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Health Care Reform: Grandfathered Health Plan Interim Final Regulations Released

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On June 14, 2010, the Departments of Labor, Health and Human Services, and Treasury released final interim regulations relating to the status of grandfathered health plans under the Affordable Care Act (the "Act").[1] These regulations, published in the June 17, 2010 *Federal Register*, explain the rules for determining whether a group health plan or health insurance coverage qualifies as a grandfathered health plan, how that status is maintained, and how a grandfathered health plan may lose its grandfathered status. In addition, the preamble to the regulations provides helpful and important guidance for plans that are not subject to the Act's mandates, such as those that cover fewer than two participants who are current employees and those that provide excepted benefits.

As part of their effort to provide as much information as possible to the regulated community, the agencies also released a Fact Sheet, FAQs, and a Model Grandfathered Health Plan Notice. Together with the regulations, this guidance provides a great deal of helpful information for employers to consider as they evaluate their plans' grandfathered status.

Knowing whether a group health plan or health insurance coverage is grandfathered is critical to determining which of the Act's coverage mandates apply to the plan. Attached to this Alert is a comprehensive table summarizing the Act's key coverage mandates and their effective dates, identifying those mandates that apply to grandfathered health plans.

Grandfathered Health Plans Defined

Defining “grandfathered health plan” coverage is simple. If coverage was provided by a group health plan, or a group or individual health insurance issuer, in which an individual was enrolled on March 23, 2010 (the date of the Act’s enactment), the coverage is “grandfathered.” To keep its grandfathered status, grandfathered health plan coverage must continuously enroll someone from March 23, 2010 forward. The regulations clarify that grandfathered status is not lost merely because one or more (or even all) individuals enrolled on March 23, 2010 cease to be covered, provided that the plan has continuously covered someone since March 23, 2010 (at all times at least one person). Having established these basic rules, the regulations then articulate a number of rules that could affect a grandfathered health plan’s status.

Grandfathering Rules Apply Separately to Benefit Packages

The regulations clarify that the grandfathering rules apply separately to each “benefit package” made available under a grandfathered health plan. Thus, the loss of grandfathering for one “benefit package” offered under a grandfathered health plan will not cause the entire plan to lose its grandfathered status.

Example: A group health plan offers three benefit packages on March 23, 2010. Option F is a self-insured option. Options G and H are insured options. Beginning July 1, 2013, the plan replaces the issuer for Option H with a new issuer. Because the change from one issuer to another generally causes a loss of grandfathered status (see discussion below), Option H is not grandfathered as of July 1, 2013. However, Options F and G remain grandfathered to the extent those options independently continue to meet the grandfathering requirements.

Adding New Enrollees and Family Members Allowed

The regulations provide specific rules whereby individuals (newly hired employees, new enrollees and their family members) may enroll in a grandfathered health plan even after March 23, 2010 without causing the plan to lose its grandfathered status. The regulations modify this basic rule, however, to add two “anti-abuse” rules designed to prevent employers from taking advantage of this rule to expand grandfathered plan status inappropriately.

Anti-Abuse Rule #1: Under the first anti-abuse rule, an employer cannot just add new enrollees to a grandfathered health plan through a merger, acquisition, or similar business restructuring if the principal purpose of the transaction is to cover new individuals under a grandfathered health plan. This is intended "to prevent grandfather status from being bought and sold as a commodity in commercial transactions." If that principal purpose exists, grandfather health plan status is lost. This may require employers to keep clear documentation in connection with business transactions where grandfathered health plan status is an issue.

Anti-Abuse Rule #2: The second anti-abuse rule is intended to prohibit employers from doing indirectly what they could not do directly. In other words, an employer cannot amend a grandfathered health plan in certain ways (described more fully below) without jeopardizing its grandfathered health plan status. Under this special anti-abuse rule, employers cannot effectively amend a grandfathered health plan by terminating one plan (or benefit package) and enrolling the covered individuals in another different grandfathered health plan (or benefit package).

According to the regulations, a grandfathered health plan will lose its grandfathered status if (1) employees are transferred to a transferee plan from a transferor grandfathered plan, (2) treating the transfer as if it were an amendment of the transferor plan to be like the transferee plan, that "amendment" to the transferor plan would cause it to lose grandfathered status, and (3) there is no bona fide employment-based reason for the transfer. Changing plan terms or concerns over the cost of coverage are not bona fide employment-based reasons for a transfer.

Example 1. A group health plan offers two benefit packages on March 23, 2010, Options F and G. During a subsequent open enrollment period, some of the employees enrolled in Option F on March 23, 2010 switch to Option G. Under this example, the group health coverage provided under Option G remains a grandfathered health plan because employees previously enrolled in Option F are allowed to enroll in Option G as new employees.

Example 2. Same facts as Example 1, except that the plan sponsor eliminates Option F because of its high cost and transfers employees covered under Option F to Option G. If instead of transferring employees from Option F to Option G, Option F was amended to match the terms of Option G, assume that Option F would cease to be a grandfathered health plan. Under this example, the plan did not have a bona fide employment-based reason to transfer employees from Option F to Option G. Therefore, Option G ceased to be a grandfathered health plan with respect to all employees. (However, any other benefit package maintained by the plan sponsor would be analyzed separately under the rules as discussed above.)

Example 3. A group health plan offers two benefit packages on March 23, 2010, Options H and I. On March 23, 2010, Option H provides coverage only for employees in one manufacturing plant. Subsequently, the plant is closed, and some employees in the closed plant are moved to another plant. The employer eliminates Option H and the employees that are moved are transferred to Option I. Assume that, if instead of transferring employees from Option H to Option I, Option H was amended to match the terms of Option I, then Option H would cease to be a grandfathered health plan. Under this example, because the plan has a bona fide employment-based reason to transfer employees from Option H to Option I, Option I does not cease to be a grandfathered health plan.

Special Rules for Collectively-Bargained Plans

The regulations clearly state that there is no delayed effective date for collectively bargained plans in effect on March 23, 2010. As stated in the preamble, “collectively bargained plans (both insured and self-insured) that are grandfathered health plans are subject to the same requirements as other grandfathered health plans and are not provided with a delayed effective date for [Affordable Care Act] provisions with which other grandfathered health plans must comply.” In other words, all of the coverage mandates that apply to grandfathered non-collectively bargained plans (like the mandate to cover children to age 26 or the prohibitions on annual or lifetime limits) apply at the same time and in the same way to all collectively-bargained plans.

That being said, however, there are two special rules that apply to insured collectively-bargained plans. Under the first rule, even if changes are made to an insured collectively-bargained plan that would otherwise cause a grandfathered plan to lose its grandfathered status, the insured collectively-bargained plan will not lose grandfathered status until termination of the last collective bargaining agreement in effect on March 23, 2010 related to the plan. At that time, the insured collectively-bargained plan either retains or loses grandfather status, determined by comparing the terms of the plan on the date of determination with the terms of the plan as it existed on March 23, 2010.

Under a second special rule for insured collectively-bargained plans, a change in insurance issuers during the period of the collective bargaining agreements related to the plan will not by itself cause a loss of grandfathered status upon expiration of the last collective bargaining agreement in effect on March 23, 2010 related to the coverage. As explained below, however, a change in insurer after the termination of that last collective bargaining agreement will cause a loss of grandfathered status.

Example 1. A group health plan maintained pursuant to a collective bargaining agreement provides coverage through a group health insurance policy from Issuer W on March 23, 2010. The collective bargaining agreement has not been amended and will not expire before December 31, 2011. The group health plan enters into a new group health insurance policy with Issuer Y for the plan year starting on January 1, 2011. In this Example 1, the group health plan and the group health insurance policy provided by Issuer Y, remain a grandfathered health plan with respect to existing employees and new employees and their families because the coverage is maintained pursuant to a collective bargaining agreement ratified prior to March 23, 2010 that has not terminated.

Example 2. Same facts as Example 1, except the coverage with Y is renewed under a new collective bargaining agreement effective January 1, 2012, with the only changes since March 23, 2010 being changes that do not cause the plan to cease to be a grandfathered health plan. In this Example 2, the group health plan and the group health insurance policy provided by Y remain a grandfathered health plan because the policy was renewed. Under this Example, had a new policy been entered into under the new collective bargaining agreement, the group health plan would have lost its grandfathered status under the general rule regarding changes in policy because the change occurred after expiration of the bargaining agreement that was in place on March 23, 2010.

Plan Modifications That Will Cause Loss of Grandfathered Status

The regulations specify seven types of changes that could cause a grandfathered health plan to lose its grandfathered status. Six of these are changes that apply to both self-insured and insured grandfathered health plans. One only affects insured grandfathered health plans.

New or Changed Insurers (insured plans only). Subject to a special rule for insured collectively bargained plans (discussed above), if an employer or employee organization enters into a new policy, certificate, or contract of insurance after March 23, 2010, then that policy, certificate, or contract of insurance is not a grandfathered health plan. However, the renewal of a policy, certificate, or contract of insurance that was otherwise grandfathered will not in and of itself cause the loss of grandfathered health plan status.

Example: A fully-insured grandfathered health plan enters into new policy of insurance (as opposed to renewing its current policy). The plan loses its grandfathered status effective with the effective date of the new policy of insurance.

Eliminate Benefits for Particular Condition. The elimination of all or substantially all benefits to diagnose or treat a particular condition will cause a grandfathered health plan to lose its grandfathered status. For this purpose, the elimination of benefits for any necessary element to diagnose or treat a condition is considered the elimination of all or substantially all benefits to diagnose or treat a particular condition.

Example. Before March 23, 2010, the terms of a group health plan provide benefits for a particular mental health condition, the treatment for which is a combination of counseling and prescription drugs. Subsequently, the plan eliminates benefits for counseling. The plan ceases to be a grandfathered health plan because counseling is an element that is necessary to treat the condition.

Any Increase in Coinsurance Percentage. As explained more fully below, the regulations are designed to allow plans to increase certain dollar limited coinsurance, out-of-pocket, or deductible amounts periodically on the theory that these limits need to be adjusted with increases in medical inflation. However, this theory does not apply to any grandfathered health plan coinsurance percentages. The reason for this is coinsurance amounts inherently automatically increase with medical inflation (*i.e.*, a 20% coinsurance amount adjusts because the service against which the 20% is measured increases with medical inflation). Therefore, any increase, measured from March 23, 2010, in a percentage cost-sharing requirement (such as an individual's coinsurance requirement) causes a grandfathered health plan to lose its grandfathered status.

Example. On March 23, 2010, a grandfathered health plan has a coinsurance requirement of 20% for inpatient surgery. The plan is subsequently amended to increase the coinsurance requirement to 25%. The increase in the coinsurance requirement from 20% to 25% causes the plan to cease to be grandfathered.

Increase Fixed-Amount Cost Sharing other than a Copayment. If a fixed-amount cost-sharing requirement other than a copayment (for example, a deductible or out-of-pocket limit), is increased by more than the rate of medical inflation plus 15 percentage points, the grandfathered health plan will lose its grandfathered status.

Example. Assume a grandfathered health plan's $1,000 deductible is increased to $1,200 (a 20% increase). Assume medical inflation measured from March 23, 2010 to the date of amendment is 22.69%. A permissible maximum increase in the deductible is 37.69% (22.69% + 15%). Because the 20% increase does not exceed 37.69%, the change does not cause loss of grandfathered status.

Increase Fixed-Amount Copayment. If a fixed-amount copayment is increased, a grandfathered health plan will lose its grandfathered status if the total increase in the copayment measured from March 23, 2010 exceeds *the greater of*: (1) $5 increased by medical inflation ($5 times medical inflation, plus $5), or (2) the rate of medical inflation plus 15 percentage points.

Example. Assume a grandfathered health plan copayment requirement of $30 per office visit for specialists is increased to $40, which represents a 33.33% increase. Assume medical inflation measured from March 23, 2010 to the date of amendment is 22.69%. A permissible maximum increase in the copayment is 37.69% (22.69% + 15%). Because 33.33% does not exceed 37.69%, the change does not cause plan to lose grandfathered status.

Example. Assume a grandfathered health plan has a copayment of $10 for office visits that is increased to $15 (a 50% increase). Assume medical inflation measured from March 23, 2010 to the date of amendment is 7.2%. A permissible maximum increase is the greater of 22.2% (15% + 7.2%), which would be $2.22 in this case OR $5.36 ($5 increased by medical inflation). A $5 increase is less than $5.36 and plan does not lose grandfathered status.

Decrease Employer (or Employee Organization) Contribution. A grandfathered health plan will lose its grandfathered status if employer (or employee organization) contributions towards the cost of any tier of coverage for any class of similarly situated individuals decreases by more than a specified amount. If the contribution rate is determined based on the cost of coverage (as in a typical self-funded health plan), the decrease in contribution cannot be by more than 5 percentage points below the contribution rate in effect for the coverage period including March 23, 2010. The cost of coverage is based on COBRA valuation rules. If the contribution rate is determined based on a formula (such as contributions based on hours worked or tons of coal mined), the decrease in contribution cannot be more than 5% below the contribution rate for the coverage period that includes March 23, 2010.

Add or Decrease Overall Annual Dollar Limits. A grandfathered health plan will lose its grandfathered status if any of the following apply:

- On March 23, 2010, the plan did not impose an overall annual or lifetime limit on the dollar value of all benefits and the plan is subsequently amended to impose an overall annual limit on the dollar value of benefits.
- On March 23, 2010, the plan imposed an overall lifetime limit on the dollar value of all benefits but no overall annual limit on the dollar value of all benefits and the plan subsequently adopts an overall annual limit at a dollar value that is lower than

the dollar value of the lifetime limit on March 23, 2010.

- On March 23, 2010, the plan imposed an overall annual limit on the dollar value of all benefits and the plan subsequently decreases the dollar value of the annual limit (regardless of whether the plan also imposed an overall lifetime limit on March 23, 2010 on the dollar value of all benefits).

Plan Modifications That Will Not Cause Loss of Grandfathering

The preamble to the regulations provide that any plan modifications other than those specifically described in the regulations generally will not cause a grandfathered health plan to lose its grandfathered status. The preamble specifically lists the following as examples of "other" modifications that will not cause a loss of grandfathered status: changes to premiums (as long as the change is not due to decrease in employer contributions of more than maximum permitted amount), a change of third-party administrators, changes to comply with Federal or state legal requirements, and changes to voluntarily comply with provisions of the Affordable Care Act.

Plan Modifications that Might Cause a Loss of Grandfathered Status in Future Guidance

The regulatory preamble indicates that the agencies are considering other rules that might cause a plan to lose its grandfathered status and they are specifically seeking comments on the extent to which that should occur. Specifically, the agencies are seeking thoughts on whether any of the following changes should affect grandfathered plan status: (1) changes to plan structure (such as switching from a health reimbursement arrangement to major medical coverage or from an insured product to a self-insured product), (2) changes in a network plan's provider network, and if so, what magnitude of changes would have to be made, (3) changes to a prescription drug formulary, and if so, what magnitude of changes would have to be made, or (4) any other substantial change to the overall benefit design. If the government issues any further restrictions that affect grandfather status, it is expected that they will be prospective only.

Transition Rules

In issuing the guidance on grandfathered health plans, the agencies realized that some plans may have already made modifications either before or after March 23, 2010 and before the grandfathering guidance was issued. Therefore, the guidance addresses several possible transition issues for plans that may have already been amended in certain respects.

Modifications Made Prior to March 23, 2010. The grandfathering rules do not apply to a plan modification adopted before March 23, 2010, even if the change is effective after March 23, 2010 as long as the modification is implemented pursuant to written contract or plan amendment. Similarly, changes that were made pursuant to a filing with a state insurance department which was filed on or before March 23, 2010 will not alter grandfathered plan status.

Grace Period to Revoke Certain Amendments. Separately, the regulations provide a grace period during which a plan may revoke any change that was made after March 23, 2010 but before June 14, 2010 (the date the regulations became publicly available). Under this grace period, to avoid losing grandfathered status the amendment must be revoked before the first day of plan year beginning on or after September 23, 2010 (i.e., January 1, 2011 for calendar year plans). Of course, the terms of the plan as so modified cannot otherwise cause the plan to cease to be a grandfathered health plan.

Good Faith Compliance. In a final transition rule, which is found in the regulatory preamble, the agencies recognized that group health plans (and health insurance coverage) often make routine changes from year to year, and some plans and issuers may have needed to implement these changes before the issuance of the regulatory guidance. Therefore, for enforcement purposes, the agencies 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 changes otherwise provided for in the regulations. It is not exactly clear what it means for the agencies to take these efforts into account and how one determines whether a change only "modestly exceeds" those in the regulations. Therefore, employers should be carefully about relying on this statement of policy.

Documentation

Apart from the technical requirements to maintain grandfathered health plan status, the regulations include specific documentation requirements whereby a grandfathered health plan must:

- Provide a specific notice in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan to the effect that the plan believes it is a grandfathered health plan. Additionally, the statement must provide contact information for questions or complaints regarding the plan's grandfathered status. The agencies have issued a model notice separately from the regulations themselves. A copy of the notice can be found *here*.
- Maintain records documenting the terms of the plan or health insurance coverage as in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan. These records must be made available for examination upon request by a government agency with oversight over the rules governing the plan. Moreover, a participant, beneficiary, or individual policy subscriber is be able to inspect these documents to verify the status of the plan or health insurance coverage as a grandfathered health plan. A plan or issuer must maintain these records and make them available for examination for as long as the plan or issuer takes the position that the plan or health insurance coverage is a grandfathered health plan.

Retiree-Only and Excepted Benefits

Apart from providing valuable grandfathered health plan guidance, the new guidance provides some specific guidance concerning certain types of plans that are excepted from the various coverage mandates otherwise applicable to group health plans. Specifically, the preamble to the regulations clarifies that HIPAA-excepted benefits are generally exempted from the Act's coverage mandates. HIPAA-excepted benefits include limited-scope dental benefits, limited-scope vision benefits, and benefits for long-term care, nursing-home care, home care, or community-based care that are provided under a separate policy of insurance or otherwise not an integral part of the coverage offered under the health plan. Also, most health care flexible spending arrangements are HIPAA-excepted benefits and, therefore, not subject to the various coverage mandates.

The preamble also clarifies that plans covering fewer than two participants who are current employees are generally exempt from many of the Act's coverage mandates. These types of plans are often referred to as "retiree-only" plans. However, as a technical matter, the exempt plans would include any plans that do not cover active employees. For example, a plan that only covers a company's former executives would be a plan that covers fewer than two participants who are current employees and ought to be exempt from the coverage mandates. This may allow such insured plans to avoid the application of the Internal Revenue Code section 105(h) nondiscrimination requirements otherwise imposed under the Act on insured plans.

To Be or Not to Be Grandfathered

Now that the grandfathered plan guidance is issued, employers need to review their grandfathered health plans carefully to determine whether they are able to maintain their plans' grandfathered health plan status. Indeed, the agency estimates (high-end estimates) are that by the year 2013, nearly 70% of all employer plans may end up relinquishing their grandfathered plan status. For many employers, this decision requires a careful analysis and balance between the costs and benefits of retaining grandfathered plan status as opposed to the costs and benefits to be gained by future amendments that would alter grandfathered plan status and cause the plan to have to comply with other health plan mandates applicable to non-grandfathered health plans.

In making this decision, employers should also bear in mind that there are many different ways to effect cost control objectives and the employer is not always required to relinquish grandfathered plan status. For example, an increase in a deductible by 30% might cause a loss of grandfathered status. However, it might be possible to achieve the same cost savings for the plan by limiting the deductible increase to something less, say 15-20%, but at the same time increasing out-of-pocket maximums or copayments or decreasing the employer's share of the premium in ways that do not affect grandfathered health plan status.

The bottom line is that employers need to review this guidance closely and make some important decisions as to whether grandfathered health plan status is worth maintaining.

Read the Comprehensive Chart on Part A Mandates and Effective Dates.

[1] The “Affordable Care Act” means The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA).

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