



Health Care Reform News

Health Care Reform — Grandfathered Health Plans

July 20, 2010 — The U.S. Departments of the Treasury, Labor, and Health and Human Services (HHS) recently issued Interim Final Rules that define “grandfathered health plan” under health care reform.

Certain requirements of the Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), do not apply to grandfathered health plans.

The Interim Final Rules also clarify the application of grandfathering to collectively bargained plans.

WHAT IS A GRANDFATHERED HEALTH PLAN?

Health care reform was enacted on March 23, 2010. A grandfathered health plan is a plan — either fully-insured or self-insured — in which someone was enrolled on March 23, 2010. So **March 23, 2010, is known as the “grandfather date.”**

- A plan does not lose its grandfathered status simply because one or more (or even all) of the individuals who were enrolled in the plan on the grandfather date are no longer enrolled — **as long as** the plan has covered *someone* continuously since the grandfather date.
 - Newly hired or newly enrolled employees and their families may enroll in the plan after the grandfather date without jeopardizing the plan’s grandfathered status.

For example, an employee can switch among various grandfathered health plans that the employer offers without causing the plans to lose grandfathered status.

- Employees who declined coverage before the grandfather date can enroll themselves and eligible family members after the grandfather date without jeopardizing the plan’s grandfathered status.
- The grandfathering rules apply separately to each benefit package offered under a group health plan.

GRANDFATHERED HEALTH PLAN DISCLOSURE AND DOCUMENTATION REQUIREMENTS

To maintain grandfathered health plan status, the group health plan must keep the following records:

- records documenting the plan terms that were in effect on the grandfather date; and
- any other documents needed to verify, explain, or clarify the plan’s status as a grandfathered health plan.

In addition, the group health plan must:

- make these records available to participants, beneficiaries, or state or federal agencies upon request; and
- keep the records for as long as the plan takes the position that it remains grandfathered.

When the group health plan gives material to a plan participant or beneficiary, the description of benefits must include a statement saying that the plan believes that it is a grandfathered health plan. The material must also include contact information, for questions and complaints.

The guidance includes a model statement that will satisfy this disclosure requirement. You can access a Word document of the model statement online at the Department of Labor (DOL) web site (<http://www.dol.gov/ebsa/grandfatherregmodelnotice.doc>).

WHAT CHANGES CAN A GROUP HEALTH PLAN MAKE WITHOUT RISKING THE LOSS OF ITS GRANDFATHERED STATUS?

The following changes do **not** cause a group health plan to lose its grandfathered status:

- Changes that take effect after March 23, 2010, pursuant to any of the following:
 - a legally binding contract entered into on or before the grandfather date;
 - a filing with a state insurance department, on or before the grandfather date; or
 - written amendments that the plan adopted on or before the grandfather date.
- Changes the plan made after March 23, 2010, and adopted before the Interim Final Rules were issued (June 17, 2010) that would otherwise cause it to lose grandfathered health plan status, **but only if**:
 - the plan revokes or modifies these changes as of the first day of the first plan year that starts on or after September 23, 2010, **and**
 - the terms of the plan on that date, as modified, would not cause the plan to lose its grandfathered status.
- Changing a self-insured plan's third-party administrator as long as the benefits continue to satisfy grandfathering.
- Voluntary changes to increase benefits or voluntarily comply with the provisions of federal and state law, as long as the changes comply with the applicable grandfathering restrictions.
- Increasing a fixed-amount copayment, as long as the total increase in the copayment **is less than**:
 - \$5 increased by medical inflations, measured from the grandfather date; or
 - a total percentage that is more than the sum of medical inflation plus 15%, measured from the grandfather date.
- Increasing a fixed-amount cost-sharing requirement other than a copayment (such as a deductible or out-of-pocket limit), as follows:
 - Total percentage increases in the cost-sharing requirement that are **less than** the maximum percentage increase. The maximum percentage increase is the increase in the overall medical care component of the CPI-U (Consumer Price Index for all Urban Consumers) plus 15%;
 - Generally, changes to accommodate mergers and acquisitions;
 - Generally, changes to a prescription drug formulary **unless** the changes act to eliminate a benefit (The federal government has indicated there may be future restrictions here.);
 - Changes to a provider network (The federal government has indicated there may be future restrictions here.);
 - Enrolling new hires, newly eligible employees, and family members.

WHAT CAUSES AN EXISTING GROUP HEALTH PLAN TO LOSE ITS GRANDFATHERED STATUS?

The following types of changes **will** cause a group health plan to lose grandfathered status:

- Changing the plan to eliminate all or substantially all benefits to diagnose or treat a particular condition, or to eliminate benefits for any necessary element to diagnose or treat a condition.
- Increasing any percentage cost-sharing requirement (for example, coinsurance).

- Increasing a fixed-amount cost-sharing requirement, other than a copayment (for example, a deductible or out-of-pocket limit), **if** the total percentage increase in the cost-sharing requirement **exceeds** the “maximum percentage increase.”
- Increasing a fixed-amount copayment if the total increase in the copayment **exceeds** the greater of:
 - \$5 increased by medical inflations measured from the grandfather date; or
 - a total percentage that is more than the sum of medical inflation plus 15%, measured from the grandfather date.
- Decreasing the employer or employee organization’s contribution rate toward the cost of any tier of coverage for any class of similarly situated individuals by more than 5%.
 - The contribution rate means the percentage of contributions that an employer or employee organization makes compared to the total cost of coverage.
 - The cost of coverage is determined in the same way the premium is calculated for COBRA continuation coverage purposes.
 - Currently, the rules are unclear about whether a plan can add new tiers of coverage without losing grandfathered status. For example, if a plan added a new “employee plus two dependents” category to help defray the added cost of covering adult dependents.
- Decreasing an annual limit on the dollar value of benefits or imposing a new annual limit.
 - Plans that already had a lifetime limit may adopt an overall annual limit at a dollar value that is lower than the plan’s lifetime limit (subject to dollar limits established by HHS).

Anti-abuse rules apply to certain mergers, acquisitions, and plan transfers that do not have a bona fide employment-based reason that a plan makes to try to keep its grandfathered status.

WHAT REQUIREMENTS APPLY DIFFERENTLY TO GRANDFATHERED PLANS?

The following table highlights some of the health care reform provisions that do not apply to grandfathered plans.

PROVISION	EFFECTIVE DATE FOR PLANS THAT ARE NOT GRANDFATHERED
No cost-sharing for certain preventive care	Plan years starting on or after September 23, 2010
Appeals procedures requirements	Plan years starting on or after September 23, 2010
Emergency care, doctor selection, and referral requirements	Plan years starting on or after September 23, 2010

Providing coverage for dependents to age 26 — Until the first plan year that starts on or after January 1, 2014, grandfathered plans can exclude adult children under age 26 who are eligible to enroll in another employer-sponsored group health plan.

SPECIAL GRANDFATHERED PLAN RULES FOR COLLECTIVELY BARGAINED PLANS

There is no special grandfathering rule for self-insured collectively bargained plans.

Therefore, a self-insured plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers is grandfathered only to the extent that it:

- meets the requirements described above; and
- does not make any changes that result in the loss of its grandfathered health plan status.

NEXT STEPS FOR PLAN SPONSORS

Here are some suggested steps that you may wish to take in relation to grandfathered health plan status:

- Review your current benefit plan offerings to determine whether the benefits of maintaining grandfathered health plan coverage outweigh the restrictions on plan design and cost-sharing changes imposed by the Interim Final Rules.
- If you decide to retain the grandfathered status of your group health plan, carefully document the plan terms in effect on the grandfather date and include the model grandfather statement in plan materials distributed to participants and beneficiaries.

Be sure to take these important steps:

- **Plan documents.** It is very important that you amend your plan documents to reflect any changes you make.
- **Stop loss coverage.** Be sure to notify your stop loss carrier promptly of any changes you make.

FOR MORE INFORMATION

You can find information about grandfathered status and the Interim Final Rules online:

- Visit the HHS web site Health Reform web site at http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html
- Read the HHS Press Release at <http://www.hhs.gov/news/press/2010pres/06/20100614c.html>
- Read the Q&A on the Regulation at <http://www.healthreform.gov/about/grandfathering.html>

This communication is not intended to provide either legal or tax advice. Please consult with your legal counsel or professional advisors to determine the effects of the statutes and regulations regarding health care reform on you and your plan members.