

Employee Benefits & Executive Compensation ADVISORY

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Summary of Interim Final Rules on Grandfather Provisions Under PPACA

Long-awaited regulations under the grandfather provisions of Section 1251 of the Patient Protection and Affordable Care Act (PPACA) were formally issued by the Departments of Health and Human Services, Treasury and Labor (the “agencies”) on June 14, 2010. The regulations are in the form of an interim final rule, and are effective immediately. They were published in the Federal Register on June 17, 2010. Comments on the regulations are due 60 days after publication in the Federal Register.

As anticipated, the regulations provide that certain changes to a grandfathered plan will result in loss of grandfathered status. However, what was not anticipated is how restrictive a view the agencies would take with respect to the types of changes that may be made without causing the loss of the grandfather. Indeed, it can be expected that most plans will lose grandfather status over time. The effect of losing grandfather status may vary on a plan-by-plan basis, and may depend on a variety of factors, including plan size and current plan provisions.

Now that the regulations have clarified a number of aspects as to what changes result in loss of grandfathered status, plan sponsors that are considering plan changes can compare the consequences (i.e., costs) of failing to make the changes compared to losing grandfather status. In some cases, the consequences of losing grandfather status may not be entirely clear, because needed regulations have not yet been issued. For example, grandfathered plans are not subject to the requirement (effective for plan/policy years beginning on or after September 23, 2010) that preventive services be covered without cost sharing. However, guidance as to the scope of preventive services that will be subject to this requirement has not yet been issued. A listing of the requirements of PPACA showing which requirements apply to grandfathered plans appears at the end of this advisory.

Grandfathered plans remain subject to the requirements of the Public Health Service Act (PHSA), ERISA and the Internal Revenue Code (the “Code”) that were applicable before the changes made by PPACA, except to the extent supplanted by the changes made by PPACA. Thus, for example, HIPAA portability and nondiscrimination requirements and the mental health parity provisions continue to apply.

In addition to addressing the grandfather issues, the preamble to the regulations provides helpful guidance (described below) with respect to which plans and products are subject to (and exempt from) the reforms included in PPACA.

The agencies may issue additional administrative guidance other than in the form of regulations prior to issuing final regulations.

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Scope of PPACA – Excepted Benefits and Retiree-Only Plans

As a result of drafting ambiguities, questions have arisen as to whether retiree-only plans and plans that provide excepted benefits as defined under HIPAA (including stand-alone vision and dental plans, specified disease and hospital indemnity plans, and accident and disability plans) are subject to PPACA. The preamble to the regulations confirms the agencies' view that the health care reforms (such as the prohibition on lifetime and annual dollar limits and required coverage of dependents to age 26) are not intended to apply to such plans.

Specifically, the preamble states the following:

- The exceptions in the Code and ERISA for self-insured retiree-only plans and HIPAA-excepted benefits remain in effect with respect to the provisions of PPACA.
- States have the primary authority to enforce the PHSA provisions with respect to group and individual market health insurance issuers, and HHS will only step in to the extent HHS believes the state has failed to substantially enforce these provisions. HHS will encourage states not to apply the market provisions of the PHSA under PPACA to fully insured retiree-only plans or to excepted benefits.
- HHS will not use its resources to enforce the requirements of PPACA with respect to nonfederal governmental retiree-only plans or excepted benefits provided by nonfederal governmental plans.

Stricter State Rules Not Preempted

The preamble confirms that states may impose requirements that are stricter than those imposed by PPACA.

Definition of Grandfathered Plan – In General

A “grandfathered plan” means coverage provided by a group health plan or a health insurance issuer in which an individual was enrolled on March 23, 2010.

A group health plan or group health insurance coverage does not stop being a grandfathered health plan merely because individuals enrolled on that date cease to be covered, provided that the plan or coverage has continuously covered at least one person (not necessarily the same person) since March 23, 2010.

The regulations apply separately to each benefit package available under a grandfathered health plan. That is, changes may result in one benefit package under a grandfathered health plan losing grandfather status while other benefit packages retain grandfather status. Thus, for example, disqualifying changes to a PPO offered under a grandfathered health plan will not cause an HMO option offered under the plan to lose grandfather status.

Entering into a new policy, certificate or contract of insurance after March 23, 2010 (as compared to renewing a policy) creates a new plan. Thus, for example, if a benefit option under a grandfathered self-insured plan became fully insured, grandfathered status would be lost, because the new policy would be considered a new plan. An exception exists for certain collectively bargained plans. (Note that the regulations are silent on the effect of a change from a fully insured plan to a self-insured plan; comments on that issue are specifically requested.)

Adding New Individuals to a Grandfathered Plan

A grandfathered health plan remains grandfathered if family members of an individual enrolled on March 23, 2010, enroll after that date. This rule applies with respect to grandfathered group health coverage and individual coverage.

New employees (including newly hired and newly enrolled employees) and their families may be enrolled in a grandfathered group health plan or grandfathered group coverage after March 23, 2010, without loss of grandfather status.

An anti-abuse rule limits an employer's ability to transfer employees between grandfathered plans unless there is a bona fide employment-based reason for the transfer. This rule is designed to prevent efforts to retain grandfather status by using a transfer to indirectly make changes that would result in loss of grandfather status if made directly. The regulations also provide that if a principal purpose of a merger, acquisition or similar business restructuring is to cover new individuals under a grandfathered plan, the plan ceases to be a grandfathered plan. This rule is intended to "prevent grandfather status from being bought and sold as a commodity in a commercial transaction."

Special Rules for Collectively Bargained Plans

There is no delayed effective date for collectively bargained plans, whether fully insured or self-insured. Thus, plans maintained pursuant to one or more collective bargaining agreements in effect on March 23, 2010, must comply with the new rules at the same time as other grandfathered plans. For example, effective for plan years beginning on or after September 23, 2010, grandfathered plans must comply with the requirement to extend dependent coverage until age 26; for plan years beginning before January 1, 2014, grandfathered group health plans may exclude an adult child if the child is eligible for other employer-sponsored coverage other than through a parent. The rules for coverage of adult dependent children apply to grandfathered collectively bargained plans the same as they do to other grandfathered plans, regardless of when the applicable collective bargaining agreement terminates.

The regulations provide that fully insured (but not self-insured) collectively bargained plans retain their grandfather status until the current agreement (i.e., the agreement in effect on March 23, 2010) expires. Thus, a change in carriers under a fully insured collectively bargained plan does not result in loss of grandfather status if the change is made before the current agreement (i.e., the agreement in effect on March 23, 2010) expires.

Changes to benefits that apply while the current collective bargaining agreement is in effect, such as increasing co-payments, do not result in loss of the grandfather. However, whether the grandfather applies after the expiration of the collective bargaining agreement is measured by comparing the benefits in effect at that time to the benefits in effect on March 23, 2010. If the changes are not within the permitted parameters (described below), then the plan will cease to be grandfathered when the relevant agreement expires.

Maintenance of Grandfather Status

As mentioned above, the regulations severely limit the changes that may be made under a plan without resulting in a loss of grandfather status. Any one of the following changes will result in the loss of grandfathered status with respect to the benefit package affected by the change:

- **Changes in insurance carriers:** Except with respect to insured grandfathered collectively bargained plans, a change in insurance carrier ends grandfather status for that benefit package option.
- **Changes in the scope of benefits:** The elimination of benefits to diagnose or treat a particular condition, even if the condition affects relatively few individuals under the plan, results in loss of grandfather status. The elimination of benefits for any necessary element to diagnose or treat a particular condition also results in loss of grandfather status. For example, if a plan covers a particular mental health condition, the treatment for which includes prescription drugs and counseling, elimination of counseling would result in loss of grandfather status. This provision is especially difficult for employers that are re-evaluating their mental health coverage in light of recent Mental health Parity and Addiction Equity Act of 2008 regulations.
- **Increases in percentage cost sharing requirements:** Any increase in any percentage cost-sharing amount (such as increasing a 20 percent coinsurance requirement for in-patient surgery to 30 percent) results in loss of grandfather status.
- **Increases in fixed amount cost sharing:** For fixed amount cost sharing other than co-payments (e.g., deductibles) the maximum permitted increase in the fixed amount (since March 23, 2010) without loss of grandfathered status is medical inflation (from March 23, 2010), plus 15 percentage points. For co-payments, the maximum permitted increase (since March 23, 2010) without loss of grandfather status is the greater of (a) the maximum percentage increase as described in the preceding sentence, and (b) \$5 increased by medical inflation. These restrictions apply to changes in any cost sharing requirement. Medical inflation is defined by reference to the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by the Department of Labor (OMCC). In March 2010, OMCC was 387.142.¹ The increase in the OMCC is computed by subtracting 387.142 from the OMCC “for any month in the 12 months before the new change is to take effect and then dividing that amount by 387.142.” An example from the regulations for co-payments helps to illustrate how this works:

On March 23, 2010, a grandfathered health plan has a co-payment requirement of \$30 per office visit for specialists. The plan is subsequently amended to increase the co-payment requirement to \$40. Within the 12-month period before the \$40 co-payment takes effect, the greatest value of the OMCC is 475.

The increase in the co-payment from \$30 to \$40, expressed as a percentage, is 33.33% ($40 - 30 = 10$; $10 \div 30 = 0.3333$; $0.3333 = 33.33\%$). Medical inflation from March 2010 is 0.2269 ($475 - 387.142 = 87.858$; $87.858 \div 387.142 = 0.2269$). The maximum percentage increase permitted is 37.69% ($0.2269 = 22.69\%$; $22.69\% + 15\% = 37.69\%$). Because 33.33% does not exceed 37.69%, the change in the co-payment requirement at that time does not cause the plan to cease to be a grandfathered health plan.

¹ See <http://www.bls.gov/cpi/#tables> for links to previous CPI reports.

It is important to note that although the regulations indicate that the increase must be “determined as of the effective date of the increase,” the OMCC is computed using “any month in the 12 months before the new change is to take effect.” In other words, it appears from the examples in the regulations that for a change that becomes effective on July 15, 2011, the OMCC between July 2010 and June 2011 with the “greatest value” can be used, and not necessarily the OMCC for July 2011.

- **Changes in rate of employer contributions for premiums:** A decrease in the employer contribution rate of more than five percent below the rate on March 23, 2010, for any tier of coverage for similarly situated individuals results in loss of grandfather status. In general, the employer contribution rate is the amount of contribution made by an employer compared to the total cost of coverage, as determined under the COBRA continuation rules. In the case of a self-insured plan, contributions by the employer are equal to the total cost of coverage minus the employee contributions toward the total cost of coverage. According to the examples in the regulations, pre-tax salary reduction contributions are considered employee contributions for this purpose. Under this rule, although the dollar amount of employee contributions may increase, there is no loss of grandfather status as long as the rate (i.e., the relative proportion) of employee contribution does not increase more than permitted.
- **Changes in annual limits:** The addition of an overall annual limit on the dollar value of benefits to a grandfathered plan that did not impose an overall annual or lifetime dollar limit on March 23, 2010, results in loss of grandfather status. If a grandfathered plan that had only a lifetime dollar limit on March 23, 2010, is modified to add an annual dollar limit on benefits, grandfather status is lost unless the annual limit is not less than the lifetime limit. If a grandfathered plan lowers an annual dollar limit on benefits below the limit in effect on March 23, 2010, grandfather status is lost. (Note, lifetime limits are prohibited for plan/policy years beginning after September 23, 2010; this prohibition applies to grandfathered plans.)

According to the preamble, changes other than those described in the regulations as resulting in loss of grandfather status do not affect the grandfather. Changes that do not result in loss of grandfather status include changes required to comply with federal or state law, changes to voluntarily comply with PPACA or increase benefits, and changes in third-party administrators with respect to a self-insured plan. (Note, the regulations specifically request comments as to whether changes in network providers should result in loss of grandfather status.)

Transition Rules

The regulations also include transition rules for plans and issuers that made changes after March 23, 2010.

- **Changes Treated as Made Before March 23, 2010:** Changes made as a result of the following situations will not result in the loss of grandfathered plan status and are considered part of the plan or policy terms on March 23, 2010, even though they are not effective until after March 23, 2010:
 - Changes made pursuant to a legally binding contract entered into on or before March 23, 2010;
 - Changes pursuant to a filing with a state insurance department on or before March 23, 2010; or
 - Changes pursuant to a written plan amendment adopted on or before March 23, 2010.

- **Grace Period for Changes Made After March 23, 2010:** Changes made after March 23, 2010, and before the date the regulations were publicly available (i.e., June 14, 2010), that would otherwise affect grandfather status may be revoked or modified in order to preserve the grandfather. Any such revocation or modification must be effective as of the first day of the first plan year (policy year in the case of the individual market) beginning on or after September 23, 2010. This transition rule applies to changes that are effective before June 14, 2010, or changes that are effective on or after such date pursuant to a legally binding contract, a state insurance filing or a written plan amendment entered into or made before such date.
- **Good Faith Compliance:** For enforcement purposes, the agencies will take into account good faith efforts to comply with reasonable interpretations of the statute prior to the issuance of regulations, and may disregard changes to plan and policy terms that “only modestly” exceed the parameters for changes that result in loss of grandfathered status set forth in the regulations and that are adopted before June 14, 2010.

Disclosure Requirements

In order to maintain grandfather status, a plan or health insurance coverage must include a statement in any plan materials provided to participants that the plan believes it is a grandfathered health plan and must provide contact information for questions (and complaints). A model notice is included in the regulations for this purpose.

Substantiation Requirements

For as long as a plan or insurance carrier takes the position that the plan or coverage is grandfathered, the following records must be maintained:

- Records documenting the terms of the plan or health insurance coverage in effect on March 23, 2010; and
- Any documents necessary to support the status as a grandfathered plan (for example, a copy of a legally binding contract in effect on March 23, 2010).

These documents must be made available for examination by participants, beneficiaries, individual policy subscribers and federal agency officials.

Insurance Reform (PHSA §)	Effective Date (in individual market, policy year is used instead of plan year)	Applicable to Grandfathered Plans?
Coverage of preventive care (without cost sharing) § 2713	First plan year beginning on or after September 23, 2010	No
Provision of additional information (transparency requirements) § 2715A	First plan year beginning on or after September 23, 2010 (under the statute, the additional information is first required in connection with the Exchanges that must be operational by January 1, 2014)	No
Nondiscrimination rules for insured plans § 2716	First plan year beginning on or after September 23, 2010	No
Certain reporting requirements (Statutory heading is "Ensuring quality of care") § 2717	First plan year beginning on or after September 23, 2010 (provision dependent on regulations; agencies must develop reporting requirements by March 23, 2012)	No
Claims appeal procedures § 2719	First plan year beginning on or after September 23, 2010	No
Patient protections (choice of primary care provider and emergency services without prior authorization) § 2719A	First plan year beginning on or after September 23, 2010	No
Fair health insurance premiums (limits factors that can be used to determine premiums) § 2701	First plan year beginning on or after January 1, 2014	No
Guaranteed availability of coverage (applicable to health insurance issuers) § 2702	Currently applies to small group (individual policies if conversion criteria met), expanded to individual and large group first policy year on/after 2014	No
Guaranteed renewability of coverage (applicable to health insurance issuers) § 2703	Currently applies to health insurance issuers.	No
Prohibition on discrimination against providers § 2706	First plan year beginning on or after January 1, 2014	No
Participation in clinical trials § 2709*	First plan year beginning on or after January 1, 2014	No

Insurance Reform (PHSA §)	Effective Date (in individual market, policy year is used instead of plan year)	Applicable to Grandfathered Plans?
Nondiscrimination based on health status § 2705	First plan year beginning on or after January 1, 2014	No (grandfathered plans remain subject to the rules in effect before health care reform)
Prohibition on preexisting condition exclusion § 2704	First plan year beginning on or after September 23, 2010 for individuals under age 19; first plan year beginning on or after January 1, 2014 for other individuals	Group – Yes Individual – No
Comprehensive health insurance coverage (requirement to provide essential benefits and cost sharing) § 2707	First plan year beginning on or after January 1, 2014. Large (100 employee+) and self-insured plans are exempt from the essential benefits mandate.	Yes
Restricted/prohibited annual limits § 2711(b)	First plan year beginning on or after September 23, 2010 “Restricted” annual limits are permitted until 2014; for plan years beginning on or after January 1, 2014, no annual limits are permitted	Group – Yes Individual – No
Prohibition on lifetime limits § 2711(a)	First plan year beginning on or after September 23, 2010	Yes
Prohibition on rescissions § 2712	First plan year beginning on or after September 23, 2010	Yes
Coverage of adult children § 2714	First plan year beginning on or after September 23, 2010; for grandfathered group plans, coverage required before 2014 only if the child is not eligible for other employer coverage (other than through parents)	Yes
Uniform explanation of coverage § 2715	First plan year beginning on or after September 23, 2010 (provision dependent on regulations; first disclosures not required under statute until March 23, 2012)	Yes
Bringing down the cost of health coverage (minimum medical loss ratio) § 2718	First plan year beginning on or after September 23, 2010	Yes (provision applies to insured plans only)
Limitation on waiting periods § 2708	First plan year beginning on or after January 1, 2014	Yes (not applicable to individual coverage)

* Due to drafting errors, there are two sections 2709 of the PHSA after PPACA. The section referred to in the table is a new section. The other section 2709 (relating to disclosure of information) is renumbered from prior law PHSA section 2713. Grandfathered plans remain subject to the pre-PPACA requirements that are still in effect.

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