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Grandfathered Plan Status — Is it Real, or Just an Illusion?

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On June 14, 2010, the Departments of the Treasury, Labor and Health and Human Services issued Interim Final Regulations ("the Regulations") regarding grandfathered health plan status under the Patient Protection and Affordable Care Act as amended by the Health Care and Education Affordability Reconciliation Act of 2010 (the "Affordable Care Act"). The Regulations provide guidance on how to maintain grandfathered plan status and set forth the circumstances under which grandfathered plan status will be lost. The Regulations amend the Internal Revenue Code, ERISA and the Public Health Service Act.

The Preamble to the Regulations also clarifies that the exemption for certain retiree-only plans has not been eliminated by the Affordable Care Act. A retiree-only plan is a plan that covers less than two participants who are current employees as of the first day of the plan year.

Background

Section 1251(a) of the Affordable Care Act provides that there will be no changes required with respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment (*i.e.*, March 23, 2010). Such plans are "grandfathered" and will continue to be treated as grandfathered plans even if coverage is renewed after March 23, 2010.

Grandfathered plans are not subject to many of the requirements set forth in Subtitles A and C of the Affordable Care Act and are deemed to constitute "minimum essential coverage" under new Internal Revenue Code section 5000A.

A separate rule applies with respect to health insurance coverage that is maintained pursuant to a collective bargaining agreement. See the section "Special Rules for Collectively Bargained Plans" below for a discussion of this special rule.

What Plans Are Grandfathered?

A plan or policy that was in effect and covered at least one individual on March 23,

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2010, and that continuously covers at least one individual after March 23, 2010, will continue to be a grandfathered plan until changes are made to the plan or policy that cause it to lose grandfathered status. The Regulations clarify that grandfathered plan status is determined separately for each benefit package made available under a group health plan or health insurance coverage. For example, if an employer has one wraparound ERISA plan document under which the employer provides a choice between a PPO medical plan, and two HMO plans — HMO Plan A and HMO Plan B, then the PPO medical plan, HMO A and HMO B would each be considered separately for purposes of determining whether grandfathered plan status is maintained. If a new benefit package option is added after March 23, 2010, such as an EPO medical plan or HMO C, then the new benefit package option would not be considered a grandfathered plan and would be subject to all of the applicable requirements set forth in Subtitles A and C of the Affordable Care Act.

A plan or health insurance coverage that believes it is a grandfathered plan must disclose that fact to participants and beneficiaries. This disclosure must be included in *any plan materials* that describe the benefits provided under the plan or health insurance coverage (*e.g.*, initial or annual open enrollment materials, the Summary Plan Description, any Summaries of Material Modification, Evidence of Coverage documents, etc.). The Regulations contain model language that can be used to meet this disclosure requirement. In addition, the plan or issuer must maintain documentation of the plan or policy terms as in effect on March 23, 2010, for as long as it maintains that it is a grandfathered plan. Such records must be made available for examination upon request by a participant, beneficiary, subscriber, or State or Federal agency official.

Changes That *DO NOT RESULT* in a Loss of Grandfathered Plan Status

The Affordable Care Act states that new employees and new family members can be added to a grandfathered plan without the plan losing grandfathered status. The Regulations clarify that new employees means not only new hires but also employees of the employer who are not currently enrolled in a plan that was in effect on March 23, 2010. For example, if an employee did not enroll in coverage under his employer's plan for the plan year beginning January 1, 2010, because he was covered under his spouse's plan (or for any other reason), the employee could enroll in his employer's plan for the plan year beginning January 1, 2011, without the plan losing grandfathered status.

The Preamble to the Regulations provides that changes in premiums, changes to comply with Federal or State legal requirements, and changes to voluntarily comply with the Affordable Care Act — such as early adoption of the rules requiring coverage of adult children to age 26 — will not cause a plan to lose grandfathered status. In addition, the Preamble to the Regulations indicates that if a self-funded plan simply changes third party administrators, that change, in and of itself, will not cause a loss of grandfathered status. However, when making such a change, plan sponsors should be aware of the ways in which a change in third party administrators may also change the provider network or other terms and conditions of the plan. The agencies have asked for comments on this issue.

Certain limited increases in cost-sharing are permitted, as are limited decreases in the amount of employer contributions. See the section "Changes That *DO RESULT* in a Loss of Grandfathered Plan Status" below for important limitations.

Changes That *DO RESULT* in a Loss of Grandfathered Plan Status

The Regulations provide that grandfathered status can be lost if benefits are eliminated, coinsurance is increased, or if fixed-amount or percentage cost-sharing is increased above maximum permissible levels specified in the Regulations. Fixed-amount and percentage cost-sharing is measured based on a reference date of March 23, 2010.

The renewal of an existing insurance policy will not in and of itself cause the plan to lose grandfathered status. However, except as discussed below with respect to the special rules for collectively bargained plans, entering into a new policy, certificate or contract of insurance after March 23, 2010, (because, for example, any previous policy, certificate or contract of insurance is not being renewed) will cause a loss of grandfathered status. In other words, *if the plan-sponsor of an insured plan changes insurance carriers then the insured plan ceases to be a grandfathered plan*.

A plan or policy in effect on March 23, 2010, will lose its grandfathered status if:

- It eliminates all or substantially all of the benefits to diagnose or treat a particular condition. For example, the Regulations provide that if a plan or policy provided benefits for counseling and prescription drugs to treat a mental health condition, and it eliminates the benefits for counseling, then the plan or policy will lose its grandfathered status.
- It increases coinsurance or any other percentage cost-sharing requirement by any amount.
- It increases a fixed-amount cost-sharing requirement other than a copayment, (such as a deductible or out-of-pocket limit) by more than medical inflation plus 15 percentage points measured from March 23, 2010 (the "maximum percentage increase"). Medical inflation is defined with reference to the overall medical care component of the Consumer Price Index for All Urban Consumers, unadjusted, as published by the Department of Labor.
- It increases a fixed-amount copayment in effect on March 23, 2010, by more than the greater of:
  - the maximum percentage increase; or
  - $5 increased by medical inflation.
- There is a decrease in the amount of contributions made by an employer or employee organization with respect to any tier of coverage for any class of similarly situated individuals that exceeds 5% of the contribution rate that was in effect on March 23, 2010. This applies both to:
  - plans with contributions based on the cost of coverage, where the contribution rate is defined as the percentage of the total cost of coverage (determined in the same manner as the applicable premium is calculated for COBRA continuation coverage) that is contributed by the employer or employee organization; and
  - plans with contributions based on a formula such as hours worked.
- It imposes new limits on the dollar value of benefits provided as follows:
  - A plan or policy that did not have an overall annual or lifetime limit in effect on March 23, 2010, adopts an overall annual limit on the dollar value of health benefits;
  - A plan or policy that had an overall lifetime limit but no overall annual limit in effect on March 23, 2010, adopts an overall annual limit that is lower than the dollar value of the lifetime limit in effect on March 23, 2010; or
  - A plan or policy that had an overall annual limit in effect on March 23, 2010, decreases the dollar value of the annual limit below the amount of the annual limit that was in effect on March 23, 2010.

Anti-abuse Rules

The Regulations also contain two "anti-abuse rules," and violation of these rules will cause a loss of grandfathered plan status. The first anti-abuse rule is applicable to mergers and acquisitions. The Regulations state that "If the principal purpose of a merger, acquisition, or similar business restructuring is to cover new individuals under a grandfathered health plan, the plan ceases to be a grandfathered health plan." The second anti-abuse rule applies when there is a change in eligibility. The Regulations state that a group health plan or health insurance coverage ceases to be a grandfathered plan if:

- Employees are transferred into a plan or health insurance coverage from a plan or health insurance coverage under which the employees were covered on March 23, 2010;
- When comparing the terms of the transferee plan with those of the transferor plan (as in effect on March 23, 2010) and treating the transferee plan as if it were an amendment of the transferor plan, the transferor plan would lose grandfathered status; and
- There was no bona fide employment-based reason to transfer the employees into the transferee plan.

For purposes of the last requirement, the Regulations state that "*changing the terms or cost of coverage is not a bona fide employment-based reason* (italics added)."

Transition Rules

The Regulations provide transition rules for plans and health insurance issuers that made changes to a plan or

health insurance coverage prior to March 23, 2010, that became, or will become, effective after March 23, 2010. The following changes will be considered part of the terms of the plan or health insurance coverage on March 23, 2010, and thus will not impact grandfathered plan status:

- Changes effective after March 23, 2010, made pursuant to a legally binding contract that was entered into before March 23, 2010.
- Changes to the terms of health insurance coverage effective after March 23, 2010, made pursuant to a filing with a State insurance department before March 23, 2010.
- Changes effective after March 23, 2010, made pursuant to written plan amendments that were adopted before March 23, 2010.

There is also a transition rule for plans and health insurance issuers that made and adopted changes that would cause a plan or policy to lose grandfathered plan status after March 23, 2010, but before June 14, 2010. In those situations, if the changes are revoked or modified effective as of the first day of the first plan or policy year beginning on or after September 23, 2010, then grandfathered plan status is preserved (provided that no other changes have been made that would cause the plan or policy to lose grandfathered plan status).

Special Rules for Collectively Bargained Plans

The Affordable Care Act provides that with respect to health insurance coverage that is maintained pursuant to collective bargaining agreements that were ratified before March 23, 2010 ("CBA"), the Affordable Care Act will not apply until the date the last CBA expires.

The Regulations make four important clarifications with respect to plans that are collectively bargained:

- Collectively bargained plans (both fully-insured and self-funded health plan options) must comply with the requirements of the Affordable Care Act that apply to grandfathered plans. These include those provisions that become effective as of the first day of the first plan year that occurs on or after September 23, 2010, (*e.g.,* no lifetime limits on "essential health benefits," coverage of adult children up to age 26, no preexisting condition exclusions can be imposed with respect to children up to age 19, and no rescission of coverage except in cases of fraud or intentional misrepresentation)[1]. No special delayed effective date applies with respect to these requirements.
- A special determination period applies for purposes of ascertaining whether health insurance coverage (*e.g.*, fully insured HMO or PPO coverage, but NOT self-funded plans) that is maintained pursuant to one or more CBAs has lost its grandfathered status. This period extends from March 23, 2010, to the date that the last CBA that provides for contributions to the plan expires. Subject to the exception noted below, if during this special determination period a fully-insured health plan option is changed in a way that would cause a plan to lose its grandfathered status under the Regulations then that fully-insured option would lose its grandfathered status as of the date that the last CBA expires (note that this is not the date that the change was actually made).
- Self-funded health plan options provided by a collectively bargained plan are not subject to any special grandfather rule. They are subject to the same rules that apply to non-collectively bargained plans. Thus, any change to a self-funded health plan option that would cause it to lose grandfathered status under the Regulations would subject the self-funded health plan option to the other requirements of the Affordable Care Act as of the date of the loss of grandfathered status, not as of the date that the last CBA expires.
- The Regulations provide one critical exception for collectively bargained plans only. A collectively bargained plan that provides insured health benefits may change health insurance issuers at any time during the special determination period referenced above and not lose its grandfathered status. This exception does not apply to any other plans.

[1] Note: Additional requirements apply to grandfathered plans beginning with the first plan year after January 1, 2014.

WHAT HAPPENS NEXT?

Many of the requirements of the Affordable Care Act are applicable for plan and policy years beginning on and after September 23, 2010, so time is of the essence. Plans that are not grandfathered are subject to more of the requirements set forth in Subtitles A and C of the Affordable Care Act than grandfathered plans. Plan sponsors who are in the process of finalizing their plan design for 2011 will want to proceed with caution. As discussed above, elimination of a benefit, or decreases of more than 5% in the amount of the employer contribution toward coverage, will cause a plan to lose grandfathered plan status. Other changes to participant costs that plan sponsors regularly make at open enrollment, such as increases in copayments, deductibles, or out-of-pocket limits may also cause a plan to lose grandfathered status. The Preamble to the Regulations indicates that the agencies expect between 49% and 80% of small plans and between 34% and 64% of large plans to lose their grandfathered status between now and 2013. Plan sponsors will want to carefully evaluate the consequences of losing grandfathered plan status before going forward. Please contact us if you have questions or need assistance with these issues.

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