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**Re: Health Care Legislation Update #3
Grandfathered Plan Rules are Clarified with New Regulatory Guidance**

Dear Clients and Other Friends:

Much anticipated by employers and insurance providers in the fast-evolving environment of health care legislation, the "grandfathered health plan regulations" were jointly issued by the U.S. Treasury Department, Labor Department and Health & Human Services Department on June 14, 2010. These important "interim final regulations" were issued under the Patient Protection and Affordable Care Act of 2010 ("PPACA") and the Health Care and Education Reconciliation Act of 2010 (the "Reconciliation Act"), and are generally effective as of June 14, 2010.

Comments on these regulations are due by August 16, 2010. The regulations are available at this website: <http://www.dol.gov/federalregister/PdfDisplay.aspx?DocId=23967>.

A Short Summary of Health Care Legislation and Grandfathered Status

These interim final regulations were issued under both PPACA, enacted on March 23, 2010, and the Reconciliation Act, enacted on March 30, 2010. These two pieces of legislation change the health care laws relating to group health plans and health insurance issuers in the group and individual markets. The term "group health plan" includes both fully insured and self-insured group health plans.

PPACA's grandfather plan rule provides that various requirements of PPACA shall not apply to group health plans or health insurance coverage in which one or more individuals were enrolled on March 23, 2010, regardless of coverage after March 23, 2010. These grandfathered health plans, however, must comply with a subset of PPACA's new requirements that ensure access to coverage. Please see our firm's earlier client letters for a summary of these rules. (You may find our client letters at the following webpage: <http://www.khblaw.com/newsletters/>.)

By making grandfathered health plans subject to some but not all of the health reforms contained in PPACA, Congress intended to balance its objective of preserving the ability to maintain existing coverage with the goals of expanding access to and improving the quality of health coverage. As originally enacted, PPACA did not address at what point changes to a group health plan or health insurance coverage in which an individual was enrolled on March 23, 2010 become significant enough to cause the plan or health insurance coverage to cease to be a grandfathered health plan. This question was left to be addressed by regulatory guidance.

The preamble to the interim final regulations states that the grandfathering rule provides a reasonable framework for the gradual implementation of the health care industry's transition towards reforms established by PPACA. Though this may be a noble intent, the reasonableness of these rules has already begun to be debated by critics of PPACA.

How to Maintain Grandfathered Status

As noted above, PPACA did not specify what types of changes could result in the loss of grandfathered plan status. The regulations clarify the grandfathered plan rules. Under the new guidance, grandfathered health plans will have the flexibility to make some changes so long as they do not dramatically reduce people's benefits or increase their cost-sharing.

- The first set of rules constrains the extent to which the scope of benefits can be reduced. The "elimination of all or substantially all benefits to diagnose or treat a particular condition" is a change that would result in plan or health insurance coverage ceasing to be a grandfathered health plan. The preamble to the regulations emphasizes this rule, stating that the elimination of benefits for "any necessary element" to diagnose or treat a particular condition is also considered to be an elimination of all or substantially all benefits to diagnose or treat a particular condition.
- A second set of rules limits the extent to which plans and issuers can increase the fixed-amount and the percentage cost-sharing requirements that are imposed with respect to individuals for covered items and services without losing grandfathered status. If the increase surpasses the limits set under the new regulations, the individual's plan or group health insurance coverage ceases to be grandfathered. (See the chart on page 5 for additional information about this set of rules.)
- A third set of rules addresses the imposition of a new or modified annual limit by a plan, or group or individual health insurance coverage. The imposition of a new annual limit on the dollar amount of benefits that did not exist on March 23, 2010 -- or a modified annual limit with a dollar amount of benefits lower than what existed on March 23, 2010 -- would cause the individual plan or group health insurance coverage to lose its grandfathered status. (The chart on page 5 provides additional information about this set of rules).

Additionally, a plan or health insurance coverage must comply with new document and disclosure requirements in order to maintain status as a grandfathered health plan. To remain grandfathered, a health plan or health insurance coverage must:

- Include a statement that the plan or health insurance coverage is believed to be a grandfathered health plan under PPACA. The statement should be included in any plan materials provided to participants or beneficiaries (in the individual market, primary subscribers) that describe the benefits provided under the plan or health insurance coverage.
- Provide contact information for questions and complaints. The model language, as provided in the regulations, is set forth below:

This [group health plan or health insurance issuer] believes this [plan or coverage] is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.]

Clarification for Collectively Bargained Health Plans

Generally, PPACA states that for health insurance coverage maintained under one or more collective bargaining agreements (“CBAs”) ratified before March 23, 2010, the coverage is grandfathered at least until the date on which the last agreement relating to such coverage terminates. The new interim final regulations clarify the application of grandfathered plan rules to collectively bargained health plans:

- In a surprising twist, the preamble notes that PPACA used the term “health insurance coverage” instead of “group health plan” when it established this rule for collectively bargained health plans. As such:
 - fully-insured collectively bargained health plans are grandfathered until the date on which the last agreement relating such coverage terminates, regardless of changes made to the plan that would otherwise cause the plan to lose grandfathered status;
 - self-insured collectively bargained health plans, however, are immediately subject to the general grandfathered health plan rules as provided under the regulations.
- After the date on which the last of the collectively bargaining agreements relating to coverage terminates, fully-insured collectively bargained health plans become subject to the general grandfathered health plan rules as provided under the regulations.
- Moreover, grandfathered collectively bargained health plans (fully-insured and self-insured) are not exempt from the reforms that apply to all grandfathered plans, such as extension of dependent coverage for adult children up to age 26 and prohibition on pre-existing condition exclusions for enrollees under age 19.

Exception for Retiree-Only Plans and Excepted Benefits

Retiree-only plans and HIPAA-excepted benefits are not subject to PPACA. In an effort to clarify recent questions, the preamble states that plans covering less than two participants who are current employees (including retiree-only plans) fall under the small employer exception and therefore are not subject to PPACA's insurance market reforms. This exception from PPACA's insurance market reforms also applies to retiree-only plans sponsored by private employers. The preamble notes that the Department of Health & Human Services ("HHS") will not enforce PPACA or HIPAA's requirements with respect to non-federal governmental retiree-only plans, and that HHS will also encourage states not to apply PPACA or HIPAA's requirements against issuers of retiree-only plans.

Additionally, the preamble asserts that an "excepted benefit" under the HIPAA portability rules would continue to be an "excepted benefit" and that PPACA's insurance market reform rules will also not apply to these plans. Benefits specifically listed under HIPAA as "excepted benefits" include: accident and disability insurance; separate limited scope dental and vision plans; supplemental coverage; independent disease-only coverage; and fixed indemnity plans.

Transition Rules

For plans that have already made changes prior to the issuance of these new regulations, the regulations include grandfather transition rules:

- Generally, changes adopted before March 23, 2010 will not cause a plan or policy to lose its grandfathered status, even if they take effect after that date. Such changes must have been adopted under a legally binding contract, insurance filing or written plan amendment in order for a plan or policy to benefit from this rule.
- For changes adopted after March 23 but before June 14 that "modestly exceed" the guidelines established by the new regulations, the regulatory agencies will consider "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.
- For significant changes adopted after March 23 but before June 14 that are contrary to the guidelines established by the new regulations, the insurer or plan sponsor may revoke such change by the first plan year beginning on or after September 23, 2010 (by January 1, 2011 for calendar year plans) and not lose grandfather status. Grandfathered status will be lost, however, if these changes are not timely revoked or modified.

Which Changes Affect Grandfathered Plan Status

The chart on the next page provides a quick summary of the rules provided under the new regulations. Changes noted as "Okay" and "Okay for Now" may be made without causing the loss of grandfathered plan status, while the changes noted as "Not Okay" will result in the loss of grandfathered plan status. "Okay for Now" changes were noted in the new regulations as those topics on which regulators wish to receive input during the comment period.

Changes Affecting Grandfathered Plan Status	
Okay	Not Okay
<ul style="list-style-type: none"> • Changes to a premium or policy. • Changes required to comply with federal law. • Changes to voluntarily comply with PPACA provisions or to increase benefits. • Changes to a plan’s third party administrator (TPA). 	<ul style="list-style-type: none"> • Elimination of all or substantially all benefits to diagnose or treat a particular condition. • Increase in coinsurance/cost-sharing – if increased by any percentage above the March 23, 2010 level. • Increase in deductible or out-of-pocket maximum – if increased more than medical inflation plus 15%, as measured from March 23, 2010.
Okay for Now (pending further guidance)	
<ul style="list-style-type: none"> • Changes to a plan’s structure - such as switching from a health reimbursement arrangement to major medical coverage or from an insured to a self-insured product. • Changes to a provider network. • Changes to a prescription drug formulary. 	<ul style="list-style-type: none"> • Increase in copayment – if increased by more than the greater of (1) \$5 (adjusted for medical inflation), or (2) medical inflation plus 15%, as measured from March 23, 2010. • Decrease in employer contribution – if decreased relating to the cost of any tier of coverage by more than 5% below the contribution rate on March 23, 2010. • Changes in annual limits – generally, any change to applicable lifetime or annual limits as in effect on March 23, 2010.

Conclusion

Changes, more changes and regulations about changes! The effect of the health care legislation will continue to be felt as additional guidance continues to be issued. These interim final regulations provide much-needed clarifying guidance about the grandfather plan rules. These new regulations clearly constrain the ability of grandfathered plans to make changes.

The next step for employers and health insurance issuers is to determine which plans and policies are grandfathered and review what changes may be possible or necessary. Ultimately, employers and health insurance issuers must determine whether maintaining grandfathered plan status makes economic and administrative sense.

We welcome your inquiries about these new grandfathered plans rules, as well as your questions about 2010 health care legislation regulatory guidance.

Very truly yours,

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