

Health Care Reform: Grandfathered Plans – Regulations Issued

June 2010

On June 14, 2010, regulations were issued under the Patient Protection and Affordable Care Act (PPACA) regarding the preservation and forfeiture of grandfathered health plan coverage. Grandfathered health coverage is defined as coverage in which an individual was enrolled on March 23, 2010. Compliance with the plan design mandates of PPACA is different for grandfathered group health plans than for plans that are not grandfathered. The regulations make a distinction between insured and self-insured plans subject to collective bargaining agreements and confirm that retiree-only and certain dental and vision plans will not have to comply with many of PPACA's coverage mandates.

PRESERVATION OF GRANDFATHER STATUS

The following events are permissible without the loss of grandfathered health plan status:

- **Dropped Coverage:** Participants may opt-out of coverage or voluntarily switch from one benefits package to another.
- **New Employees:** Newly hired employees and their families may be enrolled.
- **Existing Employees:** Existing employees and families, whether or not they were previously eligible and enrolled on March 23, 2010, may be enrolled.

In order to maintain grandfather health plan status, sponsors are subject to specific notification and record-keeping requirements:

- **Disclosure:** A grandfathered health plan must include a statement that it believes it is a grandfathered plan. The statement can be placed in any plan materials describing the benefits under the plan that are given to participants and beneficiaries. Contact information must be included in the statement for employee questions and complaints.
- **Maintenance of Records:** A grandfathered health plan must maintain records documenting the terms of the plan, coverage that was in effect on March 23, 2010 and other documents necessary to verify, explain or clarify its status as a grandfathered health plan.

FORFEITURE OF GRANDFATHER STATUS

A group health plan, or separate benefits package under a group health plan, will lose its grandfather status upon the occurrence of any of the following events:

- **New Policies, Certificates or Contracts:** Entering into (as opposed to renewing) a new policy, certificate, or contract of insurance after March 23, 2010.

- **Changing Carriers:** Entering into a new policy, certificate or contract with a new carrier whether or not the terms and costs of the coverage have changed.
- **Changing the Coverage:** With respect to any particular condition, eliminating all or substantially all benefits to treat a particular condition, or eliminating the benefits for any necessary element to diagnose or treat that condition.
- **Increasing Coinsurance Percentage:** A change in the percentage level (e.g. 15% to 20%) of coinsurance for any benefit as measured from March 23, 2010.
- **Exceeding Limits for Deductibles and Out-of-Pocket Expenses:** Any increase in deductibles, out-of-pocket limits or similar fixed-amount cost sharing requirements (other than copayments) that exceeds “medical inflation” plus 15 percentage points. Medical inflation means the increase in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted). The regulations provide a formulaic method for calculating the rate of medical inflation.
- **Exceeding Limits for Fixed-Amount Copayments:** An increase in a fixed-amount copayment, measured from March 23, 2010, that exceeds the greater of: (i) \$5.00, increased by medical inflation; or, (ii) medical inflation plus 15 percentage points.
- **Significant Decrease of Employer Contributions:** A reduction by more than five percentage points below the contribution rate on March 23, 2010 toward the cost of any tier of coverage for any class of similarly situated individuals.
- **Decreasing or Imposing New Annual Limits:** Decreasing annual limits on the dollar value of benefits in effect on March 23, 2010, or the imposition of an overall annual limit that is less than the lifetime limit in effect on March 23, 2010.

PLANS SUBJECT TO COLLECTIVE BARGAINING AGREEMENTS

There are special rules with respect to insured and self-insured group health plans that are subject to collective bargaining agreements ratified before March 23, 2010:

- **Insured Plans:** Insured plans are grandfathered to the date the final collective bargaining agreement relating to that coverage terminates. Merely changing a health insurance carrier during the period in which the agreement is in force will not cause the plan to lose grandfather status. However, the events described above that take place during that period will cause the plan to lose grandfather status upon termination of the last of the collective bargaining agreements relating to that coverage. If the plan has maintained grandfather status when all collective bargaining agreements have expired, it will be subject to the same rules and restrictions described above.
- **Self Insured Plans:** Self-insured plans are not eligible for the special treatment that insured plans are receiving. Therefore, they are subject to the same grandfather rules as plans that are not subject to collective bargaining agreements as described above in this *Briefing*.
- **Design Mandates:** Collectively bargained plans (both insured and self-insured) are subject to the same plan design mandates (e.g. child coverage to age 26) as other grandfathered health plans. These mandated changes must be made according to the same schedule that applies to other

grandfathered plans without consideration to the expiration date of any collective bargaining agreement.

TRANSITION RELIEF

Special transition rules are available for plans that made changes to their terms or health insurance coverage on or before March 23, 2010 but those changes were not effective until after that date. Under this rule, the date of the change will be deemed to be March 23, 2010 if the change was made pursuant to: (i) a legally binding contract entered into on or before March 23, 2010; or, (ii) a written plan document amendment adopted on or before March 23, 2010; or, (iii) a filing on or before March 23, 2010 with a State insurance department.

OTHER CLARIFICATIONS

Unrelated to the grandfather regulations, there is an important clarification about retiree-only plans and HIPAA excepted benefits. These plans are not subject to the insurance market reforms of the PPACA. Excepted benefits under HIPAA generally include accident and disability insurance, separate limited scope dental and vision plans, supplemental coverage, independent disease-only coverage and fixed indemnity plans. This means that free-standing dental and vision plans are not required to comply with many of the new plan design mandates such as expanded coverage for children to age 26 or the prohibition against lifetime limits.

ACTION ITEMS

Sponsors should conduct a cost-benefit analysis to determine whether the cost of forfeiting grandfather status justifies the benefit of preserving it. A decision to preserve grandfather status should be followed by the development of policies to ensure proper maintenance of plan documents, open enrollment materials, communications, etc. The Department of Labor has provided a model disclosure for sponsors which can be found at <http://www.dol.gov/ebsa/grandfatherregmodelnotice.doc>.

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