Further Clarification as to Grandfathered Health Plans Under the Patient Protection and Affordable Care Act

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PRACTICE AREAS
Employee Benefits
Health Care

The Affordable Care Act provides that certain group health plans and health insurance coverage existing as of March 23, 2010 (the date of enactment of the Affordable Care Act), are subject only to certain provisions of the Affordable Care Act. These plans are referred to as "grandfathered health plans". The Act, however, did not address at what point changes to a group health plan or health insurance coverage in which an individual was enrolled on March 23, 2010 are significant enough to cause the plan or health insurance coverage to cease to be a grandfathered health plan. As a result, interim final rules for group health plans and health insurance coverage relating to status as a "grandfathered health plan" under the Patient Protection and Affordable Care Act have been issued. This article briefly addresses these interim final rules.

HOW TO MAINTAIN STATUS AS A GRANDFATHERED PLAN

under the statute and the interim final regulations, a group health plan or group or individual health insurance coverage is a grandfathered health plan with respect to individuals enrolled on March 23, 2010.

To maintain status as a grandfathered health plan, a plan or health insurance coverage must:

1. include a statement, in any plan materials provided to participants or beneficiaries describing the benefits provided under the plan or health insurance coverage, that the plan or health insurance coverage believes that it is a grandfathered health plan within the meaning of section 1251 of the Affordable Care Act, and must provide contact information for questions and complaints. Model language is provided in these interim final regulations that can be used to satisfy this disclosure requirement.

2. maintain records documenting the terms of the 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. Such documents could include intervening and current plan documents, health insurance policies, certificates or contracts of insurance, summary plan descriptions, documentation of premiums or the cost of coverage, and documentation of required employee contribution rates. These documents must be made available for examination upon request.

ADDING OR LOSING EMPLOYEES

A group health plan that provided coverage on March 23, 2010 generally is also a grandfathered health plan with respect to new employees (whether newly hired or newly enrolled) and their families who enroll in the grandfathered health plan after March 23, 2010.

A group health plan or group health insurance coverage does not cease to be grandfathered health plan coverage merely because one or more (or even all) individuals enrolled on March 23, 2010 cease to be covered, provided that the plan or group health insurance coverage has continuously covered someone since March 23, 2010 (not necessarily the same person, but at all times at least one person).

HOW TO LOSE GRANDFATHERED STATUS

According to the interim final regulations, the changes that will cause a plan to lose its grandfathered status include:

- Elimination of all or substantially all benefits to diagnose or treat a particular condition, even if that condition affects only a few covered individuals;
- Increases in an individual's coinsurance requirement (e.g. increasing from 20% to 30% coinsurance);
- Increases in fixed-dollar cost sharing (such as deductibles and out-of-pocket expense limits, but not co-payments) in excess of the rate of medical inflation since March 23, 2010 plus 15 percentage points;
- Increases in co-payments in excess of the greater of (1) the rate of medical inflation, plus 15 percentage points, or (2) $5.00, as adjusted for medical inflation;
- Decreases in the employer contribution on the cost of any tier of coverage by more than 5% of its contribution rate in effect as of March 23, 2010. The total cost of coverage is to be determined in the same manner as the premium; and
- Certain changes to lifetime and annual benefit limits that would be adverse to plan participants.

For collectively bargained plans, if an employer or employee organization enters 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), then that policy, certificate, or contract of insurance is not a grandfathered health plan with respect to the individuals in the group health plan. Any policies sold in the group and individual health insurance markets to new entities or individuals after March 23, 2010 will not be grandfathered health plans even if the health insurance products sold to those subscribers were offered in the group or individual market before March 23, 2010.

WHAT LAWS AND REGULATIONS ARE STILL APPLICABLE TO GRANDFATHERED PLANS?

In making grandfathered health plans subject to some but not all of the health reforms contained in the Affordable Care Act, the statute attempts to balance its objective of preserving the ability to maintain existing coverage with the goals of expanding access to and improving the quality of health coverage.

The interim final regulations clarify that a grandfathered health plan must continue to comply with the requirements of the PHS Act, ERISA, and the Code that were applicable prior to the changes enacted by the Affordable Care Act, except to the extent supplanted by changes made by the Affordable Care Act. Therefore, the HIPAA portability and nondiscrimination requirements and the Genetic Information Nondiscrimination Act requirements applicable prior to the effective date of the Affordable Care Act continue to apply to grandfathered health plans. In addition, the mental health parity provisions, the Newborns' and Mothers' Health Protection Act provisions, the Women's Health and Cancer Rights Act, and Michelle's Law continue to apply to grandfathered health plans.

The following are the new health coverage reforms in part A of title XXVII of the PHS Act (as amended by the Affordable Care Act) that apply to grandfathered health plans and group health insurance coverage:

- Prohibition on preexisting condition exclusion or other discrimination based on health status[1];
- Prohibition on excessive waiting periods;
- No lifetime limits;
- No annual limits[2];
- Prohibition on rescissions;
- Extension of dependent coverage until age 26;
- Development and utilization of uniform explanation of coverage documents and standardized definitions;
- Bringing down cost of health care coverage (for insured coverage).

ANTI-ABUSE RULES

To prevent abuse, the interim final regulations provide 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 goal of this rule is to prevent grandfathered status from being bought and sold as a commodity in commercial transactions. Additionally, the rule seeks to prevent efforts to retain grandfathered status by indirectly making changes that would result in loss of that status if those changes were made directly.

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[1] Although applicable to group health plans and group health insurance coverage, this is not applicable to grandfathered individual health insurance coverage.
[2] Although applicable to group health plans and group health insurance coverage, this is not applicable to grandfathered individual health insurance coverage.