

## Grandfathered Plans

## Health Reform – June 2010

**On June 14, 2010**, the US Departments of Treasury, Health and Human Services, and Labor jointly issued final interim rules relating to “grandfathered” status for health plans. Whether a plan is “grandfathered,” and whether it maintains that status is important because several of the new federal health care reforms for health insurance apply only to “non-grandfathered” health plans. Thus, it will be helpful moving forward to know what kinds of changes you can make to your plan without losing grandfathered status.

What is currently grandfathered is straightforward: group health plans (self-insured plans) and health insurance coverage existing March 23, 2010 (the date of enactment of the federal reforms) are grandfathered health plans. Here are more specifics:

- Any grandfathered plan that is renewed without specified changes (see those changes below) maintains that status, and the plan may cover new employees and employee families members, or terminate employees without losing that status, as long as the plan has continuously covered someone since 3/23/2010.
- The rules (and status) are determined individually for each benefit package offered.<sup>1</sup>
- Materials given to plan members must state the plan is grandfathered and provide a contact for more information.
- Records must be kept to document coverage in effect on 3/21/10, and to otherwise establish grandfathered status. (The rule gives, as examples, intervening Summary Plan Documents, insurance contracts, etc).

The new rules spell out the types of changes that trigger a loss of grandfathered status. As you’ll see, some changes are absolute, but some changes only trigger the lost status if the change is significant or substantial. Here’s what I’ve gleaned from the 121-page rule are the plan changes after 3/23/2010 that *trigger a loss of status*.

**New contract for insurance**: If an employer enters into a new policy, certificate or contract for insurance, the new plan is NOT grandfathered.<sup>2</sup> This is the case even if

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<sup>1</sup> That is, an employer with multiple plan offerings may end up with grandfathered and non-grandfathered plans.

<sup>2</sup> There is an exception to this rule, under statute, for collectively bargained plans under contract before 3/23/10; the change of carrier does not trigger loss of grandfather status.

## *Grandfathered Plans*

## *Health Reform – June 2010*

the coverage is identical to a prior grandfathered plan, and if the plan was in effect for other groups on March 23, 2010. This is the case even if the plan is a grandfathered plan for other groups. (Note that a renewal of an existing coverage or contract maintains grandfathered status for the plan.)

A self-insured plan that changes plan administrators does not lose grandfather status, as long as there are no changes to the benefits covered, copayments or other changes listed below.

**Moves to circumvent the rules:** If the sole purpose of a merger or acquisition is to acquire a grandfathered plan, or if employees are all transferred into a grandfathered plan in lieu of changing the former plan, the grandfathered status is lost.

**Changes to plan coverages:** Grandfathered status (GFS) is lost if all, or substantially all, coverage to diagnose or treat a particular diagnosis or condition are eliminated. The regulations give, as an example, a plan covered drugs and counseling for a particular mental health condition, and then eliminated all counseling; that would be a substantial elimination of coverage.

**Increase in cost sharing percentage:** The rules state that *any* increase in the percentage of cost-sharing (co-insurance) triggers a loss of GFS. (Example: increase of surgery copayment from 20% to 25 %.)

**Increase in a fixed-amount cost-sharing requirement other than a copayment.** Deductibles and out-of-pocket limits can be raised without a loss of GFS, as long as the increased measured from 3/23/2010 (cumulative) does not exceed medical inflation plus 15%.

**Fixed copayment increases:** The GFS-loss trigger for fixed copayments is more complicated: The plan loses GFS if the total increase in the copayment measured from March 23, 2010 exceeds the greater of:

- An amount equal to \$5 increased by medical inflation (that is, \$5 times medical inflation, plus \$5), or
- A percentage increase greater than medical inflation plus 15%.

## *Grandfathered Plans*

## *Health Reform – June 2010*

### **Decrease in employer contribution:**

- If contribution is a fixed percentage, GFS is lost if the contribution rate is more than 5% below the contribution for the period including 3/23/2010. (If the employer always pays 60% of costs, then the employee contribution in dollars can increase without triggering GFS, because the employer contribution percentage did not decrease.)
- If contribution is based on a formula, GFS is lost if the formula produces a contribution that is more than 5% below the contribution for the period including 3/23/2010.

### **Changes in annual limits:** Three types of changes would trigger loss of GFS:

- Addition of an annual limit to a plan that had neither annual nor lifetime limit on 3/23/2010
- Addition of an annual limit to a plan that had only a lifetime limit on 3/23/2010
- Decrease in annual limit on plan with an annual limit on 3/23/2010

There are exceptions to these triggers for changes that were “in the pipeline” on 3/23/2010: any changes pursuant to a contract entered into on or before 3/23/2010, that were in a filing with the state insurance commissioner on or before 3/23/2010, or that were in plan amendments adopted on or before 3/23/2010.

***As a reminder, here’s what is at stake.*** If not already part of your plan, these are the changes you would have to make to your health plan or health insurance, GFS is lost:

- Cover any adult child of a covered person, even if the adult child has access to an employer plan. (*Until 2014, grandfathered plans can deny coverage to adult children who are eligible for an employer health plan.*)

## *Grandfathered Plans*

## *Health Reform – June 2010*

- Cover specified preventive services with no cost sharing<sup>3</sup>
- Eliminate pre-authorization for emergency services, and referral requirement for OB/GYN.
- Allow enrollees to choose, rather than be assigned, a Primary Care Provider
- No discrimination in favor of highly compensated in fully insured plans
- Provide new appeals processes to members.

**For most insured plans in Vermont, most of these are already in effect because of BISHCA's managed care regulations. The non-discrimination requirement, however, may be a change for some plans. Employers need to weigh whether holding on to GFS is worth the loss in flexibility to change cost sharing, such as premium sharing, co-pays and coinsurance.**

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<sup>3</sup> The statute specifies coverage for preventive care services and immunizations recommended by the U.S. Preventive Services Task Force (USPSTF), the Centers for Disease Control, and the Health Resources and Services Administration.