

ClientAlert

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Health Care Reform: New Grandfathered Health Plan Guidance

The Department of the Treasury, Department of Labor and Department of Health and Human Services have issued important new guidance for “grandfathered health plans.” The new guidance is issued in the form of Interim Final Rules published in the [June 17, 2010 Federal Register](#).

The new guidance makes clear that health care plans may not significantly increase co-payments, deductibles or out-of-pocket maximums, significantly cut back on benefits or change insurance carriers without becoming subject to the strict new requirements of health care reform.

Employers who wish to avoid many of the health care reform requirements should carefully consider any proposed changes to their health care plans and consult with counsel or other advisors before making any changes to their health care plans.

Highlights of New Guidance. The new guidance:

- clarifies the definition of “grandfathered health plan”;
- explains what changes will (and will not) adversely affect grandfathered health plan status;
- outlines disclosure and recordkeeping requirements for maintaining and documenting grandfathered health plan status;
- provides a model statement to satisfy the grandfathered health plans disclosure requirements;
- contains special rules for insured collectively bargained plans; and
- contains a limited grace period to “undo” plan amendments that might otherwise result in the loss of grandfathered status.

Health Care Reform. The new health care reform laws, the Patient Protection and Affordable Care Act (Public Law 111-149) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), made sweeping changes to the laws governing our nation’s health care system. Many of the changes become effective for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans). Certain health plans and health insurance coverage that were in effect as of March 23, 2010 are grandfathered and not subject to many of health care reform’s requirements. For a summary of the new health care reform laws, see [“Health Care Reform: Impact on Employers and Employees.”](#)

Grandfathered Plans Defined. Grandfathered health plans include group health plans, group health insurance coverage and individual health insurance coverage with respect to which at least one individual was enrolled on March 23, 2010. The new guidance makes clear that:

- for this purpose, group health plans include both insured and self-insured plans;

- a group health plan or group health insurance coverage will not stop being grandfathered merely because one or more (or even all) individuals enrolled on March 23, 2010 are no longer covered, as long as at least one person has been covered since March 23, 2010 (the individual does not need to be the same individual, but the plan must at all times cover at least one person);
- family members of individuals enrolled in the health plan or coverage on March 23, 2010 may enroll in the grandfathered plan or coverage after March 23, 2010; and
- new employees and new enrollees and their families may also enroll in a grandfathered group health plan after March 23, 2010, subject to certain anti-abuse rules described below.

Provisions Applicable to Grandfathered Health Plans. Grandfathered health plans are exempt from many of the requirements of health care reform, including for example the requirements to provide preventive care without cost sharing, the new requirement to impose the non-discrimination requirements on self-insured health plans and certain minimum benefit requirements. However, grandfathered health plans are subject to a number of health care reform requirements, including for example prohibitions on pre-existing condition limitations, waiting periods of over 90 days, annual and lifetime limits and rescissions (except in the case of fraud or intentional misrepresentation). For more information on the health care reform requirements that do and do not apply to grandfathered health plans, see **Exhibit A**.

Changes That Result in Loss of Grandfathered Status. The new guidance makes clear that certain plan changes made after March 23, 2010 may result in the loss of grandfathered status. These changes include for example:

- changing the insurance carrier;
- entering into a new policy, certificate or contract;
- increasing certain fixed-amount cost sharing such as co-payments, deductibles and out-of-pocket maximums above certain limits set forth in the new guidance.

The new guidance also contains anti-abuse rules that will result in the loss of grandfathered status, pursuant to which mergers, acquisitions and restructurings with a principal purpose of covering new individuals and transfers of employees without a bona fide employment-based reason may result in the loss of grandfathered status.

For a more complete list of the changes and the specific limits on fixed-amount cost sharing that result in the loss of grandfathered status, see **Exhibit B-1**.

Changes That Do Not Result in Loss of Grandfathered Status. Fortunately, the new guidance makes clear that certain changes made after March 23, 2010 do not result in the loss of grandfathered status. These changes include for example:

- changing the third party administrator;
- changes to comply with Federal or State laws;
- changes to comply with some or all of the health care reform requirements;
- increasing premiums; and

- increasing certain fixed-amount cost sharing (such as co-payments, deductibles and out-of-pocket maximums), as long as the increases are below the limits set forth in the new guidance.

For a more complete list of changes that do not result in the loss of grandfathered status, see [Exhibit B-2](#).

Changes That May or May Not Result in Loss of Grandfathered Status. The Treasury Department, DOL and HHS have requested comments on whether certain additional changes should result in the loss of grandfathered status. These changes include:

- changes in plan structure;
- changes in a network plan's provider network;
- changes to a prescription drug formulary; and
- any other substantial changes to overall benefit design.

At this time, it is unclear whether any of these changes will result in the loss of grandfathered status.

Grandfathered Health Plan Disclosure and Recordkeeping Requirements. To maintain grandfathered status, a health plan or health insurance coverage must comply with certain disclosure and recordkeeping requirements.

Health plans and health insurance coverage must include a statement describing the benefits provided under the health plan or health insurance coverage that the health plan or issuer believes are grandfathered. This statement may be provided in any plan materials provided to participants or beneficiaries. The health plan or issuer must also provide contact information for questions and complaints. The new guidance includes a model statement that can be used to satisfy these disclosure requirements.

To maintain grandfathered status, a health plan or issuer must also maintain records documenting the terms of the health plan or health insurance coverage that were in effect on March 23, 2010 and any other documents necessary to verify, explain or clarify its status as a grandfathered health plan. These documents include plan documents, health insurance policies, certificates or contracts, summary plan descriptions, premium or cost documentation and documentation of required employee contribution rates. Such records must be maintained and made available for examination so that, for example, a participant, beneficiary, individual policy subscriber, or State or Federal agency official would be able to inspect these documents.

Special Rules for Insured Collectively Bargained Plans. For health insurance coverage that was in place before March 23, 2010 and is maintained pursuant to one or more collective bargaining agreements, the coverage is grandfathered health plan coverage until the last of such collective bargaining agreements terminates. After the last collective bargaining agreement terminates, grandfathered status is determined according to the generally applicable rules, comparing the terms of the health insurance coverage after the collective bargaining agreement terminates to the terms of the health insurance

coverage that were in effect on March 23, 2010. These rules apply only to insured plans maintained pursuant to collective bargaining agreements, not to self-insured plans maintained pursuant to collective bargaining agreements.

Grace Period to Remedy Plan Amendments Made Since March 23, 2010. Employers that adopted changes that might otherwise cause their health plan or health insurance coverage to lose grandfathered status now have a grace period within which to revoke or modify those changes. This grace period applies only if the changes were adopted after March 23, 2010 and before June 14, 2010. Under this grace period:

- grandfathered status is preserved if the changes are revoked, effective as of the first day of the first plan or policy year beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans); and
- the health plan or health insurance coverage is modified to bring the terms within the limits for retaining grandfathered status.

For purposes of the grace period, changes will be considered to have been adopted before June 14, 2010 if the changes were effective:

- before June 14, 2010;
- on or after June 14, 2010 pursuant to a legally binding contract entered into before June 14, 2010;
- on or after June 14, 2010 pursuant to a filing with a State insurance department made before June 14, 2010; or
- on or after June 14, 2010 pursuant to written amendments to a plan that were adopted before June 14, 2010.

Next Steps. As a result of this new guidance, employers should review their existing health care plans and determine whether to maintain grandfathered health plan status. This will require weighing the advantages of retaining grandfathered status (generally, greater flexibility in maintaining plan design) over the disadvantages of retaining grandfathered status (including, for example, significant limits on changing insurance carriers and on fixed-amount cost sharing).

In addition, any changes made in connection with mergers, acquisitions and restructurings and plan transfers should be carefully considered to ensure that such changes will not result in the loss of grandfathered status.

Employers should exercise care in making any amendments to group health plans and should consult with counsel or other advisors on whether any change may result in the loss of desired grandfathered status. To the extent that a health plan or health insurance coverage has been amended or changed since March 23, 2010, employers should consult with counsel or other advisors to determine whether the employer may take advantage of the grace period to remedy plan amendments that may otherwise result in the loss of grandfathered status.

Finally, employers that wish to maintain grandfathered status should take steps to document their grandfathered health plan status and should update plan-related documents to include the disclosure required for grandfathered plans.

Comments Requested. The Treasury Department, DOL and HHS have requested comments on the Interim Final Rule. Comments must be submitted on or before August 16, 2010.

Our client alerts are for general informational purposes and should not be regarded as legal advice. If you would like additional information or have any questions, please contact:

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EXHIBIT A

HEALTH CARE REFORM PROVISIONS THAT APPLY/DO NOT APPLY TO GRANDFATHERED PLANS

PROVISIONS THAT APPLY TO GRANDFATHERED PLANS

- Prohibition on pre-existing condition exclusions or other discrimination based on health status*
- Prohibition on excessive waiting periods
- Prohibition on lifetime limits
- Prohibition on annual limits*
- Prohibition on rescissions (except in cases of fraud or intentional misrepresentation)
- Extension of dependent coverage until age 26
- Use of uniform explanation of coverage documents and standard definitions
- Reducing cost of health coverage (for insured coverage) (applies to insured grandfathered plans)

PROVISIONS THAT DO NOT APPLY TO GRANDFATHERED PLANS**

- Requirement to offer minimum levels of benefits (except as noted above)
- Requirement to offer preventive care without cost sharing
- Application of Internal Revenue Code Section 105(h) (non-discrimination requirements) to self-insured health plans
- New requirements for processing health plan claims
- Requirement that women select OB/GYN of their choice
- Requirements for guaranteed-issue and renewability of coverage

* Applies to grandfathered group health plans and group health insurance coverage, but does not apply to grandfathered individual health insurance coverage.

** This list is not exhaustive, but is intended to provide examples of certain health care reform provisions that do not apply to grandfathered health plans.

EXHIBIT B

CHANGES THAT RESULT OR DO NOT RESULT IN LOSS OF GRANDFATHERED STATUS

B-1 CHANGES THAT RESULT IN LOSS OF GRANDFATHERED STATUS

- Elimination of all or substantially all benefits to diagnose or treat a particular condition (for example, eliminating benefits for participants with cystic fibrosis)
 - Elimination of benefits for any necessary element to diagnose or treat a condition (for example, eliminating counseling for treatment of mental health disorders) is considered the elimination of all or substantially all benefits to diagnose or treat a particular condition
- Increases in a percentage cost sharing requirement (such as coinsurance) above the level at which it was on March 23, 2010
- Increases in fixed-amount cost sharing requirements (other than co-payments), such as a \$500 deductible or a \$2,500 out-of-pocket limit, by a total percentage measured from March 23, 2010 that is more than the sum of medical inflation plus 15 percentage points
- Increases in co-payments by an amount that exceeds the greater of: (1) a total percentage measured from March 23, 2010 that is more than the sum of medical inflation plus 15 percentage points, or (2) \$5 increased by medical inflation measured from March 23, 2010
- For a group health plan or group health insurance coverage, an employer or employee organization decreases its contribution rate by more than 5 percentage points below the contribution rate on March 23, 2010
- With respect to annual limits:
 - a group health plan percentage points, or group or individual health insurance coverage, that, on March 23, 2010, did not impose an overall annual or lifetime limit on the dollar value of all benefits, imposes an overall annual limit on the dollar value of benefits
 - a group health plan, or group or individual health insurance coverage, that, on March 23, 2010, imposed an overall lifetime limit on the dollar value of all benefits but no overall annual limit on the dollar value of all benefits, adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010

- a group health plan, or group or individual health insurance coverage, that, on March 23, 2010, imposed an overall annual limit on the dollar value of all benefits, decreases the dollar value of the annual limit (regardless of whether the plan or health insurance coverage also imposes an overall lifetime limit on the dollar value of all benefits)

- Mergers, acquisitions and restructurings with a principal purpose of covering new individuals

- Certain transfers of employees without a bona fide employment-based reason

- Entering into a new insurance policy, certificate or contract

- Changing a group health plan's insurance carrier, except:
 - For plans with more than one benefit option that change the carrier for only one option, the options for which there is no carrier change will not lose grandfathered status as a result of such change
 - Pursuant to collective bargaining agreements that are changed during any existing agreement

B-2 CHANGES THAT DO NOT RESULT IN LOSS OF GRANDFATHERED STATUS

- Changes to the plan's third party administrator

- Changes to premiums

- Changes to comply with Federal or State legal requirements

- Changes to voluntarily adopt health care reform requirements

- Changes that are effective after March 23, 2010 pursuant to a legally binding contract entered into on or before March 23, 2010

- Changes pursuant to a filing on or before March 23, 2010 with a State insurance department

- Changes effective after March 23, 2010 pursuant to written plan amendments that were adopted on or before March 23, 2010

- Changes adopted before June 14, 2010 that would otherwise cause the plan or coverage to lose grandfathered health status, if such changes are revoked or modified effective as of the first day of the first plan or policy year on or after September 23, 2010 (January 1, 2011 for calendar year plans)

- Increases to fixed-amount cost sharing that do not exceed the limits described in Exhibit B-1 above

- Individuals enrolled on March 23, 2010 ceasing to be covered (provided that the plan or group health insurance coverage has at all times covered at least one person since March 23, 2010)

- Enrollment of new employees, new enrollees and their family members in the grandfathered group health plan or group health insurance coverage