

Health Care Reform

Grandfathered Plans

Revised October 2011

Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan

The 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 (PPACA) were issued by multiple agencies on June 14, 2010. A subsequent amendment to the final rule was issued and effective on Nov. 15, 2010.

The interim final rules, as amended, provide six changes that alter a health plan so significantly that they will cause a group health plan or health insurance coverage to relinquish grandfathered status. A group health plan or health insurance coverage will no longer be considered a grandfathered health plan if a plan sponsor or an issuer makes any of the six changes (measured from March 23, 2010) outlined below:

1. Eliminates all or substantially all benefits to diagnose or treat a particular condition.
2. The plan increases a percentage cost-sharing requirement (such as coinsurance) above the level at which it was on March 23, 2010.
3. The plan increases fixed-amount cost-sharing requirements other than copayments (e.g., a \$500 deductible or a \$2,500 out-of-pocket limit) more than the maximum percentage increase identified by the rule.
4. The plan increases fixed-amount cost-sharing requirements for copayments more than the allowed amount.
5. A group health plan or group health insurance coverage decreases the employer's contribution rate by more than five percentage points below the contribution rate on March 23, 2010.
6. A plan makes certain changes with respect to annual or lifetime limits.

For more information on these six changes, please see the detailed explanations and examples provided below.

1. Eliminates all or substantially all benefits to diagnose or treat a particular condition.

The elimination of benefits *for any necessary element* to diagnose or treat a condition is considered the elimination of all or substantially all benefits to diagnose or treat a particular condition.

Example: If a plan eliminates all benefits for cystic fibrosis, the plan ceases to be a grandfathered health plan.

Example: If a plan provides benefits for a particular mental health condition, the treatment for which is a combination of counseling and prescription drugs, and subsequently eliminates benefits for counseling, the plan is treated as having eliminated all or substantially all benefits for that mental health condition.

2. The plan increases a percentage cost-sharing requirement (such as coinsurance) above the level at which it was on March 23, 2010.

Changes to the level of coinsurance would significantly alter the level of benefits provided; thus, any increase in a percentage cost-sharing requirement causes a plan or health insurance coverage to cease to be a grandfathered health plan.

Example: On March 23, 2010, a grandfathered health plan has a coinsurance requirement of 20 percent for inpatient surgery. The plan is subsequently amended to increase the coinsurance requirement to 25 percent. The increase in the coinsurance requirement from 20 percent to 25 percent causes the plan to cease to be a grandfathered health plan.

3. The plan increases fixed-amount cost-sharing requirements other than copayments (e.g., a \$500 deductible or a \$2,500 out-of-pocket limit) more than the maximum percentage increase identified by the rule.

The maximum percentage increase is defined as medical inflation (from March 23, 2010), expressed as a percentage, plus 15 percentage points. The term medical inflation means the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted). The increase in the overall medical care component is computed by subtracting 387.142 from the index amount for any month in the 12 months before the new change is to take effect and then dividing that amount by 387.142.

Example: On March 23, 2010, a grandfathered health plan has a copayment requirement of \$30 per office visit for specialists. The plan is subsequently amended to increase the copayment requirement to \$40. Within the 12-month period before the \$40 copayment takes effect, the greatest value of the overall medical care component of the CPI-U (unadjusted) is 475. In this example, the increase in the copayment from \$30 to \$40, expressed as a percentage, is 33.33 percent ($40 - 30 = 10$; $10 \div 30 = 0.3333$; $0.3333 = 33.33\%$). Medical inflation from March 2010 is 0.2269 ($475 - 387.142 = 87.858$; $87.858 \div 387.142 = 0.2269$). The maximum percentage increase permitted is 37.69 percent ($0.2269 = 22.69\%$; $22.69\% + 15\% = 37.69\%$). Because 33.33 percent does not exceed 37.69 percent, the change in the copayment requirement at that time does not cause the plan to cease to be a grandfathered health plan.

4. The plan increases fixed-amount cost-sharing requirements for copayments more than the allowed amount.

The rule stipulates that a plan or health insurance coverage ceases to be a grandfathered health plan if there is an increase that exceeds the greater of: a total percentage (measured from March 23, 2010) that is more than the sum of medical inflation plus 15 percentage points, or \$5 increased by medical inflation (measured from March 23, 2010).

Example: On March 23, 2010, a grandfathered health plan has a copayment of \$10 per office visit for primary care providers. The plan is subsequently amended to increase the copayment requirement to \$15. Within the 12-month period before the \$15 copayment takes effect, the greatest value of the overall medical care component of the CPI-U (unadjusted) is 415. In this example, the increase in the copayment, expressed as a percentage, is 50 percent ($15 - 10 = 5$; $5 \div 10 = 0.5$; $0.5 = 50\%$). Medical inflation from March 2010 is 0.0720 ($415.0 - 387.142 = 27.858$; $27.858 \div 387.142 = 0.0720$). The increase that would cause a plan to cease to be a grandfathered health plan is the greater of the maximum percentage increase of 22.20 percent ($0.0720 = 7.20\%$; $7.20\% + 15\% = 22.20\%$), or \$5.36 ($\$5 \times 0.0720 = \0.36 ; $\$0.36 + \$5 = \$5.36$). The \$5 increase in copayment in this example would not cause the plan to cease to be a grandfathered health plan, which would permit an increase in the copayment of up to \$5.36.

5. A group health plan or group health insurance coverage decreases the employer's contribution rate by more than five percentage points below the contribution rate on March 23, 2010.

If the contribution rate is based on the cost of coverage or on a formula, such as hours worked, a group health plan or group health insurance coverage ceases to be a grandfathered health plan if the employer decreases its contribution rate toward the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below the contribution rate on March 23, 2010. For this purpose, contribution rate is defined as the amount of contributions made by an employer compared to the total cost of coverage, expressed as a percentage. Total cost of coverage is determined in the same manner as the applicable premium is calculated under the COBRA continuation provisions. In the case of a self-insured plan, contributions by an employer are calculated by subtracting the employee contributions from the total cost of coverage.

Example: On March 23, 2010, a self-insured group health plan provides two tiers of coverage: self-only and family. The employer contributes 80 percent of the total cost of coverage for self-only and 60 percent of the total cost of coverage for family. Subsequently, the employer reduces the contribution to 50 percent for family coverage, but keeps the same contribution rate for self-only coverage. In this example, the decrease of 10 percentage points for family coverage in the contribution rate based on cost of coverage causes the plan to cease to be a grandfathered health plan. The fact that the contribution rate for self-only coverage remains the same does not change the result.

6. A plan makes certain changes with respect to annual or lifetime limits.

Three scenarios are discussed in the interim final rules. With respect to annual limits: (1) a group health plan, or group or individual health insurance coverage, that, on March 23, 2010, did not impose an overall annual or lifetime limit on the dollar value of all benefits imposes changes to an overall annual limit on the dollar value of benefits; (2) a group health plan, or group or individual health insurance coverage, that, on March 23, 2010, imposed an overall lifetime limit on the dollar value of all benefits but no overall annual limit on the dollar value of all benefits adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010; or (3) a group health plan, or group or individual health insurance coverage, that, on March 23, 2010, imposed an overall annual limit on the dollar value of all benefits decreases the dollar value of the annual limit (regardless of whether the plan or health insurance coverage also imposes an overall lifetime limit on the dollar value of all benefits).

Changes other than those described above will not cause a plan or coverage to cease to be a grandfathered health plan. Examples include changes to premiums, changes to comply with federal or state legal requirements, changes to voluntarily comply with provisions of PPACA, changing third-party administrators, and, effective Nov. 15, 2010, changing insurance carriers.

Other Insights Provided by the Interim Final Rules

Policies Sold After March 23, 2010

Any policies sold in the group and individual health insurance markets to new entities 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. Thus a change in carriers will eliminate grandfathered status.

Example: A group health plan not maintained pursuant to a collective bargaining agreement provides coverage through a group health insurance policy from Issuer X on March 23, 2010. For the plan year beginning Jan. 1, 2012, the plan enters into a new policy with Issuer Z. In this example, for the plan year beginning Jan. 1, 2012, the group health insurance coverage issued by Z is not a grandfathered health plan because the policy issued by Z did not provide coverage on March 23, 2010.

Update: Change in Carrier Will Not Cause Loss of Grandfathered Status

Originally, one of the ways a fully insured group health plan could lose its grandfathered status was if the employer changed carriers or issuers (i.e., switched from one insurance company to another). The original regulations (the June 14, 2010, interim final rules) only allowed self-funded plans to change third-party administrators without losing their grandfathered plan status. However, an amendment to the original regulations was released on Nov. 15, 2010, which allows all fully insured group health plans to switch insurance companies and maintain their grandfathered status, so long as the structure of the coverage does not violate one of the other six prohibited changes as described in the previous paragraphs. However, that amendment is not retroactive.

Since the amendment is not retroactive, a fully insured group health plan that switched from one insurance carrier to another between March 23, 2010, and Nov. 14, 2010, lost their grandfathered status. If the fully insured plan changed carriers on or after Nov. 15, 2010, the plan would not lose grandfathered status due to the change in carrier.

This amendment also provides that, to maintain status as a grandfathered health plan, a group health plan that enters into a new policy, certificate or contract of insurance must provide to the new health insurance issuer documentation of plan terms (including benefits, cost sharing, employer contributions and annual limits) under the prior health coverage sufficient to determine whether any change is being made, other than a change in carriers, that would cause the plan to lose grandfathered status.

Disclosure Required to Maintain Grandfathered Status

To maintain status as a grandfathered health plan, a plan or health insurance coverage (1) must 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 PPACA and (2) must provide contact information for questions and complaints (model language provided in the interim final rules is provided below).

It appears this disclosure requirement would apply to any Summary Plan Description (SPD), Summary of Material Modifications or benefit enrollment materials provided to participants or beneficiaries beginning with the first plan year on or after Sept. 23, 2010. The agencies have clarified that it is not necessary for a grandfathered plan to provide a disclosure statement regarding its grandfathered status every time it sends out a communication (e.g., an explanation of benefits) to participants and beneficiaries. A grandfathered plan will be in compliance with the disclosure requirement if it includes the model disclosure language (provided below) or a similar statement "whenever a summary of benefits under the plan is provided." An example is given of SPDs provided upon initial eligibility, at open enrollment and "upon other opportunities to enroll in, renew, or change coverage."

Documentation Required to Maintain Grandfathered Status

To maintain status as a grandfathered health plan, a plan or issuer must also 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, SPDs, documentation of premiums or the cost of coverage, and documentation of required employee contribution rates. In addition, the plan or issuer must make such records available for examination. The plan or issuer must maintain such records and make them available for examination for as long as the plan or issuer takes the position that the plan or health insurance coverage is a grandfathered health plan.

Collective Bargaining Agreements

In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements ratified before March 23, 2010, the coverage is a grandfathered health plan at least until the date on which the last agreement relating to the coverage terminates. Thus, before the last of the applicable collective bargaining agreement terminates, any health insurance coverage provided pursuant to the collective bargaining agreements is a grandfathered health plan, even if there is a change in

issuers (or any other change) during the period of the agreement. This provision only applies to insured plans maintained pursuant to a collective bargaining agreement and not to self-insured plans. After the date on which the last of the collective bargaining agreements terminates, the determination of whether health insurance coverage maintained pursuant to a collective bargaining agreement is grandfathered health plan coverage is made in accordance with other group health plans.

List of the New Health Reform Provisions of Part A of Title XXVII of the PHS Act That Do and Do Not Apply to Grandfathered Health Plans

PHS Act Statutory Provisions That Do Apply	
PHS Act Statutory Provisions	Application to Grandfathered Health Plans
§ 2704 — Prohibition of pre-existing condition exclusion or other discrimination based on health status	Applicable to grandfathered group health plans and group health insurance coverage; not applicable to grandfathered individual health insurance coverage
§ 2708 — Prohibition on excessive waiting periods	Applicable
§ 2711 — No lifetime limits	Applicable
§ 2711 — No annual limits	Applicable to grandfathered group health plans and group health insurance coverage; not applicable to grandfathered individual health insurance coverage
§ 2712 — Prohibition on rescissions	Applicable
§ 2714 — Extension of dependent coverage until age 26	Applicable
§ 2715 — Development and utilization of uniform explanation of coverage documents and standardized definitions	Applicable
§ 2718 — Bringing down cost of health care coverage (for insured coverage)	Applicable to insured grandfathered health plans

PHS Act Statutory Provisions That Do NOT Apply	
PHS Act Statutory Provisions	Application to Grandfathered Health Plans
§ 2701 — Modified community rating	Not applicable
§ 2702 — Guaranteed issue	Not applicable
§ 2703 — Guaranteed renewability	Not applicable
§ 2705 — Nondiscrimination based on health status	Not applicable
§ 2706 — Nondiscrimination of health care providers	Not applicable
§ 2707 — Comprehensive health insurance coverage (essential benefits and cost-sharing requirements)	Not applicable
§ 2709 — Individual participation in clinical trials	Not applicable
§ 2713 — Mandated preventive services	Not applicable
§ 2715A — Transparency reporting	Not applicable
§ 2716 — Nondiscrimination based on salary	Not applicable
§ 2717 — Quality of care reporting	Not applicable
§ 2719 — Appeals process	Not applicable
§ 2719A — Choice of PCP; ER services at in-network rates; access to OB/GYN; access to pediatrician	Not applicable
§ 2704 — Prohibition of pre-existing condition exclusion or other discrimination based on health status	Not applicable to grandfathered individual health insurance coverage
§ 2711 — No lifetime or annual limits	Not applicable to grandfathered individual health insurance coverage
§ 2714 — Extension of dependent coverage until age 26	Not applicable to group health plans that are grandfathered if the dependent is eligible to enroll in an employer-sponsored group health plan other than the group health plan of a parent.

Model Language for the Required Disclosure

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. 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.]

For More Information

The U.S. Department of Labor’s Employee Benefits Security Administration posted the following resources related to grandfathered health plans under PPACA:

- Interim Final Regulation, available at: <http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=23967&AgencyId=8>
- Fact Sheet, available at: www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html
- FAQs, available at: www.healthreform.gov/about/grandfathering.html
- Amendment to the Interim Final Rules, Nov. 15, 2010, available at: <http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=24413&AgencyId=8&DocumentType=2>

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