



Employee Benefits Law Information Memo

November 2010

Electronic Dispatch

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DEPARTMENTS CLARIFY HEALTH CARE REFORM GRANDFATHER RULES

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act ("PPACA") provides that group health plans existing as of March 23, 2010 – referred to as grandfathered plans – are not subject to certain provisions of PPACA. Such provisions include the preventative care mandate, certain nondiscrimination requirements, mandatory internal and external appeal rules, and restrictions on pre-authorizations for OB/GYN, pediatric and emergency care services.

On June 17, 2010, the Departments of Labor, Health and Human Services and Treasury (collectively, the "Departments") issued interim final regulations addressing what constitutes a grandfathered plan and what changes to such a plan might result in the loss of grandfathered plan status. The interim final regulations generally provide that grandfathered plan status could be lost by a group health plan if the plan's insurer is changed, benefits are eliminated, participant cost-sharing requirements are increased, participant co-payments and contribution requirements are increased by more than a permissible level, or annual limits are imposed on the dollar value of all benefits below specified amounts. Special grandfathering rules apply for collectively bargained plans. In addition to other PPACA mandates, a plan that loses grandfathered status is subject to the preventative care, external appeal and other mandates noted above.

Recently, the Departments amended the interim final regulation to provide that a change in a group health plan's insurer, in and of itself, will not cause an otherwise grandfathered plan to lose grandfathered status if certain requirements are satisfied. Additionally, the Departments issued a number of frequently asked questions ("FAQs") that, among other things, clarify the application of the grandfathered plan rules. The amendment to the interim final regulation and the FAQs are described below.

Amendment to Interim Final Regulations

Under the interim final regulations, a group health plan could lose grandfathered status if the plan changed from one insurer to another after March 23, 2010. This restriction only applied to insured group health plans. A self-insured plan may change third-party administrators without losing its grandfathered status (provided such plan otherwise satisfied the grandfathered plan requirements). The amendment to the interim final regulations generally provides that a group health plan does not cease to be a grandfathered plan merely because the plan (or plan sponsor) enters into a new policy, certificate, or contract of insurance after March 23, 2010. However, grandfathered plan status can be maintained only if, notwithstanding a change in insurers, the plan does not make coverage or cost-sharing changes that would result in the loss of grandfathered plan status. To maintain status as a grandfathered health plan, a group health plan entering into a new policy, certificate, or contract of insurance must provide the new health insurance issuer with documentation of the plan terms that is sufficient to determine whether the health plan has lost grandfathered status based upon the otherwise applicable grandfathered plan rules.

The interim regulation does not apply to a group health plan that entered into a new policy, certificate, or contract of insurance after March 23, 2010, that is effective before November 15, 2010 (the effective date of the regulation). Such a plan would cease to be a grandfathered plan based upon a change in insurers.

FAQs

Changes That Result In Loss of Grandfathered Status

The FAQs provide that the six specific changes identified in the interim final regulations are the only changes that a plan existing on March 23, 2010 needs to consider when evaluating its grandfathered status. In general, the six changes are described in the FAQs as:

1. the elimination of all, or substantially all, benefits to diagnose a particular condition;
2. an increase in a percentage cost-sharing requirement (e.g., raising an individual's coinsurance requirement from 20% to 25%);
3. an increase in a deductible or out-of-pocket maximum by an amount that exceeds medical inflation plus 15 percentage points;
4. an increase in a copayment by an amount that exceeds medical inflation plus 15 percentage points (or, if greater, \$5 plus medical inflation);
5. a decrease in an employer's contribution rate towards the cost of coverage by more than 5 percentage points; and
6. the imposition of annual limits on the dollar value of all benefits below specified amounts.

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Multiple Benefit Packages: The FAQs provide that the grandfathered plan analysis applies on a benefit-package-by-benefit-package basis. Accordingly, if a single group health plan offers three benefit packages (e.g., a PPO, a POS arrangement, and HMO), and only one of the benefit packages loses grandfathered status, that fact alone does not affect the grandfathered status of the other benefit packages.

Tiers of Coverage: One of the ways a group health plan may lose grandfathered status is if the employer decreases its contribution rate towards the cost of coverage by more than 5 percentage points. The interim final regulations indicated that this analysis applies on a tier-by-tier basis. The FAQs clarify that, if a group health plan modifies the tiers of coverage it had in effect on March 23, 2010 (e.g., from employee-only and family to employee-only, employee-plus one, employee-plus-two), the employer contribution for any new tier is tested by comparison to the corresponding tier on March 23, 2010. Accordingly, if the employer contribution rate for family coverage was 50 percent on March 23, 2010, the employer contribution rate for any new tier of coverage other than employee-only (i.e., employee-plus-one, employee-plus-two, employee-plus-three or more) must be within 5 percentage points of 50 percent.

However, if a plan adds one or more new coverage tiers without eliminating or modifying previously tiers, and those new coverage tiers cover classes of individuals not previously covered, the new tiers would not cause the plan to lose grandfathered status. For example, if a plan that previously offered employee-only coverage (i.e., did not offer family coverage) added a family tier, the level of contribution toward the family tier would not cause the plan to lose grandfathered status.

Different Copayment Levels: The Departments clarified that if a plan sponsor raises the copayment level for one category of services (e.g., outpatient primary care) by an amount that exceeds the permissible copayment increase standards, but retains the copayment for other categories of services, the change in the copayment for the one category of services will cause the entire plan to lose grandfathered status. Each change in cost sharing is tested against the applicable grandfathered standard in the interim final regulations.

Wellness Programs: The FAQs indicate that penalties (such as cost-sharing surcharges) imposed by wellness programs may implicate the grandfathered rules and should be analyzed carefully (e.g., the imposition of a surcharge could result in a decrease in the employer's contribution rate by more than 5 percent in violation of the grandfathering rules).

Disclosures: Under the interim final regulations, in order to maintain grandfathered status, a group health plan must include a statement in materials provided to a participant or beneficiary describing the benefits provided under the plan that the plan is intended to be a grandfathered plan. The FAQs provide that such a statement does not need to be provided each time a plan sends an explanation of benefits ("EOB") to a participant. The Departments did indicate that plan sponsors should look to identify other plan communications (such as a plan's summary plan description) in which the disclosure of grandfathered plan status would be appropriate.

Recommended Actions

Plan sponsors that are in the process of evaluating changes to their group health plans should consider the grandfathered plan rules as part of that process. In undertaking the grandfathered plan analysis, plan sponsors will need to decide whether the additional mandates imposed by PPACA for non-grandfathered plans outweigh the ability of the plan sponsor to modify plan cost-sharing, premiums, and other provisions without constraint by the grandfathered plan requirements. The amendment to the interim final regulation provides plan sponsors who desire to maintain grandfathered plan status, while seeking to change insurance carriers effective after November 15, 2010, with helpful relief. The FAQs also provide useful guidance for plan sponsors looking for clarification regarding the application of grandfathered plan rules. A complete list of the FAQs can be found on the Employee Benefits Security Administration's website at www.dol.gov/ebsa.

If you have any questions about this memorandum, please contact John Godsoe in our Buffalo office (716-566-2850, jgodsoe@bsk.com) or any of the other members of our Employee Benefits and Executive Compensation Practice Group listed below.

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