

## **Summary of the Interim Final Rule for Grandfathered Health Plan Status in PPACA**

On June 14, 2010 the Departments of Health and Human Services, Labor and Treasury (IRS) filed the [Interim Final Rule](#) regarding grandfathered health plan status. This Rule is effective June 14, 2010, except certain amendments to Treasury, Labor and HHS regulations described below that are effective July 12, 2010. The Rule was published in the *Federal Register* June 17, 2010 and allows for a 60 day comment period; comments are due on or before August 16, 2010. The Departments may issue further guidance as necessary prior to the issuing the Final Rule. As a result, *the details of this summary may change based on further regulatory action.*

**Definition of Grandfathered Health Plan Coverage:** Coverage provided by a group health plan or a health insurance issuer in which an individual was enrolled on March 23, 2010 is considered grandfathered health plan coverage for as long as the plan maintains that status.

- A grandfathered plan does not lose its status merely because one or more individuals in the plan on March 23, 2010 are no longer covered, assuming someone has been continuously covered since March 23, 2010.
- The rules apply separately to each benefit package made available under a group health plan or health insurance coverage.

### **How to Maintain Grandfathered Status:**

The Interim Final Rule allows for changes, other than those described below while allowing plans to maintain their grandfathered status. Examples of allowable changes include those to premiums, changes to comply with Federal or State legal requirements, changes to voluntarily comply with provisions of the new law, and the changing of third party administrators.

### **Changes that will Cause a Grandfathered Plan to Lose its Status:**

- Elimination of benefits. A plan may not eliminate all or substantially all benefits to diagnose or treat a particular condition. Elimination of any necessary element is considered elimination of all benefits to diagnose or treat a particular condition.
- Increase in percentage of cost-sharing required. Based on the percentage as of March 23, 2010, any increase in the percentage cost-sharing is not allowed. (ex: an individual's coinsurance requirement)
- Increase in a fixed-amount cost-sharing requirement other than a copayment. Any increase in a fixed-amount cost-sharing other than a copayment is not allowed (ex: deductible or out-of-pocket limit) if the total percentage increase exceeds the maximum percentage increase<sup>1</sup> (Based on March 23, 2010 and the effective date of the increase).

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<sup>1</sup> Maximum percentage increase is medical inflation expressed as a percentage, plus 15 percentage points.

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- Increase in a fixed-amount copayment. An increase in the fixed-amount copayment is not allowed if the total increase, measured from March 23, 2010, exceeds the greater of:
  - \$5 multiplied by medical inflation<sup>2</sup> plus \$5
  - OR-
  - The maximum percentage increase (total increase in copayment as a percentage).
- Decrease in the contribution rate<sup>3</sup> by employers and employee organizations. A decrease *based on cost of coverage or formula* towards any tier of coverage for similarly situated individuals of more than 5 percentage points below the rate for the coverage period including March 23, 2010 is not permitted.
- Changes in annual limits.
  - If a plan did not impose an overall annual or lifetime limit as of March 23, 2010, the plan may not impose an overall limit on the dollar value of benefits.
  - If a plan imposed an over lifetime limit but no overall annual limit on the dollar value of benefits as of March 23, 2010, the plan may not adopt an overall annual limit less than the dollar limit of the lifetime limit on March 23, 2010.
  - If a plan imposed an overall annual limit as of March 23, 2010, the plan may not decrease the dollar value of the annual limit.

**Transition Rules:**

Permitted changes made prior to and effective after March 23, 2010:

- Changes made by a legally binding contract entered into on or before March 23, 2010.
- Changes made by a filing with a State insurance department
- Changes in a written amendment to a plan adopted on or before March 23, 2010.

Changes made after March 23, 2010 and adopted prior to issuance of regulations:

- Grandfathered status will be maintained if the changes are revoked or modified effective as of the first day of the first plan year beginning on or after September 23, 2010 and the terms of the plan would not cause cessation of grandfathered status.
- Changes will be considered to have been adopted prior to date of filing for public inspection (June 14, 2010) if:
  - Changes are effective before that date.
  - Changes are effective after that date due to legally binding contract.
  - Changes are made by a filing with a State insurance department before that date.

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<sup>2</sup> Medical inflation is the increase since March 2010 in the overall medical care component of the CPI-U published by DOL.

<sup>3</sup> Contribution rate based on cost of coverage means the amount of contributions made by an employer or employee organization compared to the total cost of coverage, expressed as a percentage. Contribution rate based on formula means for plans than on March 23, 2010 made contributions based on a formula, the formula.

- Changes are due to a written amendment adopted before that date.

**Disclosure of Grandfather Status Required:** To maintain status, a plan or coverage must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan, that states that the plan believes it is a grandfathered plan. Contact information for questions and complaints must also be provided. The rule provides the following language that can be used to satisfy the disclosure requirement:

This [group health plan or health insurance issuer] believes this [plan or coverage] is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov).]

**Recordkeeping by Plan or Issuer to Maintain Status:**

- Maintain records documenting the plan or policy terms for the coverage in effect on March 23, 2010, and any other documentation necessary to verify, explain or clarify status as a grandfathered plan.
- Make such records available for examination upon request to a plan or coverage participant, beneficiary, individual policy subscriber, or State or Federal agency official.
- Records must be available for as long as the plan claims to have grandfathered status.

**Family Members Enrolling in Grandfathered Plan:** Family members of an individual enrolled in a grandfathered plan can also enroll in the individual’s

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grandfathered plan after March 23, 2010 and be considered as having grandfathered health plan coverage.

**New Employees Joining the Grandfathered Plan:** New hires or newly enrolled employees and their families can enroll in a grandfathered plan after March 23, 2010.

**Anti-abuse Rules:** There are two rules that were put in place to prevent a plan or issuer from skirting the limits on allowed changes so as to avoid loosing its grandfathered status.

- First, if the principal purpose of a merger, acquisition or similar business transaction is to cover new individuals under the grandfathered plan, the plan ceases to be a grandfathered plan. The Rule reasons that this is to prevent grandfathered status from being bought and sold.
- Second, the Rule disallows transfers of employees from one grandfathered plan to another, amending one plan with another, or transferring employees to another grandfathered plan for no bone fide reason (terms and cost of coverage not considered bone fide reasons). The second rule is intended to prevent indirect changes to plans that would otherwise have resulted in loss of grandfathered status.

**Provisions Applicable to Grandfathered Plans:** Grandfathered plans are exempted from some, but not all, requirements of the PPACA.

| <b>Effective Date</b><br>(Plan year beginning on or after) | <b>Provision</b>  | <b>Application to Grandfathered Plans</b>  |
|--|---|--|
| 9/23/2010  | Pre-existing condition exclusions for children under age 19 not allowed | Applicable.  |
| 9/23/2010  | Enhanced appeals process  | Not Applicable.  |
| 9/23/2010  | Lifetime and annual limits prohibited                                   | Lifetime: Applicable<br><br>Annual: Applicable to grandfathered group health plans, not applicable to grandfathered individual coverage. |
| 9/23/2010  | No rescissions of coverage  | Applicable.  |
| 9/23/2010  | Extension of coverage to adult dependents until age 26                  | Applicable for group health plans until 2014, only if the adult child is not eligible for other employer-sponsored health plan coverage. |

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|           |   | After 2014, all adult children until age 26.  |
| 9/23/2010 | Standard summary of coverage provided for employees   | Applicable.   |
| 9/23/2010 | Non-discrimination requirements   | Not Applicable.   |
| 9/23/2010 | Choice of primary care physician; Emergency services requirements; no referral needed for OB/GYN services | Not Applicable.   |
| 9/23/2010 | Coverage of preventive services   | Not Applicable.   |
| 1/1/2014  | Pre-existing condition exclusions for all prohibited  | Applicable to grandfathered group health plans.<br><br>Not Applicable to grandfathered individual coverage. |
| 1/1/2014  | No waiting periods longer than 90 days  | Applicable.   |
| 1/1/2014  | Limits on cost-sharing  | Not Applicable.   |

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