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Guidance Issued Relating to Grandfathered Health Plans Under Health Reform Law

The three agencies responsible for enforcing the new health reform law have issued interim final regulations on "grandfathered" health plans and how grandfather status may be lost. The regulations also clarify the application of the rules to collectively bargained plans and provide some welcome guidance for retiree-only health plans.

Background

The Patient Protection and Affordable Care Act was enacted on March 23, 2010 and amended on March 30, 2010 by the Health Care and Education Reconciliation Act of 2010. The new health reform law includes provisions that exempt health coverage in existence on March 23, 2010 (grandfathered health plans) from certain of the insurance market reform requirements, such as those relating to coverage of preventive care, choice of providers, and external review of claims, but not others, such as the prohibition on annual and lifetime dollar limits, the extension of dependent coverage to age 26 and the prohibition of preexisting condition exclusions. (See our April 21, 2010 *For Your Information*. See also a chart prepared by the agencies on the application of the new health reform provisions to grandfathered plans.) Because many of the provisions will be in effect for the first plan year beginning on or after September 23, 2010, guidance on what constitutes a grandfathered plan and how this status is to be maintained was sorely needed.

The Departments of Health and Human Services, Labor and Treasury have now issued interim final regulations that provide guidance regarding grandfathered health plans, including how these rules apply to collectively bargained plans. In addition, the agencies clarify in the preamble that the insurance market reform provisions in the health reform law do not apply at all to certain stand-alone retiree plans.

Interim Final Regulations on Grandfathered Health Plans

Grandfathered Health Plan. The regulations define a grandfathered health plan as health coverage provided by a group health plan or an insurance issuer in which an individual was enrolled on March 23, 2010. The grandfather status of the coverage is maintained as long as the plan continuously covers at least one person (not necessarily the same person) since that date. The regulations clarify that the renewal of an insurance policy in effect on March 23, 2010 will not affect a plan's grandfather status. Grandfather status is generally determined separately for each benefit option, so a plan may have some options that are grandfathered and some that are not.

New Enrollees. The regulations provide that the enrollment of family members of an enrolled individual or new employees will not affect the plan's grandfather status. Individuals may also enroll during an open enrollment period, HIPAA special enrollment period or after a change in status without jeopardizing grandfather status.

Loss of Grandfather Status. The regulations provide that a plan will lose its grandfather status if the sponsor or issuer does any of the following –

- switches to a new insurer
- eliminates all or substantially all benefits to diagnose or treat a particular condition (e.g., eliminates treatment for cystic fibrosis)
- increases a percentage cost sharing requirement (e.g., coinsurance) above the level at which it was on March 23, 2010
- increases fixed-amount cost sharing requirements other than copayments, such as a $500 deductible or a $2,500 out-of-pocket limit, by more than the increase in the medical inflation component of CPI-U since March 23, 2010 plus 15 percentage points
- increases copayments by an amount that exceeds the greater of (1) a total percentage that is more than medical inflation measured from March 23, 2010 plus 15 percentage points, or (2) $5, increased by medical inflation measured from March 23, 2010.

Further, the coverage will also lose its grandfather status if the employer or employee organization decreases its contribution rate by more than five percentage points below the contribution rate on March 23, 2010 (or in the case of a contribution strategy based on a formula, such as dollars or cents per hour worked, the employer reduces the rate). For this purpose, employer contributions are calculated as a percentage of the overall plan costs on March 23, 2010, determined in the same way as for COBRA rates.

> ***BUCK COMMENT.*** *The regulations do not specifically address an employer contribution strategy under which an employer pays a percentage of the lowest cost plan or a salary-based contribution strategy. Nor do they address whether changes to tier structures or wellness incentives would affect grandfathering.*

There are special rules for plans with overall and annual dollar limits –

- A plan that has no overall lifetime or annual dollar limit will lose grandfather status if it imposes an annual limit.
- A plan with an overall lifetime dollar limit but no annual limit will lose grandfather status if it imposes an annual limit of less than the overall lifetime limit.
- A plan with an overall annual dollar limit (whether or not there is a lifetime limit) will lose grandfather status if it imposes a lower annual limit.

BUCK COMMENT. *The regulations request comments on whether other changes should affect grandfather status, such as a change in plan structure from a health reimbursement account (HRA) to major medical, changes in provider network, or changes to prescription drug formularies.*

The preamble to the regulations clarifies that the following changes can be made without a plan losing grandfather status as long as they do not run afoul of the standards described above –

- changes in premiums
- changes to comply with federal or state laws
- changes to voluntarily comply with the health reform law early
- changing third-party administrators.

BUCK COMMENT. *Compliance with federal mandates such as the Mental Health Parity and Addiction Equity Act may involve plan design changes that will not meet the above standards and thus will cause the plan to lose its grandfather status.*

Anti-Abuse Rules. The regulations include some rules intended to prevent plans from making certain indirect changes to employees' coverage that would result in the loss of grandfather status if made directly. If, for example, a grandfathered plan or option is eliminated and employees are "transferred" to another grandfathered plan or option, the transferee option will lose grandfather status if both of the following conditions are met –

- The eliminated option would lose grandfathered status if its terms were modified to match the transferee option.
- There is no bona fide employment based reason for the transfer. A higher cost would not constitute a bona fide reason. (Unfortunately, the regulations give no indication of what reasons *would* be acceptable.)

A plan will also lose grandfather status if the principal purpose of a business reorganization is to cover new individuals under a grandfathered plan.

BUCK COMMENT. *The use of the term "transfer" suggests an employer-initiated action that does not give the employee a choice regarding the new coverage in which he or she can enroll. More clarification by the regulators would be helpful.*

Transition Relief. The regulations provide some relief for changes made before issuance of the regulations that would cause a loss of grandfather status. Changes effective after March 23, 2010 will be treated as part of the terms of the plan on that date if made pursuant to any of the following –

- a binding contract entered into on or before March 23, 2010
- an insurance filing on or before March 23, 2010
- a written plan amendment adopted on or before March 23, 2010.

In addition, changes made between March 23, 2010 and June 17, 2010 may be revoked or modified by the first plan year beginning on or after September 23, 2010 to retain grandfather status.

Notice and Record Retention Requirements. The regulations impose new notice requirements on grandfathered health plans. To retain grandfather status, plans must include a statement in any plan materials describing benefits that are provided participants that the plans are grandfathered, and provide contact information for questions or complaints. The regulations provide model disclosure language. Further, the regulations require plans to maintain records documenting the terms of the plan that were in effect on March 23, 2010 and any other document necessary to support that the plan has maintained grandfather status. Plans are required to make these records available for examination by participants or the agencies on request.

Collectively Bargained Plans. The regulations provide some much-needed clarification on the application of the grandfather rules to collectively bargained plans and how the delayed effective date for such plans is to be applied. The regulations clarify that collectively bargained plans in existence on March 23, 2010 are subject to all of the mandates applicable to grandfathered health plan coverage regardless of when the last collective bargaining agreement terminates. The delayed effective date only applies to insured coverage and only affects when the grandfather status may be lost. Any circumstances that would cause a plan to lose grandfather status will be disregarded until such time as the last collective bargaining agreement ratified before March 23, 2010 relating to the coverage terminates. Once the last collective bargaining agreement terminates, the terms of the plan at that time (other than a change in insurer) will be compared with the coverage in effect on March 23, 2010 to determine whether the plan still retains grandfather status. Any change in insurance carrier after the date the last agreement terminates will also result in the loss of grandfather status.

> ***BUCK COMMENT**. The regulations refer to the date on which grandfather status is lost as the date on which the last collective bargaining agreement terminates – not the first plan year thereafter. Thus, for many insured union plans, the new rules could be effective mid-year.*

Retiree-Only Plans. The preamble to the regulations makes a very important clarification regarding the status of retiree-only plans. A plan that only covers retirees and no active employees will not be subject to any of the new insurance market reforms. Thus, for example, a retiree-only plan will not have to provide dependent coverage to adult children and may continue to include annual or lifetime dollar limits. Retiree-only plans are also exempt from the HIPAA portability requirements and other mandates, such as those imposed by the Mental Health Parity and Addiction Equity Act.

> ***BUCK COMMENT.** Sponsors of plans that currently cover both active employees and retirees may want to establish a separate plan for retirees, which should, at a minimum, include separate plan documents and administration. Such a plan could continue to have lifetime dollar limits on benefits. Action to carve out a retiree-only plan should be done before the beginning of the next plan year.*

Penalties for Mischaracterizing a Plan as Grandfathered. If a plan does not meet the requirements to maintain grandfather status, the employer (or in the case of a multi-employer plan, the plan) may be subject to the excise taxes imposed under HIPAA. This penalty is generally $100 per day for each affected individual up to the date of correction (which essentially means making a correction that would give the participant the benefits to which he or she is entitled under the health reform law).

Conclusion

The regulations provide useful guidance for plan sponsors, but they suggest that it may be difficult for many plans to retain grandfather status, and some plans may lose this status as soon as 2011. Buck's consultants can discuss the regulations with you and help you understand the implications of losing grandfather status for your health plans.