SEGAL Bulletin

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Regulations on "Grandfathering" under the Affordable Care Act

Some of the requirements of the Affordable Care Act[1] — the new health reform law — do not apply to employment-based health plans that were in existence on March 23, 2010, when the law was passed. These are referred to as "grandfathered plans." Since enactment, it has been an open question whether a health plan that is changed in some way after that date is still grandfathered. On June 14, 2010, the agencies implementing the Affordable Care Act released interim and temporary regulations explaining the grandfathering rules, and how much plans can be changed before they lose grandfathered status.[2] This *Bulletin* outlines key features of those new regulations. The rules are applicable for plan years beginning on or after September 23, 2010. Comments are due on or before August 16, 2010.

In some cases, the financial burden to stay grandfathered may be outweighed by the need for plan changes. Adopting the new standards that apply to "new plans" may be modest for some health plans. As a result, plan sponsors that are undergoing major cost-savings efforts (*e.g.*, aggressive new insurer bids or plan redesign) may want to forgo grandfathered status in order to be able to implement those strategies.

Regardless of whether a plan is grandfathered, it must comply with a number of the Affordable Care Act's requirements, starting with the first plan year beginning on or after September 23, 2010, as noted in the first column of the table below.

NO EXTRA DELAY FOR COLLECTIVELY BARGAINED PLANS

Although it is common for benefits laws to set a later date for collectively bargained plans to comply so that the issues can be addressed in bargaining, the language in the Affordable Care Act is confusing on that point. In the new regulations,

Requirements for All Plans	Additional Requirements for Non-Grandfathered Plans
All employment-based health plans, grandfathered or not, must meet these requirements of the Affordable Care Act: **Starting in 2011** ➢ Coverage for children up to age 26 ➢ Elimination of lifetime and most annual dollar limits on benefits ➢ No preexisting condition exclusions for children under age 19 ➢ Rescission of coverage only for fraud or intentional misrepresentation of material facts **Starting in 2012** ➢ New rules for plan summaries and other disclosures to participants **Starting in 2014** ➢ Waiting periods limited to 90 days ➢ No preexisting condition exclusions for any participants	A new health plan, or one that changes enough to lose grandfathered status, must also meet the following requirements: **Starting in 2011** ➢ No deductibles, copayments or coinsurance for immunizations or designated types of preventive care ➢ A pediatrician can be a child's primary care physician ➢ Women can obtain OB/GYN services without a referral ➢ Equal coverage for emergency services from in-network or out-of-network providers ➢ Process for internal appeals and external review of claims ➢ Insured plans may not discriminate in favor of highly compensated individuals (following the principles that already apply to self-funded plans) **Starting in 2014** ➢ Limits on cost sharing and deductibles based on limits for Health Savings Account-compliant high-deductible plans ➢ Coverage for routine services provided in connection with clinical trials ➢ Covered services may be provided by any health care provider acting with scope of license (*e.g.*, no discrimination against nurse practitioners or chiropractors).

[1] All of The Segal Company's publications, articles and other resources on the Affordable Care Act (the shorthand name for the Patient Protection and Affordable Care Act) can be accessed from the following Web page: http://www.segalco.com/health-care-reform/

[2] The regulations were published in the June 17, 2010 *Federal Register*: http://edocket.access.gpo.gov/2010/pdf/2010-14488.pdf Identical rules were adopted by the Internal Revenue Service, the Department of Labor and the Department of Health and Human Services.

the agencies explain that collectively bargained plans do not have a special delayed effective date for compliance with the new rules that apply to all plans, whether or not the plan is grandfathered.

Grandfathered status means that certain additional rules do not apply to the plan. Collectively bargained plans that are self-insured are subject to the same rules governing loss of grandfathered status as any other self-insured plan. Insured collectively bargained plans have more leeway to make changes and keep their grandfathered status, until the termination date of the last agreement relating to the coverage that was ratified by March 23, 2010.[3]

CHANGES THAT WILL CAUSE LOSS OF GRANDFATHERED STATUS

A group health plan will lose grandfathered status if any one of the following changes is made after March 23, 2010:

- Changing insurance companies or health maintenance organizations, or entering into a new policy, certificate or contract with the current carrier,
- Eliminating or cutting back significantly on the coverage for a particular condition,
- Increasing an individual's coinsurance requirement,
- Increasing an individual's copayment, if the total increase is more than the greater of $5 (adjusted annually for medical inflation) or medical inflation plus 15 percentage points,
- Increasing deductibles or out-of-pocket limits, if the total percentage increase exceeds medical inflation plus 15 percentage points,
- Increasing the share of the cost of coverage that must be paid by employee contributions (pretax or post-tax) by more than five percentage points, or
- Making various changes in the plan's annual limits.

Changes outside of these scenarios would not affect the plan's status as a grandfathered plan. This would include changes to the premium, changes to comply with any state or federal legal requirement, changes to voluntarily comply with provisions of the Affordable Care Act, and changing a third party administrator, provided these changes do not result in the cutbacks for participants set out above.

All of the tests are based on a comparison with the benefit plan in place on March 23, 2010, regardless of when the change is made. The rules apply separately to each benefit package.

[3] After the termination of the last collective bargaining agreement, the judgment whether an insured plan is still grandfathered is based on the magnitude of changes made to the plan since March 23, 2010, under the rules listed in the "Changes that Will Cause Loss of Grandfathered Status" section.

TRANSITION RULES

Because plan sponsors may have taken some of these listed actions after March 23, 2010, the regulations state that certain changes to which the plan was committed before that date will not be taken into account in considering whether the plan remains grandfathered. For example, post-enactment changes will not affect a plan's grandfathered status if they were made pursuant to written plan amendments adopted, or contracts entered into, prior to March 23, 2010.

Plans will also be allowed to keep grandfathered status by reversing changes made after March 23, 2010 but before the issuance of these rules. For this to work, the plan must revoke or modify these changes by the first day of the first plan year beginning on or after September 23, 2010.

DISCLOSURE AND DOCUMENTATION OF GRANDFATHERING

Grandfathered plans must include a statement — in any plan materials sent to participants and beneficiaries that describe the benefits — that the plan believes it is grandfathered. The regulations offer model language. A grandfathered plan must maintain records documenting the plan terms in effect on March 23, 2010.

RULE FOR RETIREE-ONLY PLANS

The agencies confirmed that, despite somewhat confusing language in the Affordable Care Act, retiree-only plans continue to be excluded from provisions passed under the Health Insurance Portability and Accountability Act and the laws that followed it (*e.g.*, the Mental Health Parity and Addiction Equity Act). Retiree-only plans are also exempt from all of the new group health plan standards added by the Affordable Care Act.

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As with all issues involving the interpretation or application of laws and regulations, plan sponsors should rely on their attorneys for authoritative advice on the interpretation and application of the Affordable Care Act and related regulations. Segal can be retained to work with plan sponsors and their attorneys on compliance issues.