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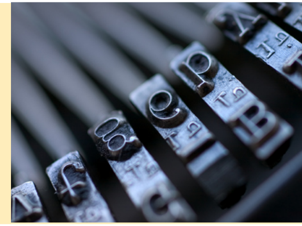

June 2010

Government Guidance Issued on Grandfathered Plans under the Patient Protection and Affordable Care Act

By Jennifer Lunski, Esq., *Vice President, Compliance Officer*

Section 1251 of the Patient Protection and Affordable Care Act (PPACA) provides that certain group health plans and health insurance coverage are subject only to certain particular provisions. The statute refers to plans in existence as of March 23, 2010 as "grandfathered" health plans. However, the statute does not address the point at which changes to a grandfathered plan would be significant enough to cause the plan to cease to be grandfathered, leaving this issue to be addressed in regulatory guidance. On June 14, 2010, the Department of Health and Human Services, Labor and Treasury issued a new regulation clarifying what plans are considered "grandfathered" under PPACA.

A grandfathered plan is a plan in existence on March 23, 2010 (the date of PPACA's enactment). The grandfather rules will apply separately to each benefit package made available by a plan, meaning that a single sponsor may offer grandfathered as well as non-grandfathered packages. Additionally, a grandfathered plan may add new employees, or enroll new dependents, without losing grandfathered status. A plan would not lose grandfathered status merely because some (or even all) individuals enrolled in the plan on March 23, 2010 cease to be enrolled, so long as the plan has continuously covered someone since March 23, 2010. Grandfathered plans may make the changes required of it by PPACA and state law without losing grandfathered status.

The regulation clarifies that any of the following will cause a plan to lose its grandfathered status:

- Eliminating all or substantially all benefits to diagnose or treat a particular condition.

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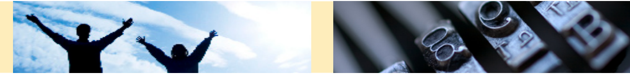
- Increasing a percentage cost-sharing requirement (such as coinsurance) above the level it was at on March 23, 2010.
- Raising co-pays "significantly" compared with those in effect on March 23, 2010. "Significantly" is defined as increasing those co-pays by more than the greater of $5 (adjusted annually for medical inflation) or a percentage equal to medical inflation (as of March 23, 2010) plus 15 percentage points.
- Raising fixed-amount cost-sharing such as deductibles and out-of-pocket limits "significantly" compared with the fixed-amount cost-sharing required as of March 23, 2010. "Significantly" is defined as increasing these amounts by a percentage equal to medical inflation plus 15 percentage points.
- An employer or employer organization decreasing its contribution rate by more than 5 percentage points below the contribution rate that was in effect on March 23, 2010.
- Adding or decreasing any annual dollar limit in place as of March 23, 2010. Plans that do not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit.
- If an employer decides to buy insurance from a different insurance company, this new insurer will not be considered a grandfathered plan. This does not apply when self-insured plans switch plan administrators and it does not apply to collective bargaining agreements.
- If an employer requires employees to switch to another grandfathered plan that, compared to



the current plan, has less benefits or higher cost sharing "as a means of avoiding new consumer protections," grandfathered status will be revoked.

- Merging with or engaging in a sale to another plan to avoid complying with the law will cause grandfathered status to be revoked.

Plans must implement the following requirements of the PPACA, regardless of whether or not the plans are grandfathered:

2010 (for plan years beginning on or after October 1, 2010)

- No lifetime coverage limits can be allowed for "essential benefits." A list of specific "essential benefits" must be developed by HHS. However, the PPACA describes general categories of such benefits including: ambulatory services, emergency services, hospitalization, prescription drugs, lab services, preventive and wellness services, chronic disease management and pediatric care.
- No annual coverage limits allowed on essential benefits except as may be permitted by HHS. After 2014, annual limits are completely prohibited.
- Group health plans and issuers in the individual and group markets are prohibited from excluding coverage for pre-existing health conditions for individuals under 19 (only applies to children younger than 19 from 2010 until 2014; applies to all thereafter).
- A ban on policy rescissions except in cases of fraud.
- Insurers must extend coverage to an employee's child up to age 26 if the adult child is not eligible to enroll in their own employer-sponsored plan. (In 2014, all dependents may be covered regardless of their employer-provided coverage).

2014

- A ban on waiting periods for plan participation in excess of 90 days.

Plans that choose not to maintain grandfathered status will have the following additional requirements imposed by the PPACA:

2010 (plan years beginning on or after October 1, 2010)

- New group health plans and plans in the individual market must provide first dollar coverage for preventive services.
- Requirement for group and individual plans to provide an effective appeals process for coverage determinations (allowing claimants to present testimony as part of their administrative appeals process and to continue receiving coverage during the appeals process).
- Primary care physician designation right for plan participants.
- Insured group health plans will have to satisfy the nondiscrimination requirements of Code Section 105(h) (2) (the eligibility and benefits tests).

2014

- Participants will have rights to participate in certain clinical trials.
- Employers would be subject to assessments in the event that an employee elected to purchase insurance through a State Exchange. In 2014, the exchanges initially would be limited to employers of fewer than 101 employees. In 2017, the states would have the option to reduce this to employers with less than 51 employees or expand its exchange to accommodate larger employers. To the extent that an individual is covered under, or an employer offers, a grandfathered plan the individual and the employer will be treated as satisfying the minimum essential coverage respective mandates and be exempt from the penalty.

If a plan wishes to remain grandfathered, they must disclose that they are considered grandfathered in any plan materials provided to participants or beneficiaries. Grandfathered plans must provide contact information for any questions or complaints about their grandfathered status. Grandfathered plans will also have recordkeeping obligations with respect to the information necessary to verify grandfathered status (e.g., records documenting the terms of the plan that were in effect on March 23, 2010) and must make such records available for examination by participants or regulators.

Impact: The benefits of remaining grandfathered should be specifically assessed by plans and weighed against the benefits the plan seeks to achieve by making changes that would result in loss of grandfathered status. Keep in mind that making any substantial changes (such as raising copayments, deductibles and/or coinsurance, etc.) in future years will also cause a grandfathered plan to lose its status. From a cost benefit perspective, it may not make sense to maintain this status. If plan sponsors choose to maintain grandfathered status, plan designs will have to remain substantially the same as they are today. It is expected that only 36-66% of current grandfathered plans of large employers will remain grandfathered in 2013.

To read more about the new regulations or to view them, refer to the links below.

http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html

http://healthreform.gov/about/grandfathering.html

Table on Applicability of Provisions to Grandfathered Plans, available at http://www.dol.gov/ebsa/pdf/grandfatherregtable.pdf

Model disclosure language, available at http://www.dol.gov/ebsa/grandfatherregmodelnotice.doc

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