annual Limits:** A policy or plan that imposed an overall annual limit on the dollar amount of all benefits will lose grandfather status if the policy or plan thereafter decreases the dollar value of the annual limit (regardless of whether the plan also imposed a lifetime limit on March 23, 2010).

D. Eligibility and Enrollment Rules

The regulations provide that an insurer or plan may add new employees (whether newly hired or newly enrolled) after March 23, 2010, without loss of grandfather status. For example, employees may move between benefit options at Annual Enrollment without affecting the grandfather status of either option.

Plans also may transfer employees from one plan to another plan without impacting grandfather status, as long as there is a bona fide employment-based reason for the transfer. (The Rule provides that changing the terms or cost of coverage is *not* a bona fide employment-based reason). Specifically with respect to mergers and acquisitions, the Rule states that if the "principal purpose" of a merger, acquisition, or restructuring is to cover new individuals under a grandfathered plan, the plan will lose its grandfathered status.

E. Administrative Requirements

The Rule provides that in order to maintain grandfathered status, insurers and plans must maintain records documenting policy or plan terms that were in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as grandfathered plan. The insurer or plan must make records available upon request. The Preamble to the Rule states that participants, beneficiaries, subscribers, or state or federal agencies must be able to inspect such documents to verify the plan's status as a grandfathered plan.

To maintain grandfathered status, an insurer or plan must include a statement, in any plan materials provided to participants that describe benefits, that the insurer or plan "believes" that it is grandfathered under PPACA. Additionally, the insurer or plan must provide contact information for questions and complaints. The plan administrator's contact information must be provided, along with contact information for the DOL (in the case of an ERISA plan) or HHS

(for individual or nonfederal government plan). The Rule provides model language that insurers and plans may use to satisfy this disclosure obligation.

F. Special Rule for Collectively Bargained Plans

For health insurance coverage maintained pursuant to a collective bargaining agreement ("CBA") that was ratified prior to March 23, 2010, the coverage is deemed to be grandfathered until the date on which the last of the CBAs in effect on March 23, 2010 terminates. Then, the otherwise applicable grandfather rules apply.

Example: A plan maintains insured coverage pursuant to a CBA in effect prior to March 23, 2010, which does not expire until December 31, 2011. The plan switches its insurance policy from Insurer W to Insurer Y. The plan remains grandfathered because it is still under a CBA in effect on March 23, 2010.

The Preamble to the Rule clarifies that this special rule only applies to *insured* plans maintained pursuant to a CBA (not self-funded collectively bargained plans).

The Preamble also provides that the special grandfathering rule for collectively bargained plans does *not* delay the effective date for insured collectively bargained plans to comply with the reforms in Subtitles A and C that are applicable to grandfathered plans. In other words, an insured collectively bargained plan is subject to the same PPACA reforms that apply to other grandfathered plans at the same time as such reforms are applicable to other grandfathered plans. For example, an insured collectively bargained plan must comply with PPACA's age 26 dependent rule to the same extent as other grandfathered plans.

III. Transition Rules

The Interim Final Rule also includes some transition rules for plans that already have made changes prior to the publication of the regulation.

- **Changes Adopted Prior to March 23, 2010:** The Rule provides that a policy or plan will *not* lose grandfather status based on changes that would otherwise cause a loss of such status, if such changes were adopted *before* March 23, 2010 (even if they take effect after March 23, 2010) so long as such changes were adopted pursuant to a legally binding contract, insurance filing, or written plan amendment.
- **Good Faith Compliance:** The Preamble to the Rule states that for plan changes adopted *after* March 23, 2010 but before issuance of the Rule, which "only modestly exceed" the parameters established by the Rule, the agencies will "take into account good-faith efforts to comply with a reasonable interpretation of [PPACA]" in deciding whether such changes have caused the policy or plan to lose grandfathered status.
- **Grace Period:** For more significant changes to a policy or plan adopted *after* March 23, 2010 but before the Rule's issuance, which contravene the parameters

established by the Rule, the insurer or plan sponsor may revoke such change by the first plan year beginning on or after September 23, 2010 and not lose grandfather status. If such changes are not revoked or modified, the plan will lose grandfathered status.

IV. Retiree-Only Plans and Excepted Benefits Guidance

The Preamble to the Rule clarifies that retiree-only plans and HIPAA excepted benefits are not subject to the insurance market reform provisions of PPACA.

With respect to retiree-only benefits, the Preamble notes that the HIPAA portability provisions originally contained a small employer exception for plans with less than two participants who are current employees, which included retiree-only plans that cover less than two participants who are current employees. The Preamble further states that while the small employer exception was removed from the PHSAs by PPACA, it remains in effect in ERISA and the Internal Revenue Code (the "Code"). Accordingly, the Preamble provides that "the exceptions of ERISA section 732(a) and Code section 9831(a) for very small plans and certain retiree-only health plans remain in effect[.]" and PPACA's insurance market reforms will *not* apply to retiree-only plans sponsored by employers in the private sector. The Preamble also notes that HHS will not enforce the requirements of PPACA or HIPAA with respect to non-federal governmental retiree-only plans, and HHS will encourage states not to apply PPACA or HIPAA's requirements against issuers of retiree-only plans.

The Preamble also states that coverage that was considered an "excepted benefit" under the HIPAA portability rules still would be considered an "excepted benefit," and the new insurance market reform rules would not apply to these plans. Excepted benefits under HIPAA generally include benefits specifically listed under HIPAA (*e.g.*, accident and disability insurance, separate limited scope dental and vision plans, supplemental coverage, independent disease-only coverage and fixed indemnity plans).

V. Request for Comments

Comments on the Interim Final Rule are due 60 days from the date of publication in the Federal Register.

The agencies specifically asked for comments on whether the Rule's list of changes that result in a loss of grandfather status is appropriate, and "what other changes should be added to [the] list." The agencies also invited comment on the specific parameters identified in the Rule related to changes in benefits, cost sharing, and employer contributions, and whether these parameters should be modified.

Additionally, as noted in Section II. B., the agencies asked whether the following should result in cessation of grandfathered status:

- Changes to plan structure (such as switching from insured to self-funded coverage, or from a health reimbursement arrangement to major medical coverage);

- Changes to a provider network or drug formulary; and
- Other substantial changes to overall benefit design.

VI. Conclusion

The Interim Final Rule appears to permit insurers and plans to make at least some changes to coverage in the normal course of business, without loss of grandfather status, such as changes to a policy or plan's premiums, changes required by law, and possibly changes to a plan's prescription drug formulary and provider network. However, the Rule does limit when and how a plan may change benefits, cost sharing, or employer contributions. Insurers and plan sponsors must carefully evaluate any plan change in light of these new rules and consider how a change could impact grandfather status.

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