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CLIENT ALERT

Health Care Reform Regulations Arrive – Now What? What You Need to Know Right Now About Health Care Reform Regulations (So Far)

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As discussed in our May 12, 2010 Labor & Employment Law Alert, in March 2010, President Obama signed into law both the Patient Protection and Affordable Care Act ("PPACA") and the Health Care and Education Tax Credit Reconciliation Act ("HCERA"), which supplemented and modified PPACA (this Alert will refer to these two laws collectively as "Health Care Reform" or "Health Reform Laws"). As we noted in our May 12 Alert, Health Care Reform is an on-going process with compliance requirements developing over time, and the pace of those developments has proven to be quite impressive. To date, in just over 3 months since PPACA was signed into law, the Department of Health and Human Services ("HHS"), Department of Labor ("DOL"), and Department of the Treasury ("Treasury") have jointly issued interim final rules on the following four major provisions of Health Care Reform:

I. **Requirement to Cover Older Children:** As discussed in our May 12 Alert, the Health Reform Laws generally require plans, if they offer dependent coverage, to cover a participant's adult children until age 26, even for married children. On May 13, HHS, DOL and Treasury jointly released interim final regulations on this requirement. Notably, in addition to restating the statutory requirements, the regulations imposed a "uniformity" requirement under which the terms of a plan providing dependent coverage of children cannot vary based on age (except for children who are age 26 or older). For a fuller discussion of the requirements of these regulations, please follow this link.

II. **Grandfathered Health Plans:** As discussed in our May 12 Alert, under PPACA, a group health plan in effect on March 23, 2010 is considered to be a "grandfathered health plan," meaning that, except as specifically indicated otherwise, the provisions of the Health Reform Laws that apply to group health plans will not apply to such grandfathered plans. On June 17, interim final regulations were released governing the application and retention of such grandfather status. The regulations not only further define grandfather status, but also discuss new notice and recordkeeping requirements, detail how new employees may be added to a grandfathered plan, describe special rules for collectively bargained plans, detail the plan changes that will cause a plan to lose grandfather status, and provide certain transition and good-faith compliance rules. This guidance makes it very clear that it will be difficult for most plans to maintain grandfathered status. For a fuller discussion of the requirements of these regulations, please follow this link.

III. **Early Retiree Reinsurance Program:** In our May 12 Alert, we described the statutory provisions for the Early Retirement Reinsurance Program ("ERRP") under which the government will provide reimbursement of 80% of the cost (up to a cap of $90,000) of health benefits provided to pre-Medicare early retirees between the ages of 55 and 64 (and to their dependents). Since the publication of that Alert, HHS has issued interim final regulations and other guidance that provides more details regarding the coverage of the program and the manner in which plans can become certified for the statutory reimbursements. Among the important points in the regulations are: (a) plan sponsors are now included among the groups that can receive reimbursement, thereby making it possible for self-funded (i.e., non-insured) plans to participate fully in the reimbursement program; (b) plans are allowed significant leeway in identifying and implementing programs and procedures to provide cost savings to participants with chronic and high-cost conditions, including, for example, direct reductions in financial requirements for such participants or the adoption of disease-

specific wellness or health improvement programs; and (c) once a plan is certified for participation in the program, annual re-applications for continued participation in the program are not required.

Because of the limited four-year duration (through 2014) and limited funding ($5 billion) of this program, it is imperative that plans and plan sponsors apply for certification as soon as possible. (Although the official start-up date for the program was June 21, 2010, the application for participation in the program was not made available until June 29). This is particularly true because HHS noted in a series of FAQs published in early June 2010 that applications will be handled on a first-filed basis. For a fuller discussion of the requirements of the ERRP, please follow this link.

IV. **Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections:** On June 28, HHS, DOL and Treasury released interim final regulations covering a broad array of topics under PPACA, including preexisting condition exclusions, lifetime and annual limits, rescission, and other patient protections (such as choice of health care professionals and emergency services coverage). These regulations will be effective on August 27, and we will summarize them in a future Alert.

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We expect Health Care Reform will continue to be an on-going process with further compliance requirements developing over time. We will, of course, keep you apprised of any important developments over the coming weeks, months and years as they occur.

If you have any questions about this Alert, Health Care Reform generally, or about any other employee benefits matter, please contact the attorneys listed at the bottom of this page or your usual Crowell & Moring contact.

Requirement to Cover Older Children

The Health Reform Laws generally require that if a plan offers dependent coverage, it must cover a participant's adult children until age 26, even in the case of married children. For plan years beginning before January 1, 2014, grandfathered plans are required to cover such adult children only where the children are not eligible to enroll in another employer-provided plan. For plan years beginning on or after January 1, 2014, however, this limitation for grandfathered plans is lifted, and this coverage expansion will apply equally to both grandfathered and non-grandfathered plans. (However, plans are still not required to provide coverage for the child of a child or the spouse of a child).

On May 13, HHS, DOL and the Treasury jointly released interim final regulations on this matter. The interim final regulations are applicable for plan years beginning on or after September 23, 2010. In addition to restating the statutory requirements discussed above, the regulations include two new standards not explicitly included in the statute. First, the regulations impose a "uniformity" requirement under which the terms of a plan providing dependent coverage of children cannot vary based on age (except for children who are age 26 or older). The regulations provide several examples of this uniformity requirement. One such example makes clear that employers and plans are not allowed to impose an additional premium surcharge on children who are older than age 18 because such a surcharge would constitute an impermissible variation based on age. Another example makes

clear that plans may not restrict certain ages of children to only one benefit option (for example, a plan may not limit children who are older than age 18 to only an HMO option if an indemnity option is also available).

Second, the regulations establish a transitional rule for individuals whose coverage ended by reason of reaching a plan's age threshold, but who will be eligible under this adult-child coverage expansion. The transitional rule requires that plans allow such children a special 30-day enrollment period, beginning no later than the first day of the first plan year beginning on or after September 23, 2010 (i.e., January 1, 2011 for a calendar-year plan), to enroll in plan coverage, with such new coverage to be effective no later than (for a calendar-year plan) January 1, 2011. The regulations also require that children be provided (either directly or through their parents) with notice of this special-enrollment period no later than (for a calendar-year plan) January 1, 2011.

Although the adult-child expansion provision is not effective for most plans until 2011, the Health Reform Laws also amended the Internal Revenue Code, effective in 2010, to allow (but not require) plans to extend coverage to an employee's children on a more generous basis than had been previously allowed (up to age 27). However, any such coverage expansions are only effective (at least for tax purposes) after the plan has been amended. The Internal Revenue Service has issued guidance to clarify that this Code amendment applies to permit the value of health care coverage expanded to cover adult children (i.e., the premium) to be excluded from the income of the employee, and has also indicated that the cafeteria plan regulations will be amended to accommodate mid-year election changes due to this change in law (i.e., for adult children who are newly eligible under the PPACA change in the law).

Grandfathered Health Plans

Under section 1251 of PPACA, a group health plan in effect on March 23, 2010 is considered to be a "grandfathered health plan," meaning that, except as specifically indicated otherwise, the provisions of PPACA that apply to group health plans will not apply to such grandfathered plans. On June 17, HHS, DOL and Treasury jointly issued interim final regulations regarding grandfathered plan status. The preamble to the regulations states that they are effective on June 14, 2010, and any comments on the regulations are due on or before August 16, 2010. These regulations not only further define grandfather status, but also address several pertinent issues for grandfathered plans, including, importantly, how a plan can lose such status.

Definition of Grandfathered Health Plan

At the outset, the regulations define grandfathered health plan coverage by reference to the statutory definition in PPACA, i.e., a group health plan or group or individual health insurance coverage is a grandfathered health plan with respect to individuals enrolled on March 23, 2010. The regulations then note that a grandfathered plan must continuously cover at least one person from March 23, 2010 onward (not necessarily the same person, but at all times at least one person). The regulations then go on to state that the purchase of new insurance policies and/or the change in insurance carriers will cause a plan to lose its grandfathered status. This loss of grandfathered status will occur regardless of whether the newly purchased insurance policy is itself considered to be grandfathered with respect to any other policy holders. In other words, the grandfathered status of a policy only attaches in regards to a policy held by a specific individual or entity prior to March 23, 2010.

Notice and Recordkeeping Requirements

The regulations require that, in order for a plan to maintain its status as a grandfathered plan, it must (1) include a statement (model language is provided in the regulations) regarding its status as a grandfathered plan in any plan materials provided to participants or beneficiaries describing the benefits provided under the plan, (2) maintain records necessary to verify its status as a grandfathered plan, including records documenting the terms of the plan or health insurance coverage that were in effect on March 23, 2010, and (3) make such records available for inspection by participants, beneficiaries and appropriate State and Federal agency officials, so that these parties can verify the status of the plan as a grandfathered health plan.

Adding New Employees

Under the regulations, plans are allowed to enroll "new employees" and their families after March 23, 2010 without losing grandfathered plan status. The term "new employees" is explained briefly in the regulations to mean both employees who are newly hired *and* employees who are newly enrolled in the plan. The effect of this provision appears to be that companies will be free to allow current employees to change their plan enrollments without endangering grandfathered plan status.

Collectively Bargained Plans

The regulations also clarify how grandfather status will apply to fully insured collectively bargained plans. Such plans will essentially enjoy relief from the potential of losing grandfather status until the expiration of the last collective bargaining agreement relating to the coverage that was in effect on March 23, 2010. However, once this last collective bargaining agreement terminates, all of the regulatory provisions will apply to such a plan as of that date.

Maintenance of Grandfather Status

The regulations make clear that there are several actions a plan can take that would cause it to lose grandfather status, including the following:

- Change in insurance policy or insurance carrier.
- 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).
- Any increase in coinsurance (and other percentage cost-sharing requirements).
- Any increase after March 23, 2010 in fixed-amount cost-sharing requirements other than co-payments, if the increase is greater than medical inflation (from March 23, 2010) plus 15 percentage points.
- Any increase after March 23, 2010 in fixed-amount co-payments if the increase exceeds the greater of (a) medical inflation (from March 23, 2010) plus 15 percentage points or (b) five dollars increased by medical inflation.
- Any decrease by the employer or employee organization in its contributions for coverage, if the aggregate decrease is more than 5 percentage points below the contribution rate on March 23, 2010.
- The imposition of a new or modified annual limit on coverage.

Permissible Plan Changes

The preamble to the regulations, after reviewing all of the actions that could cause a plan to lose grandfather status (as detailed above), notes that changes other than those described in the regulations will not cause a plan to cease to be a grandfathered plan. The preamble goes on to note that examples of permissible plan changes include changes to premiums, changes that are

necessary to comply with Federal or State legal requirements, changes to voluntarily comply with provisions of PPACA, and changes in third party administrators by a self-insured plan (provided that none of these actions otherwise violates the prohibited plan changes discussed above).

Transition and Good-Faith Compliance Rules

The regulations establish certain transitional and good-faith compliance rules. First, if a plan or issuer legally obligated itself, prior to March 23, 2010, to make certain plan changes (for example, pursuant to a legally binding contract entered into prior to the enactment of PPACA), such changes will not be taken into account in considering whether the plan or health insurance coverage remains a grandfathered plan. Second, the regulations also establish two separate good-faith compliance rules for any plan changes made between March 23, 2010 and the issuance of the regulations: (1) the regulations provide plans with a grace period to revoke or modify any changes adopted prior to June 14, 2010 if the changes might otherwise cause the plan to cease to be a grandfathered plan; and (2) the preamble to the regulations states that any changes made between March 23 and June 14 may be disregarded if they were part of a good-faith effort to comply with a reasonable interpretation of the statutory requirements and only "modestly" exceeded the prohibited plan changes discussed above.

Comment Period

The preamble to the regulations invites public comments on the substance of these interim final regulations, with such comments due on or before August 16, 2010. Interestingly, the preamble specifically invites comments on whether certain other plan changes should cause a plan to lose grandfathered status, including the following: Changes to plan structure (such as switching from an insured plan to a self-insured plan); changes in a plan's provider network; changes to a prescription drug formulary; and "any other substantial change to the overall benefit design." The preamble notes, however, that if any of these changes (or other changes, if they are more restrictive than the interim final rules) are added to the list of prohibited plan changes in the final grandfather regulations, they would apply only prospectively to changes made after the publication of the final rules.

Conclusion

The interim final grandfather plan regulations provide a great deal of clarity regarding the actions a plan can and cannot take if the plan wishes to retain grandfather status. However, the rules seem very restrictive and, according to even the language of the preamble to the regulations, most plans will eventually lose grandfather status. The preamble notes that after some period of time, more and more plans will decide to relinquish their grandfather status, and it estimates that, for large employer plans, somewhere between 34 and 64 percent of plans will relinquish grandfather status by the end of 2013 alone (and for small employer plans, the numbers are even more stark, with the estimates being that between 49 and 80 percent of such plans will relinquish grandfather status). Making things even more difficult, the preamble (as noted above) suggests that the agencies involved are considering making these regulations even more restrictive, which would likely push even more plans out of grandfather status. For the time being, however, with careful planning and diligence, a plan should be able to retain grandfather status if it desires.

The Early Retiree Reinsurance Program

The Health Reform Laws require HHS to establish a temporary reinsurance program to reimburse participating employer plans for a portion of the cost of providing health insurance to early retirees and their spouses and dependents. Although the original statutory terms were relatively straightforward, a number of areas of uncertainty persisted regarding the coverage and operation of the program. On May 5, 2010, HHS issued interim final regulations (75 Fed. Reg. 24450) regarding the Early Retiree Reinsurance Program ("ERRP"), and followed them up with a series of FAQs finalized on June 8, 2010. Read together, these documents provide the basis for the activation of the ERRP on June 21, 2010, and as detailed below, contain some important clarifications regarding the application and administration of the program.

(1) Coverage Provided for Plan Sponsors and Self-Funded Plans. There was some initial question about whether the ERRP could provide reimbursements directly to the plan sponsor, and whether it would apply only in the case of insured plans. The regulations make it clear that plan sponsors are entitled to apply directly for reimbursement of their "health benefit costs" under the ERRP, and that such "costs" would not be limited solely to insurance premiums, thereby providing equal treatment for insured and self-funded plans. HHS indicated that these clarifications made sense in light of the fact that most plans covered by ERRP would also likely be eligible for the Medicare Part D early retiree drug reimbursement benefits and that, therefore, both ERRP and Medicare Part D should use the same definitions and cover the same entities.

(2) Chronic and High-Cost Conditions. One of the prerequisites for participation in the program is that a plan must implement programs and procedures that result in cost savings for participants and beneficiaries with chronic or high-cost health conditions (i.e., those that are likely to lead to claims for individual participants or beneficiaries in excess of the $15,000 annual floor amount set forth in the statute). The regulations make it clear that plans and plan sponsors have considerable leeway in both identifying and implementing such programs. The preamble to the regulations notes, for example, that this requirement could be satisfied where a plan identifies diabetes as a chronic condition and provides wellness or disease management programs for its participants. Similarly, a plan could identify cancer as a high cost condition and reduce required co-payments or co-insurance for participants with cancer. The regulations also indicate that a plan does not have to have procedures in place to deal with all conditions that are likely to fall into this category. Rather, the plan (or plan sponsor) must be able to demonstrate that it has taken a reasonable approach towards identifying these conditions and is taking steps that are likely to result in cost savings for affected individuals.

(3) Additional Guidance. In addition, the regulation addresses a number of other issues, including: (a) for purposes of the statutory $15,000/$90,000 floor and ceiling, the claims of each retiree and his or her spouse and covered dependents are aggregated into a single claim, rather than counted individually; and (b) certain other requirements must be satisfied in order to be eligible to participate in the Program, including certain HIPAA certifications and certifications regarding policies and programs to detect and reduce fraud, waste and abuse. However, one issue that is not clarified by the regulations is the tax effect of these reimbursements; although PPACA states that reimbursements may not be included in the sponsor's gross income, it is not clear whether receiving reimbursement for amounts that would otherwise be deductible health expenses will affect such deductions. It is hoped that the IRS will clarify this last point soon.

(4) ERRP Administrative Issues. As noted above, a total of $5 billion has been earmarked for ERRP payments. Even though the program is scheduled to extend into 2014, most commentators believe that this amount will be totally committed before 2012. As a result, there is a premium placed on filing applications as early as possible to assure the availability of funds. This imperative

is increased by two factors. First, HHS has indicated that it will process applications in the order in which they are received. If, as is likely, the plans with the largest exposure to retiree health costs are the first to file, even an application filed relatively early in the second half of 2010 may miss out. Second, HHS has stated that it will reject incomplete applications. A plan or plan sponsor whose application is rejected would then have to re-file with a totally new application. Because a new, corrected application will only be accepted on a back-of-the-queue basis, this could result in the applicant being effectively foreclosed from participation in the program. In other words, in order to take full advantage of the ERRP, both accuracy and speed in the application process are necessary.

For more information, please contact the professional(s) listed below, or your regular Crowell & Moring contact.