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LEGAL ALERT

May 5, 2010

Health Care Reform: Understanding the Grandfather Rules

The coverage mandates and insurance reforms in Subtitles A and C of the Patient Protection and Affordable Care Act (PPACA) will require significant changes to employer-sponsored health plans. Several of the mandates become effective in 2010 or 2011, requiring immediate attention, while others become effective over the next several years. Also, though PPACA generally applies to all group health plans and health insurance coverage going forward, certain existing plans and coverage are exempted, or "grandfathered," from a number of the new requirements. The grandfather provision delays the time a new rule will apply to a grandfathered plan in some cases and in other cases seems to provide a complete exemption from the rules.

The grandfather provision, found in section 1251 of PPACA[1], is intended to provide plan sponsors and insurers with greater certainty regarding their current benefit arrangements. Grandfathered plans will be able to maintain many of their current coverage provisions and will require fewer changes to plan documents and administrative procedures in order to comply with the new law. However, with its caveats, ambiguities and exceptions, the grandfather provision has raised as many questions as it has answered, particularly for large employers with complex benefits arrangements.

This Alert addresses the ten most frequently asked questions regarding grandfather protection for large employer-sponsored group health plans. The Alert also includes a quick-reference chart with details on key provisions that are applicable to grandfathered plans, as well a final section summarizing the rules that grandfathered plans are able to avoid – at least for the time being.

Q-1: What is a grandfathered group health plan?

A-1: A grandfathered group health plan is a plan in which an individual was enrolled on March 23, 2010. A grandfathered plan can be a single employer plan, a multi-employer plan, or a multiple employer plan; it can also be an insured or a self-insured arrangement.

Q-2: My plan appears to be grandfathered. What does that mean?

A-2: Depending on the provision, grandfathered plans may benefit from either a delayed effective date for compliance with, or a total exception from, certain insurance market reforms and coverage mandates under Subtitles A and C of PPACA. However, it is important to note that grandfathering does not protect a plan from the reforms found in other parts of the statute, including, for example, the mandatory requirement to include the value of coverage on each employee's Form W-2 (effective January 1, 2011), the large-employer mandate to offer affordable coverage to full-time employees (effective January 1, 2014), the high-cost health plan excise tax (effective January 1, 2018) and the mandatory automatic enrollment requirement (effective once regulations are issued).

[1] As amended by section 10103 of PPACA and section 2301 of the Health Care and Education Affordability Reconciliation Act of 2010.

Q-3: Is grandfathering indefinite? In other words, for any rule that does not expressly include a delayed effective date, does the grandfather rule mean that we will never need to amend the plan for that provision?

A-3: While the grandfather provision does not include a general sunset date for non-collectively bargained grandfathered plans, it is unlikely that these plans will have a permanent exception from compliance with any of the insurance market reforms and coverage mandates in the statute that do not expressly include a delayed effective date. Given the flexibility of the language of the grandfather rule, the federal agencies invested with regulatory authority over the new law (specifically, the Internal Revenue Service, the Department of Labor, and the Department of Health and Human Services) are likely to issue guidance that places certain parameters around grandfather protection.

Q-4: If I add new employees (or new enrollees) to my currently grandfathered plan, does the plan lose its grandfathered status?

A-4: No. Section 1251(c) of PPACA specifically provides that a grandfathered plan may enroll new employees and their families in the plan without losing the plan's grandfather status. In addition, the statute also states that grandfathering continues to apply to the coverage of an individual covered by the plan on the date of enactment regardless of whether the individual renews coverage or adds family members after the date of enactment. Although the statute does not specifically state that a plan may add other new enrollees (*i.e.*, current employees who have not previously enrolled in the plan), it is unlikely that enrollment of such employees in the ordinary course will cause the plan to lose its grandfathered status. Guidance is needed as to whether more significant changes in enrollment will cause a plan to lose grandfather status (*e.g.,* the enrollment of a large group of employees following a corporate acquisition).

Q-5: Can I amend my grandfathered plan without losing the grandfathered status?

A-5: Presumably some amendments are permitted, but the complete answer to this question is still unclear. Unlike the grandfather provisions of other legislation, section 1251 of PPACA does not expressly prohibit amendments to a grandfathered plan, nor does it contain a mandate requiring plan sponsors to maintain benefits at current levels in order to preserve grandfather status. Arguably, this means that plan sponsors may freely amend their grandfathered plans without jeopardizing the plan's grandfathered status. However, it is unlikely that such a liberal reading of the provision accurately reflects legislative intent. Until further guidance is issued, plan sponsors must consider amendments to grandfathered plans on a case-by-case basis to determine (1) whether the amendment substantively alters the nature of the plan's coverage in a manner that may jeopardize the plan's grandfathered status, and (2) the true cost impact of losing grandfather status.

Q-6: How does the grandfather rule apply to collectively bargained plans?

A-6: Section 1251(d) of PPACA provides that health insurance coverage maintained pursuant to one or more collective bargaining agreements that were ratified before March 23, 2010, is not subject to the insurance market reforms and coverage mandates in Subtitles A and C of PPACA until the date on which the last collective bargaining agreement relating to coverage terminates. The provision also states that any coverage amendments made pursuant to a collective bargaining agreement that amends the coverage to conform with Subtitles A or C will not cause the plan to lose its grandfathered status. However, the application of the rule to collectively bargained plans remains unclear in several respects. For instance, the statute does not clarify whether the termination of the collective bargaining agreement subjects the collectively bargained plan to <u>all</u>

provisions of Subtitles A and C, or whether "regular" grandfathering (as described above) will then apply. In addition, the language of the statute suggests that grandfathering may only apply to fully insured (not self-insured) collectively bargained plans. Finally, it is also unclear how the grandfather rule will apply to plans subject to "evergreen" bargaining agreements.

Q- 7: Are all of my medical plans that covered employees as of March 23, 2010, grandfathered?

A-7: Grandfathering applies to all group health plans that are welfare benefit plans under ERISA section 3(1) and all health insurance coverage to the extent that the plan or coverage provides medical care to employees and their dependents through insurance, reimbursement, or otherwise, even if coverage is offered through a medical service policy or an HMO offered by a health insurance issuer.

Q- 8: Will my grandfathered plan satisfy the minimum essential coverage requirement under Section 5000A and 4980H of PPACA?

A-8: PPACA creates a new section 5000A of the Internal Revenue Code (IRC), which mandates that individuals maintain "minimum essential coverage." PPACA also creates new IRC section 4980H, which mandates that large employers offer the minimum essential coverage to their full-time employees. Each of these provisions becomes effective January 1, 2014. To the extent that an individual is covered under, or an employer offers, a grandfathered plan (that otherwise meets the provisions of the PPACA, as amended) the individual and the employer will be treated as satisfying the respective mandates as of the effective date.

Q-9: When will I need to make amendments to the plan to comply with the market reform provisions that are applicable to grandfathered plans?

A-9: The effective date for each of the provisions applicable to grandfathered plans is outlined on the attached chart. Grandfathered plans should be amended to comply with these provisions before each applicable effective date. However, depending on individual circumstances, some employers that are in the process of drafting amendments for the 2011 plan year may consider making one set of amendments to comply with provisions that become effective as late as 2014. The last section of the chart lists provisions that it currently appears will never apply to grandfathered plans.

Q-10: Are the agencies planning to issue guidance on the grandfather provisions in PPACA in the near future?

A-10: While it is difficult to predict when any particular PPACA guidance will be issued, agency officials have informally indicated that clarifying the grandfather rules is an important issue that will likely receive priority as guidance is developed.

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Required compliance provisions for grandfathered Group Health Plans[2]
Subtitle A and Subtitle C Provisions

Grandfathered plans must comply with the following provisions as of March 23, 2010:
Utilization of a uniform explanation of benefits - requires plans and insurers to issue standardized summaries of benefits and coverage explanations pursuant to standards established by the Secretary of HHS. *(Patient Protection and Affordable Care Act (PPACA) §§1001, 1562(e), 10103*; *Public Health Services Act* (*PHSA) §§2715, 2715A)*
Reporting loss ratios - requires fully insured plans and insurers to submit a report regarding non-claims expenses to the Secretary of HHS, and to provide annual rebates to enrollees if the ratio of costs to premium revenue exceeds 85%. *(PPACA §§1001, 1562(e), 10103; PHSA §2718)*

Grandfathered plans must comply with the following provisions for plan years beginning on or after September 23, 2010:
Prohibition on lifetime limits - prohibits plans and insurers from placing lifetime limits on the dollar value of certain essential benefits. *(PPACA §1001, 10101; Health Care and Education Affordability Reconciliation Act (Reconciliation Act) §2301; PHSA §2711)*
Prohibition on rescissions - prohibits plans and insurers from rescinding an enrollee's coverage (except in the case of fraud or misrepresentation), or cancelling coverage without prior notice. *(PPACA §1001, Reconciliation Act §2301, PHSA §2712)*
Extension of dependent coverage to adult children - requires plans and insurers that offer dependent coverage to children to extend such coverage to adult children up to age 26 (regardless of marital or student status). However, for plan years beginning prior to January 1, 2014, grandfathered group health plans are only required to extend coverage if an adult dependent is not eligible to enroll in an employer-sponsored health plan other than a grandfathered plan. After January 1, 2014, all plans must extend this coverage regardless of the child's ability to obtain other coverage. *(PPACA §1001, Reconciliation Act §2301, PHSA §2714)*
Restriction on annual limits - prohibits plans and insurers from placing annual limits on the dollar value of certain essential benefits for any participant or beneficiary. However, for plan years beginning prior to January 1, 2014, a grandfathered plan may establish a restricted annual limit on essential health benefits,[3] as defined by HHS in forthcoming guidance. *(PPACA §§1001, 10101, Reconciliation Act §2301, PHSA §2711)*
Prohibition on pre-existing condition exclusions - prohibits plans and insurers from imposing any preexisting condition exclusion on coverage. Generally effective for plan years beginning prior to January 1, 2014; however, for enrollees who are under age 19, the provision is effective for plan years beginning on or after September 23, 2010. *(PPACA §1201, Reconciliation Act §2301; PHSA §2704)*

Grandfathered plans must comply with the following provision for plan years beginning on or after January 1, 2014:
Prohibition on excessive waiting periods - prohibits plans and insurers from applying a waiting period that exceeds 90 days. *(PPACA § 1201, Reconciliation Act §2301, PHSA §2708)*

[2] The provisions described in this chart apply only to non-collectively bargained plans with 100 or more employees.

[3] Essential health benefits, as defined under section 1302(b) of PPACA, includes ambulatory patient services, emergency services, hospitalization coverage, maternity and newborn care coverage, mental health and substance abuse disorder services (including behavioral health treatment), prescription drug coverage, rehabilitative and habilitative services and devices, lab services, preventive and wellness services, chronic disease management, and pediatric services, including oral and dental care. It is unclear whether the Secretary will follow this definition.

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Provisions NOT applicable to grandfathered Group Health Plans (until further guidance is issued):

SUBTITLE A provisions (generally effective for non-grandfathered plans for plan years beginning on or after September 23, 2010)	**SUBTITLE C provisions (generally effective for non-grandfathered plans for plan years beginning on or after January 1, 2014)**
Requirements regarding preventive health services - requires plans and insurers to cover, with no cost-sharing requirements, certain types of preventive health care, including certain immunizations and cancer screenings. *(PPACA §1001, PHSA §2713)*	**Prohibition against discrimination based on health status -** prohibits plans from establishing eligibility rules based on certain health status factors; codifies wellness program rules and increases maximum reward amounts for wellness programs. *(PPACA §1201, PHSA §2705)*
Prohibition against discrimination in favor of highly compensated individuals - applies the nondiscrimination provisions of IRC section 105(h) to fully insured health plans, preventing such plans from discriminating in favor of highly compensated individuals (as defined in IRC section 105(h)(5)). *(PPACA §§1001, 10101; PHSA §2716)*	**Prohibition against discrimination against health care providers -** prohibits plans from discriminating against any health care provider acting within the scope of his or her provider's license with regard to benefits coverage or participation under the plan. *(PPACA §1201; PHSA §2706)*
Required reporting on quality features - requires group health plans and insurers to submit a report on certain quality of care structures to the Secretary of Health and Human Services (HHS) and enrollees. *(PPACA §1001, PHSA §2717)* (becomes effective in practice only after the Secretary of HHS issues guidance).	**Comprehensive health insurance requirement -** requires that plans limit cost-sharing and offer certain minimum coverage levels as set out in section 1302 of PPACA. *(PPACA §1201; PHSA §2706)*
Requirement regarding internal appeals - appears to extend certain ERISA protections regarding claims appeals to the individual insurance market. *(PPACA §§1001, 10101; PHSA §2719)*	**Coverage requirement for clinical trials** - prohibits group health plans and insurers from denying coverage for participation in a clinical trial. *(PPACA §10101, PHSA §2709)*
Prohibitions on restrictions regarding health care providers and other patient protections - prohibits plans and insurers from limiting the types of health care providers that may be designated as a primary care provider; requires plans that cover emergency services to do so without requiring prior authorization and prohibits limits on coverage or additional cost-sharing for emergency services provided by non-network providers; prohibits plans and insurers from requiring a referral in order for a female participant to obtain access to an obstetrician or gynecologist. *(PPACA §10101, PHSA §2719A)*	