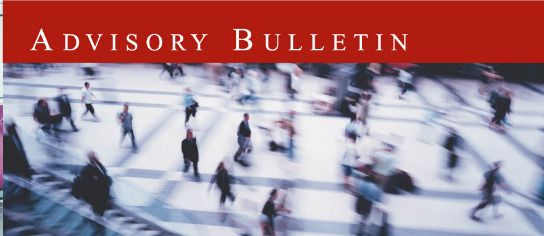

ADVISORY BULLETIN

July 2010

EMPLOYEE BENEFITS & EXECUTIVE COMPENSATION UPDATE

Thompson Hine's employee benefits lawyers understand the rising costs, increasing scrutiny and changing legal landscape facing employers who provide group health plan benefits to employees. We are working closely with our clients to help design, implement and administer health plans in this challenging environment. The breadth and depth of our experience allows us to identify best practices as they emerge and provide responsive, legally compliant and cost-effective solutions. For more information on ensuring that the design of your group health plan, employee communications and plan documentation comply with the Reform Legislation, please contact any member of our **Employee Benefits & Executive Compensation** practice group.

Health Care Reform: Grandfathered Plan Status

This bulletin discusses certain provisions of the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA), signed into law by President Obama on March 23 and 30, 2010, respectively (referred to collectively in this bulletin as the "Reform Legislation"), and Interim Final Regulations published in the Federal Register on June 17, 2010 relating to grandfathered plan status. This bulletin is the third in a series that will examine the impact of the legislation and implementing guidance on employer-sponsored group health plans. Specifically, this bulletin addresses the definition of grandfathered group health plan, documentation and disclosure requirements applicable to grandfathered group health plans, the circumstances that cause a group health plan to lose grandfathered plan status, certain transition relief for group health plans that unintentionally lost grandfathered plan status, Reform Legislation requirements applicable only to non-grandfathered group health plans and special rules applicable to retiree-only and insured collectively bargained group health plans.

The Reform Legislation specifies that certain group health plans in existence on the date of enactment (March 23, 2010) are subject to only certain of the provisions of the Reform Legislation. Although the Reform Legislation does not provide any guidance on what changes to a "grandfathered plan" will cause a group health plan to lose its grandfathered status, the Interim Final Regulations provide such guidance.

Additionally, the Interim Final Regulations specify that retiree-only plans (i.e., plans covering fewer than two active participants) are not subject to the Reform Legislation's market reform provisions and that insured collectively bargained plans (but not self-insured collectively bargained plans) are deemed to be grandfathered until the expiration of the last collective bargaining agreement in effect on March 23, 2010.

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WHAT IS A GRANDFATHERED GROUP HEALTH PLAN?

A grandfathered group health plan is one that provides grandfathered health plan coverage. Grandfathered health plan coverage is coverage provided by a group health plan in which an individual was enrolled on March 23, 2010 and that has not been revised to lose grandfathered plan status, as described below. The Interim Final Regulations indicate that a group health plan does not cease to be a grandfathered group health plan merely because one or more (or even all) individuals enrolled on March 23, 2010 cease to be covered, provided that the group health plan has continuously covered someone, not necessarily the same person, but at all times at least one person since March 23, 2010.

The Reform Legislation and the Interim Final Regulations also provide that a grandfathered group health plan can provide grandfathered health plan coverage to previously unenrolled dependents of participants who were enrolled in the group health plan on March 23, 2010; employees who enroll in the group health plan after March 23, 2010 and their dependents; and employees hired after March 23, 2010 and their dependents.

Finally, the Interim Final Regulations specify that the grandfathered plan status rules apply separately to each benefit package under a group health plan.

DOCUMENTATION AND DISCLOSURE REQUIREMENTS APPLICABLE TO GRANDFATHERED GROUP HEALTH PLANS

To maintain grandfathered plan status, a group health plan must maintain records documenting the terms of the group health plan in effect on March 23, 2010 and any other documents necessary to verify, explain or clarify its status as a grandfathered group health plan.

- The Interim Final Regulations provide that this documentation must be maintained for as long as the group health plan takes the position that it is a grandfathered plan. However, group health plan sponsors should consider maintaining the documentation for a longer period of time in case future audits raise concerns about the operation of the plan during the grandfathered period.

Additionally, any materials provided to a participant or beneficiary that describe the benefits provided under a grandfathered group health plan must indicate that the plan believes that it is a grandfathered group health plan and must provide contact information for questions and complaints.

- The Interim Final Regulations provide model notice language. Plans that intend to maintain grandfathered status for the 2011 plan year should include notice of grandfathered plan status with open enrollment materials and in the plan’s summary plan description.

WHAT CAUSES A PLAN TO LOSE ITS GRANDFATHERED STATUS?

Any of the following will cause a grandfathered plan to lose its grandfathered plan status:

Elimination of benefits. The elimination of all or substantially all benefits to diagnose or treat a particular condition, including the elimination of benefits for any necessary element to diagnose or treat a condition.

Increase in percentage cost-sharing requirement. Any increase in a percentage cost-sharing requirement above the level in place on March 23, 2010.

- Plan sponsors that adjust cost-sharing requirements in response to the Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act of 2008 and regulations issued thereunder need to be aware of how changes impact grandfathered plan status. Raising co-insurance levels on medical/surgical benefits, for example, could cause a plan to lose grandfathered plan status.

Increase in fixed-amount cost-sharing requirement other than a copayment. Any increase in a fixed-amount cost-sharing requirement (other than a copayment) by a total percentage measured from March 23, 2010 that is more than the sum of medical inflation plus 15 percent.

- For this purpose, medical inflation is expressed as a percentage and is defined as the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by the Department of Labor using the 1982-1984 base of 100.

Increase in fixed-amount copayment. Any increase in a fixed-amount copayment by an amount that exceeds the greater of: a total percentage measured from March 23, 2010 that is more than the sum of medical inflation plus 15 percent; or $5 increased by medical inflation since March 23, 2010 ($5 times medical inflation, plus $5).

Decrease in contribution rate. Any decrease in an employer's contribution rate for any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below the contribution rate in effect on March 23, 2010.

- A large premium increase will not cause a plan to lose its grandfathered plan status unless the plan sponsor makes a disqualifying change. For example, if the plan sponsor contributes 80 percent of the premium cost of coverage and the total premium cost of coverage increases by 10 percent in a single plan year, the premium increase will not cause the plan to lose its grandfathered plan status. However, if the plan sponsor adjusts its contribution percentage so that it contributes 70 percent of the new premium cost for coverage, the plan will lose its grandfathered plan status.

Changes in annual limits. The addition of an overall annual limit (for a plan that did not impose an overall annual limit or lifetime limit as of March 23, 2010); the addition of an overall annual limit in an amount exceeding the amount of a plan's overall lifetime limit (for plans that imposed a lifetime limit, but no annual limit, as of March 23, 2010); or any decrease in the overall annual limit in effect as of March 23, 2010 (for plans that imposed an overall annual limit as of March 23, 2010).

Abusive transactions. Entering into a merger, acquisition or business restructuring for the principal purpose of covering new individuals under a grandfathered health plan; or transferring employees from an old plan (or coverage option) to a new plan (or coverage option), for any reason other than a bona fide employment-based reason, where if the features of the new plan were an amendment to the old plan the old plan would lose its grandfathered status.

- It is unclear how the abusive transactions provisions of the Interim Final Regulations apply to corporate transactions where a buyer maintains a seller's employees in a seller health plan for some period of time and then transfers seller's employees into a buyer health plan in accordance with its normal business procedures.

New policy, certificate or contract of insurance. Entering into a new policy, certificate or contract of insurance after March 23, 2010.

- It appears that changing third-party administrators would not cause a self-insured group health plan to lose grandfathered plan status, but it is unclear whether entering a new stop-loss contract of insurance would cause a self-insured group health plan to lose grandfathered plan status.

Relief for Plans That Unintentionally Lost Grandfathered Status

Many plan sponsors made plan design decisions for the upcoming plan year before the grandfathering rules were made clear. In cases where those decisions would otherwise cause a group health plan to lose grandfathered plan status, the Interim Final Regulations provide relief based on whether the decisions were made before or after the Reform Legislation was enacted.

A plan sponsor that decided before March 23, 2010 to implement disqualifying changes to its group health plan may retain grandfathered status for its group health plan if the changes become effective after March 23, 2010 pursuant to a legally binding contract entered into on or before March 23, 2010, a filing with a state insurance department made on or before March 23, 2010, or a written plan amendment adopted on or before March 23, 2010.

- The fact that a plan sponsor decided upon or announced plan changes before March 23, 2010 does not necessarily satisfy these requirements. The changes must have been incorporated in a contract or amendment adopted before that date. Plan sponsors should consult legal counsel to determine whether a particular action could be considered a plan amendment.

A plan sponsor that implemented disqualifying changes to its group health plan after March 23, 2010 may retain grandfathered status for its group health plan if the changes were adopted before June 17, 2010 and are revoked (or otherwise modified so as not to cause the plan to lose grandfathered status) effective as of the first day of the first plan year beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans).

Reform Legislation Requirements That Apply Only to Non-Grandfathered Plans

Many group health plan sponsors believe that the cost savings available from plan design changes that will cause a group health plan to lose grandfathered plan status far outweigh the additional costs that will be incurred as a result of the additional Reform Legislation requirements applicable to non-grandfathered group health plans. To make this determination with respect to your group health plan, consider the following Reform Legislation requirements that apply only to non-grandfathered plans.

Effective for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar year non-grandfathered group health plans):

Preventive care services: Non-grandfathered group health plans must provide preventive care services without any cost-sharing.

- The Reform Legislation defines the preventive care services that are required to be provided without cost-sharing. Plans that already provide preventive care services without cost-sharing should be reviewed to compare the plan definition to the statutory definition and thus determine whether any additional services need to be covered without cost-sharing.

Primary care provider: Non-grandfathered group health plans that require or permit participants to designate a primary care provider must allow each participant to designate any participating primary care provider who is available to accept such participant.

Access to pediatric care: Non-grandfathered group health plans that require or permit participants to designate a primary care provider must allow participants who are children to designate a pediatrician as the child's primary care provider if such provider participates in the network of the plan.

Access to OB/GYN care: Non-grandfathered group health plans must provide coverage for obstetrical and gynecological care to female participants without requiring an authorization or referral by the plan, primary care provider or any other person, as long as the coverage is provided by a participating health care professional who agrees to otherwise adhere to the plan's policies and procedures.

No pre-authorization for emergency services: Non-grandfathered group health plans must cover emergency services without any prior authorization determination; whether the health care provider furnishing the services is a participating provider with respect to such services; without imposing more restrictive limitations on coverage for services provided by nonparticipating health care providers or higher cost-sharing requirements for services provided by out-of-network providers; and

without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, any applicable affiliation or waiting period and the applicable cost-sharing).

- The Reform Legislation uses a “prudent lay person” standard to define the emergency services that must be covered pursuant to these special rules. All non-grandfathered group health plans should be reviewed to ensure that all necessary emergency services are covered in compliance with the Reform Legislation.

New claims appeals processes: Non-grandfathered group health plans must provide an internal claims appeals process and an external claims appeals process.

- Compliance with the current Department of Labor regulations will satisfy the internal claims appeals process requirement.
- To comply with the external claims appeals process, non-grandfathered group health plans must establish an effective external review process that meets the minimum standards established by the Secretary of Health and Human Services similar to applicable state external review processes that include the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners.

Nondiscrimination rules for insured plans. Insured group health plans now must comply with the nondiscrimination requirements contained in Section 105(h) of the Internal Revenue Code.

- Many plan sponsors previously used insured plans to avoid issues under Section 409A of the Internal Revenue Code when providing post-termination or otherwise discriminatory benefits to current or former executives. The consequences of providing discriminatory benefits under insured plans are significantly different than the consequences of providing discriminatory benefits under self-insured plans, so plan sponsors should review their employment and severance agreements and consult with legal counsel on the best way to provide post-termination health coverage.

No limitation on eligibility for coverage for adult children: Non-grandfathered group health plans must allow adult children (up to age 26) to enroll regardless of eligibility for coverage under another employer’s group health plan.

- Grandfathered group health plans are permitted to deny coverage to an adult child who has coverage under an employer-sponsored group health plan other than a group health plan of a parent for plan years beginning before January 1, 2014.

Reporting requirements: Non-grandfathered group health plans must make available to the Secretary of Health and Human Services, the applicable state insurance commissioner and the public claims payment policies and data, enrollment (and disenrollment) data, data on rating policies, financial disclosures, information on cost-sharing and payments with respect to out-of-network coverage and information on participants’ rights under the Reform Legislation.

- These reporting requirements are particularly onerous. When deciding whether to maintain or give up grandfathered plan status, a plan sponsor should consider whether it is willing to make all of the required information public.

Effective within two years of March 23, 2010 (after the Secretary of Health and Human Services issues reporting requirements guidance):

Quality reporting: Non-grandfathered group health plans must report specified information regarding plan benefits and health care provider reimbursement structures to the Secretary of Health and Human Services and to participants annually during open enrollment.

Effective for plan years beginning on or after January 1, 2014:

Cost-sharing limitations: Non-grandfathered group health plans must limit cost-sharing (including deductibles, coinsurance, copayments or similar charges and any other expenditure required that is a qualified medical expense) to the amount of out-of-pocket expenses that would qualify a plan as a high-deductible health plan as of 2014.

- These limits are currently $5,950 for self-only (individual and not family) coverage and $11,900 for other coverage.
- For plan years beginning in 2015 and later, these amounts will be indexed.

Right to participate in clinical trials: Non-grandfathered group health plans must not deny coverage for participation in a clinical trial.

No discrimination based on health status: Non-grandfathered group health plans must not establish rules for eligibility or continued eligibility based on any specified health status related factors in relation to any participant or any other health status related factor determined inappropriate by the Secretary of Health and Human Services.

No discrimination against health care providers: Non-grandfathered group health plans must not discriminate with respect to participation under the plan against any health care provider who is acting within the scope of his license or certification under applicable state law.

- It is unclear how this requirement applies to HMOs.

Special Rules Applicable to Retiree-Only Plans

The preamble to the Interim Final Regulations confirms that the requirements of HIPAA (including the Reform Legislation's market reform provisions) do not apply to plans covering fewer than two active participants (including retiree-only plans) or plans providing only HIPAA-excepted benefits (including limited-scope dental and vision plans and certain health care flexible spending account plans). As a result, the requirements described in this bulletin, as well as the age 26 child coverage

requirement and certain other Reform Legislation provisions, do not apply to retiree-only plans and plans providing only HIPAA excepted benefits.

Special Rules Applicable to Collectively Bargained Plans

The Interim Final Regulations clarify that there is no delayed effective date for collectively bargained group health plans. As a result, collectively bargained group health plans are required to comply with the Reform Legislation in the same manner as non-collectively bargained group health plans.

- Sponsors of self-insured collectively bargained plans need to review the applicable collective bargaining agreement and consult with legal counsel to determine whether plan changes can be made without interim bargaining.

In addition, insured (but not self-insured) collectively bargained group health plans are deemed to be grandfathered group health plans until the expiration of the last collective bargaining agreement in effect on March 23, 2010.

Upon the expiration of the last collective bargaining agreement in effect on March 23, 2010, an insured collectively bargained group health plan determines its status as a grandfathered group health plan or a non-grandfathered group health plan by comparing the terms of the plan in effect at that time to the terms of the plan in effect on March 23, 2010. If any of the changes described above that cause a plan to lose its grandfathered status have occurred (except entering into a new insurance policy), the plan will cease to be a grandfathered plan.

To view our prior Reform Legislation bulletins, go to:

www.ThompsonHine.com/publications/publication2092.html
www.ThompsonHine.com/publications/publication2083.html

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