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**HEALTH CARE REFORM:
Grandfathered Health Plans**

Guidance concerning “grandfathered health plan” status was issued on June 17, 2010, by the Departments of Labor, Treasury and Health and Human Services with respect to the Patient Protection and Affordable Care Act, as modified by the Health Care and Education Reconciliation Act (referred to herein, collectively, as “ACA”). This summary of the new Interim Final Regulations (the “IFR”) identifies considerations for employer-sponsored plans.

What is a grandfathered health plan?

Grandfathered health plan coverage is coverage:

- that is provided by a group health plan or a health insurance issuer;
- in which an individual was enrolled on March 23, 2010; and
- that complies with the requirements for continued status as grandfathered coverage.

The grandfathered plan rules apply separately to each benefit package made available under a group health plan or health insurance coverage. Thus, for an employer plan that offers multiple coverage options (e.g., PPO, HDHP, HMO) under a single ERISA plan, the grandfather analysis must be performed with respect to each separate option.

What is the relevance of being a grandfathered plan?

Certain ACA insurance market reforms apply to all plans and insurance coverages that are subject to the HIPAA portability rules,¹ regardless of their grandfathered plan status. However, certain other requirements are not applicable to a grandfathered plan for so long as the plan or insurance coverage remains a grandfathered plan.

¹ The exemptions from HIPAA pre-existing condition and nondiscrimination rules for retiree-only plans and so-called “excepted benefits” also exempt such plans from the new ACA rules.

The following table identifies the various reforms for group health plans and group health insurance coverage and their application to grandfathered plans. Different rules apply to individual insurance coverage.

Year Effective	Requirement	Applies to GF plan	Applies to non-GF plan
Plan years beginning on or after 9/23/10	Adult child coverage to age 26 subject to a limited other coverage exception for grandfathered plans	Yes	Yes
	Lifetime limits prohibited for essential benefits	Yes	Yes
	Annual limits for essential benefits allowed if "restricted"	Yes	Yes
	Rescission prohibited except for fraud, misrepresentation	Yes	Yes
	Pre-existing condition exclusions prohibited for enrollees under age 19	Yes	Yes
	Automatic enrollment for employers with more than 200 employees (if and when regulations issued)	Yes	Yes
	Coverage of preventive services without cost sharing required	No	Yes
	Nondiscrimination rules applied to insured plans (similar to IRC section 105(h) rules that apply to self-insured plans)	No	Yes
	Internal claims appeals process like ERISA rules required; external process based on state law or by future regulation	No	Yes
	Certain "patient protections" required relating to choice of provider and emergency treatment paid on an in-network basis	No	Yes
	Disclosures to federal government regarding health improvement programs (effective by regulation)	No	Yes
Disclosures to regulators and public to enhance transparency regarding claim practices, enrollee rights and cost sharing (effective date unclear)	No	Yes	
2012	Uniform 4-page description of coverage	Yes	Yes
Plan years beginning on or after 1/1/14	Waiting periods may not exceed 90 days	Yes	Yes
	Annual limits prohibited for essential benefits	Yes	Yes
	Pre-existing condition exclusions prohibited for all participants	Yes	Yes
	Certain clinical trial coverage required	No	Yes
	New wellness incentive rules	No	Yes
	Nondiscrimination rules regarding providers practicing within their scope of license	No	Yes

What design changes will cause a loss of grandfathered plan status?

The IFR provide that the following changes will cause a plan or insurance coverage to lose grandfathered plan status:

- Acquisition of a new insurance policy after March 23, 2010.
- Elimination of all or substantially all benefits to diagnose or treat a particular condition.
- Any increase in a coinsurance percentage above the level in effect on March 23, 2010.
- An increase in a deductible or out-of-pocket maximum from the amount in effect on March 23, 2010, if the increase is greater than “medical inflation” plus 15 percentage points.
 - “Medical inflation” is determined by reference to the medical care component of the Consumer Price Index. The IFR include a specific method for determining medical inflation.
- An increase in a copayment from the amount in effect on March 23, 2010, if the increase exceeds the greater of: (i) \$5 (increased by medical inflation); and (ii) medical inflation plus 15 percentage points.
- A decrease in an employer’s or employee organization’s contribution rate (whether based on the cost of coverage or on a formula) towards the cost of any tier of coverage, if such decrease is greater than 5% below the contribution rate in effect on March 23, 2010.
- Any of the following changes in an annual or lifetime limit on benefits:
 - The imposition of an overall annual or lifetime limit on the dollar value of all benefits (for a plan or insurance coverage that did not impose an overall annual or lifetime limit on March 23, 2010).
 - The imposition of an overall annual limit on the dollar value of all benefits that is lower than a lifetime limit that was in effect on March 23, 2010 (for plans that imposed an overall lifetime limit on March 23, 2010, but not an overall annual limit).
 - A decrease in an annual limit on the dollar value of all benefits from the annual limit in effect on March 23, 2010 (for plans or insurance coverage that imposed an annual limit on March 23, 2010, regardless of whether the plan or insurance coverage also imposed a lifetime limit).

The Preamble to the IFR provides that, for purposes of enforcement, the regulators will take into account good-faith efforts to comply with a reasonable interpretation of the statutory requirements and may disregard changes to plan and policy terms that only modestly exceed the grandfathered plan limitations described in the IFR and that are adopted after March 23, 2010, and before June 14, 2010.

What changes may a grandfathered plan make?

The IFR state that the following will not cause a loss of grandfathered plan status:

- One or more individuals enrolled on March 23, 2010, cease to be covered, provided that the plan or insurance coverage continuously covers someone after March 23, 2010.
- For an individual who is enrolled in a plan or health insurance coverage on March 23, 2010, the enrollment of such individual's family members in such plan or coverage after March 23, 2010.
- The enrollment of new employees (whether newly hired or newly enrolled) and their families enrolling after March 23, 2010.

Please note, however, that the IFR describe potential exceptions:

- If the principal purpose of a merger, acquisition, or similar business restructuring is to cover new individuals under a grandfathered plan, the plan ceases to be a grandfathered plan.
- The transfer of employees from one plan to another without a bona fide employment-based reason for the transfer can cause the transferee plan to cease to be a grandfathered plan. A change in terms or cost of coverage is not a bona fide employment-based reason for this purpose.

The Preamble to the IFR indicates that the following will not cause a loss of grandfathered plan status, though the scope of these permitted changes is unclear:

- Changes to premiums.
- Changes to comply with federal or state legal requirements.
- Changes to voluntarily comply with provisions of the ACA.
- Change of third party administrator(s).

The agencies have also requested comments on whether the following should result in loss of grandfathered plan status:

- Changes to plan structure (e.g., "switching from a health reimbursement arrangement to major medical coverage or from insured to self-insured")
- Changes in a network plan's provider network.
- Changes to a prescription drug formulary.

What administrative actions are required to maintain grandfathered plan status?

In addition to the restrictions on benefit design changes discussed above, plans and insurers must take the following actions to remain a grandfathered plan:

- Plans and insurers must include a statement, in any plan materials describing plan benefits: (i) indicating the plan's or insurer's belief that the plan or coverage is a grandfathered plan; and (ii) providing contact information for questions and complaints. The IFR include model language that can be used for this purpose.
- Plans and insurers must, for as long as the plan or insurance coverage takes the position that it is a grandfathered plan, maintain records documenting the terms of the plan or coverage in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered plan. The grandfathered plan must make such records available for examination by participants and regulators upon request.

What if a plan has been amended prior to issuance of the Interim Final Regulations?

A prohibited coverage change described above causes a coverage to lose its grandfathered plan status. However, the regulators recognize and allow certain changes adopted before March 23, 2010 (or subsequent changes that are reversed) as follows:

- A change to a plan or insurance coverage that was **adopted before March 23, 2010**, will not cause the plan or coverage to lose grandfathered plan status, even if the change does not become effective until after March 23, 2010.
- A change to a plan or insurance coverage that was adopted **after March 23, 2010, and before June 14, 2010**, will not cause the plan or health insurance coverage to cease to be a grandfathered plan **if the change is revoked or modified** effective as of the first day of the first plan year beginning on or after September 23, 2010, and the terms of the modified plan or insurance coverage, as modified, would not cause the plan or coverage to cease to be a grandfathered plan.

How do the grandfathered plan rules apply to collectively bargained plans?

Health insurance coverage maintained pursuant to one or more collective bargaining agreements ("CBAs") that was ratified before March 23, 2010, is grandfathered plan coverage at least until the date on which the last of such CBAs terminates. The regular grandfather rules apply after such date.

The Preamble to the IFR includes two important points regarding collectively bargained plans:

- The special grandfather rule described above does not apply to self-insured plans maintained pursuant to a CBA. Only insured plans are eligible for the rule.
- The special grandfather rule only impacts the timing of when an insured collectively bargained plan may lose grandfathered plan status. It does not delay the effective date for collectively bargained plans, insured or self-insured, to comply with the ACA insurance reform requirements that are applicable to all grandfathered plans (e.g., expansion of dependent coverage; limitation on preexisting conditions). An amendment that is made solely to comply with an ACA requirement is not treated as a termination of a CBA.

Important clarifications regarding retiree-only plans and excepted benefits

Many employers that offer retiree coverage were concerned that a minor change in the ACA may have caused retiree-only plans to be subject to the HIPAA portability rules and to the new reforms. The Preamble to the IFR confirms the regulators' views that the ACA insurance market reforms do not apply to plans with less than two participants who are current employees. Thus, retiree-only plans are not subject to these changes.

The Preamble also confirms that the ACA insurance market reforms do not apply to coverages that are "excepted benefits" for purposes of the HIPAA portability rules, such as certain limited-scope dental and vision benefits and most flexible spending account arrangements.

Is grandfathered plan status worth keeping?

Many employers are questioning whether the reforms avoided by grandfathered plan status are worth the corresponding design restrictions. The value of grandfathered plan status appears to be greatly reduced by the fact that the permitted changes are allowed only once and not annually or periodically. Few group health plans can continue coverage designs for more than a few years without changes due to cost and health services changes.

Generally, we expect that many health plans with broad coverage will forego grandfathered plan status to make desired plan changes. This is likely to be true for group health plans that already cover many preventive services or satisfy the patient protection requirements. For group health plans with significant limitations on coverage, grandfathered plan status may be more attractive.

Note: Loss of grandfathered plan status for insured plans will trigger application of nondiscrimination rules similar to those under Internal Revenue Code § 105(h) that apply to self-insured plans. These rules generally prohibit the provision of more favorable employer-provided benefits for highly compensated individuals (generally the top paid 25%) relative to non-highly compensated individuals. Insured plans that forego grandfathered plan status will need to consider whether any changes to the plan structure or employer contribution amount will be required to comply with the nondiscrimination requirements.

We encourage employers to review cost estimates for the required changes with their advisors as soon as possible to identify a course of action for a busy period of change during the next several years. Please keep in mind that this summary does not include all aspects of the grandfathered health plan guidance. We encourage you to review the guidance and options carefully with your plan advisors.