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What it means to be a Grandfathered Health Plan under Healthcare Reform

By Dan S. Brandenburg, Paul M. Heylman and Seth J. Groman

The main body of healthcare reform legislation, the Patient Protection and Affordable Care Act (“PPACA”), was signed into law by President Obama on March 23, 2010. On March 30, 2010, President Obama signed the Health Care and Education Reconciliation Act of 2010 (the “Reconciliation Act”) modifying PPACA. Together, these two laws impose many new obligations on employers. (There is a summary of the basic requirements of healthcare reform legislation at the end of this Client Alert.)

The new requirements for group health plans have a series of effective dates, some starting as soon as September. However, Congress, under section 1251 of PPACA, allowed existing plans to delay complying with some, but not all, of these new rules by qualifying as “grandfathered health plans.” Until June 14, 2010, when the Department of Treasury, Department of Health and Human Services and Department of Labor (the “Agencies”) released interim final rules, there was little guidance on what changes could be made to a plan without the plan losing its grandfathered status. The interim final rules were effective when published in the Federal Register on June 17, 2010. Now that the interim regulations have been issued, employers and other plan sponsors can begin the process of determining whether it is worthwhile to remain a grandfathered plan.

Grandfathered status depends on whether benefits that were part of the plan on March 23, 2010 have been changed. Benefits are considered part of a plan on March 23, 2010 even if they were scheduled to go into effect at a later date. The following changes are considered part of the plan or policy terms on March 23, 2010, even though they were not effective until after March 23, 2010:

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

Changes to a plan made between March 23, 2010 and June 17, 2010 that would take a plan out of grandfathered status can be revoked until the first day of the first plan year beginning on or after September 23, 2010. If the changes are revoked, the plan remains in grandfathered status.

A plan may choose to stay a grandfathered plan for now and later give up grandfathered status. For example, a sponsoring employer may decide to give up grandfathered status because it wishes to make certain changes for cost saving or benefit design purposes that are outside of those that are permitted within grandfathered status.

WHAT PLANS ARE GRANDFATHERED AND WHY IS IT IMPORTANT TO REMAIN GRANDFATHERED?

Generally, any group health plan in effect on March 23, 2010, is a grandfathered health plan until it undergoes substantial changes. Grandfathered plans are exempt from the following parts of the healthcare reform legislation:

Provisions Effective for Plan Years Beginning on or After 9/23/2010

- **Preventative Health Services** - Grandfathered plans are not covered by the legislation's requirements to provide coverage of certain preventative services and immunizations.

- **Nondiscrimination** - Grandfathered plans are exempt from the legislation's extension of nondiscrimination rules relating to the coverage, eligibility and benefits of highly compensated employees to insured plans. This may be important if a plan provides significantly more generous benefits to current or former executive level employees.
- **Appeals Process** - Grandfathered plans are not obligated by the legislation to develop internal and external systems for enrollees to appeal coverage determinations and claims that are more strenuous than the current ERISA requirements.
- **Patient Protections** - Unlike other plans, grandfathered plans are exempt from the rules requiring plans to allow enrollees to designate their primary care providers. Grandfathered plans may also impose prior authorization requirements on emergency department services, and may require women to obtain authorization or referral for OB-GYN services.

Provisions Effective for Plan Years Beginning on or After 1/1/2014

- **Guaranteed Renewability of Coverage** - Grandfathered plans need not guarantee that coverage will be renewed.
- **Nondiscrimination Based on Health Status** - Grandfathered plans are exempt from the legislation's prohibitions on refusing to allow individuals to enroll or renew based on health status, medical conditions, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. (Note: this applies only to the application of the legislation's new rules and does NOT affect ADA, GINA, HIPAA or other existing rules)

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- **Clinical Trials** - Grandfathered plans are not required to cover routine costs of participation in certain clinical trials.
- **Cost-Sharing Limitations** - Grandfathered plans are not subject to any limitation on the amount of cost-sharing they may impose on enrollees.

In order to maintain grandfathered status, a plan can only make limited changes and must maintain plan documents and records that establish the plan terms in effect on March 23, 2010 and other records that are necessary to verify, explain, or clarify the plan's status as a grandfathered plan. Further, all plan materials provided to participants or beneficiaries must include a notice that the plan is grandfathered. A sample notice is included in the interim regulations.

Employers are eager to explore if they qualify for grandfathered status under healthcare reform because implementing the mandated changes are expected to result in additional employer cost for medical benefits.

GRANDFATHERED PLANS ARE STILL SUBJECT TO SOME HEALTHCARE REFORM RULES

Grandfathered plans are not exempt from every change required under the healthcare reform legislation. Some changes grandfathered plans must make include:

Provisions Effective for Plan Years Beginning on or After 9/23/2010

- **Lifetime or Annual Limits** - All group plans are prohibited from imposing lifetime limits and annual limits on the value of essential benefits received by enrollees. While the prohibition on lifetime limits will be imposed starting September 23, 2010, the annual limit prohibition is phased in through January 1, 2014 for “essential health benefits.” Under PPACA

essential health benefits include the following categories, and items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. No guidance has been issued to date regarding which other benefits may qualify as “essential health benefits.” Until guidance is issued, the interim regulations provide the regulators will take into account consistent and good faith efforts to comply with a reasonable interpretation of the definition of essential health benefits. The interim final regulations provide that the annual dollar limit imposed on essential health benefits may not be less than the following amounts:

- \$750,000 for plan years beginning on or after September 23, 2010 but before September 23, 2011
 - \$1,250,000 for plan years beginning on or after September 23, 2011 but before September 23, 2012
 - \$2,000,000 for plan years beginning on or after September 23, 2012 but before January 1, 2014.
- **Prohibition on Rescissions** - All group plans are prohibited from retroactively rescinding coverage except in cases of fraud or intentional misrepresentation of a material fact by participants.

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- **Extension of Coverage for Young Adults** - All group plans must cover participants' children up to age 26, whether or not the children are legal dependents, so long as the children are not eligible to be covered under the child's employer's plan.
- **Pre-Existing Conditions** - Group plans may not exclude enrollees under the age of 19 from coverage because of a pre-existing condition.

Provisions Effective for Plan Years Beginning on or After 1/1/2014

- **Excessive Waiting Periods** - Waiting periods to be covered under a group plan may not exceed 90 days.
- **Pre-Existing Conditions** - Group plans may not impose any pre-existing condition limitations.
- **Annual Limits** - Group plans may not impose any annual limit on the dollar value of benefits for any enrollee.

WHAT CHANGES WILL CAUSE A PLAN TO LOSE GRANDFATHERED STATUS?

In general, a plan loses its grandfathered status if it significantly reduces benefits or increases costs to enrollees. The new regulations state that a grandfathered plan that makes any of the following changes loses its grandfathered status (subject to the September 23, 2010 correction period for pre-June 17 changes discussed above):

- **Changes in Insurance Issuer** - If an employer buys an insurance policy for employees after March 23, 2010, that policy is not grandfathered. If the employer retains other policies that were in place on March 23, 2010, those policies will continue to be grandfathered. Assume for example, that an employer

has a separate insurance policy for each of Plant A and Plant B. If the employer were to change the insurance policy covering Plant A and keep the policy covering Plant B, the policy covering Plant A would lose its grandfathered status while the policy covering Plant B would retain its grandfathered status. A plan can change its Third Party Administrator (“TPA”) under a self-funded plan and not lose its grandfathered status.

- **Elimination of all or substantially all Benefits to Diagnose or Treat a Particular Condition** - A plan that eliminates all or substantially all benefits to diagnose or treat a particular condition loses its grandfathered status. Even if a plan only eliminates the benefits for any necessary element to diagnose or treat a condition, it is considered to be eliminating all or substantially all benefits to diagnose or treat that condition.
- **Increases in Percentage Cost-Sharing Requirements** - Coinsurance plans may not increase the percentage of certain medical costs that enrollees are required to pay.
- **Increases in Fixed-Amount Cost-Sharing Requirements Other than Copayments** - Plans may increase deductibles, but not by more than the Consumer Price Index for All Urban Consumers plus 15 percent.
- **Increases in Fixed-Amount Copayments** - Plans may increase copayments, but not by more than the greater of \$5 (indexed for inflation) or the Consumer Price Index for All Urban Consumers plus 15 percent.
- **Decreases in Employer Contribution Rates** - Employer contributions toward the cost of any tier of coverage for any class of similarly situated individuals may not be reduced by more than 5 percent.

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- **Decreasing or Imposing Annual Limits on the Value of Benefits** - Plans that did not have an overall annual or lifetime limit on March 23, 2010 may not impose an annual limit. Plans that had an annual limit on March 23, 2010 may not adopt an annual limit that is lower than the limit in place on March 23, 2010. Plans that had a lifetime limit on March 23, 2010 may adopt an annual limit as long as the dollar value of the annual limit is at least as high as the dollar value of the lifetime limit.

The interim final regulations also contain an anti-abuse rule which results in the loss of grandfathered status if the *principal* purpose of a business restructuring is to cover new employees under a grandfathered plan. The anti-abuse rule also applies if employees are moved into a plan with lesser benefits without a bona fide purpose assuming that amending their existing plan in a similar fashion would result in loss of grandfathered status.

In addition, the agencies have left the door open for other changes to result in a loss of grandfathered status. The agencies have requested comments regarding whether the following changes should result in loss of grandfathered status: (i) changes to plan structure, (ii) changes in a plan's provider network, (iii) changes to prescription drug formularies and (iv) any other substantive change to overall benefit design. Moreover, the regulations state that the agencies have the authority to issue additional guidance to clarify or interpret the grandfather rules.

WHAT OTHER CHANGES ARE PERMISSIBLE FOR GRANDFATHERED PLANS?

Under the interim final regulations, plan sponsors may make changes to comply with federal or state legal requirements and changes to voluntarily comply with the healthcare reform legislation as long as these changes do

not violate other rules previously described. Further, a plan will not lose its grandfathered status if current enrollees re-enroll in the plan or new employees enroll in the plan after March 23, 2010. Employees may also add family members or dependents to their coverage after March 23, 2010 without jeopardizing a plan's grandfathered status if the plan permitted such coverage as of that date.

The regulations apply separately to each benefit package available under a plan. Thus, an impermissible change will only cause the relevant benefit package to lose its grandfathered status, while any other benefit package offered under the plan will retain its grandfathered status. For example, if a plan provides a PPO and an HMO benefit package, and makes an impermissible change to the HMO benefit package; the plan could lose grandfathered status for the HMO package, but not for the PPO package.

SPECIAL RULE FOR COLLECTIVELY BARGAINED PLANS

Health insurance coverage (as compared to a self-funded arrangement) maintained under a collective bargaining agreement ratified before March 23, 2010 is grandfathered until at least the date the final collective bargaining agreement relating to the coverage that was in effect on March 23, 2010 terminates (“Termination Date”). The coverage will not lose grandfathered status even if it is changed in any of the ways described above that would generally result in the loss of grandfathered status. Unlike coverage not maintained under a collective bargaining agreement, plans subject to the collective bargaining exception may change insurance carriers without loss of grandfathered status. The plan may keep the new insurance carrier even after the last of the collective bargaining agreements expire without losing grandfathered status. However, the plan must make whatever changes are required by PPACA that are not protected by grandfathered status even if the effective date occurs during a collective bargaining agreement. After the

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Termination Date, the determination as to whether the coverage is grandfathered is based on a comparison of the terms of coverage on March 23, 2010 and the Termination Date. Thus, while any of the impermissible changes listed above will not cause the coverage to lose grandfathered status before the Termination Date, if such a change is in effect on the Termination Date, the coverage will lose grandfathered status immediately at that time. Coverage maintained under a collective bargaining agreement ratified after March 23, 2010 is not grandfathered.

Collective bargaining agreements negotiated after March 23, 2010 should attempt to anticipate the effect of the mandated changes upon cost or what certain changes might do to grandfathered status. Unfortunately, guidance is still necessary to fully understand and anticipate the requirements.

SPECIAL RULE FOR RETIREE-ONLY PLANS AND EXCEPTED BENEFITS AS DEFINED UNDER HIPAA

It should be noted that the preamble to the interim final regulations specifically recognizes that retiree-only plans and plans that provide excepted benefits as defined under HIPAA (including stand-alone vision and dental plans, specified disease and hospital indemnity plans, and accident and disability plans) are not subject to PPACA. The preamble to the regulations confirms the Agencies’ view that the health care reforms (such as the prohibition on lifetime and annual dollar limits and required coverage of dependents to age 26) are not intended to apply to these plans.

COMPARISON TABLE

Effective Date	Reform Provision	Applicable to Grandfathered Plans?
09/23/2010	Required Coverage of Preventative Health Services Prohibition of Discrimination in Favor of the Highly Compensated Required Appeals Process Mandatory Patient Protections	No
	No Lifetime Limits or Unreasonable Annual Limits Prohibition on Rescissions Extension of Coverage for Young Adults up to Age 26 No Pre-Existing Conditions Exclusion for Enrollees Under Age 19	Yes
01/01/2014	Guaranteed Renewability of Coverage Prohibition of Discrimination Based on Health Status Required Coverage of Clinical Trials Limitation on Cost-Sharing	No
	Prohibition of Excessive Waiting Periods No Pre-Existing Conditions Exclusion for Any Enrollee No Annual Limits	Yes

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OVERVIEW OF THE SUBSTANTIVE REFORMS AND EFFECTIVE DATES

Effective 1/1/2010

- **Small Business Tax Credit Part I** - Eligible small employers that purchase healthcare for employees will receive a tax credit of up to 35 percent of the cost of premiums they pay for health coverage for their employees. Employers with 10 or fewer employees and average annual wages of less than \$25,000 will receive the full 35 percent credit. The credit will completely phase out for employers with 25 or more employees and average annual wages of \$50,000 or more. Tax-exempt small employers may also take the credit and are subject to the same restrictions as taxable employers, though the maximum credit is 25 percent of the cost of premiums they pay for health coverage for their employees. The amount of the credit increases in 2014 as explained in greater detail below.
- **Closing the Medicare Part D “Donut Hole” Part I** - Medicare Part D participants who have incurred costs for drugs in excess of the initial coverage limit will receive a one-time \$250 coverage gap rebate.

Effective 6/21/2010

- **Reinsurance for Early Retirees** - The government effectively has established a temporary reinsurance program to reimburse participating employment-based plans (including multi-employer plans) for part of the cost of providing health insurance to retired employees age 55 to 64 and their families. Plans will be reimbursed for 80 percent of costs of bene-

fits provided between \$15,000 and \$90,000 per employee. The reimbursement amount will be adjusted each year based on the Consumer Price Index. The reinsurance program ends in 2014 with the establishment of the Health Insurance Exchange (the “Exchange”). An Exchange under PPACA generally is a geographically-based marketplace where standardized insurance packages can be purchased on what are expected to be more favorable terms than the commercial marketplace.

Effective 9/23/2010

- **No Lifetime or Annual Limits** - Lifetime limits and “unreasonable” annual limits on the value of benefits for any participant are prohibited. Annual limits will be completely banned in 2014 when the Exchange is operational.
- **Prohibition on Rescissions** - Group health plans and health insurance issuers are prohibited from rescinding coverage except in cases of fraud or misrepresentation by enrollees.
- **Preventative Health Services** - Individual and group health plans must provide coverage of certain preventative services and immunizations including services recommended especially for children and women. Plans may not impose cost-sharing on these services.
- **Extension of Coverage for Young Adults** - Individual and group health plans must cover unmarried children up to age 26, as long as the children are not eligible to be covered under the child’s employer’s plan.
- **Pre-Existing Conditions** - Enrollees under the age of 19 may not be excluded from coverage because of a pre-existing condition.

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Effective 1/1/2011

- **Inclusion of Cost of Employer Sponsored Health Coverage on Form W-2** - Employers must report the value of the benefit they provide for each employee's health insurance coverage on each employee's form W-2.
- **Distributions for Medicine Qualified only if for Prescribed Drug or Insulin** - Reimbursements from health flexible spending accounts, health reimbursement arrangements, and health savings accounts for drug purchases will be treated as nontaxable reimbursements only for purchases of prescription drugs and insulin. Over-the-counter medicines and drugs (other than insulin) will require a prescription to be eligible as a tax free benefit under a section 125 cafeteria plan for expenses incurred on or after January 1, 2011 regardless of the plan year used for the cafeteria plan. The guidance has not yet defined what constitutes a “prescription” for this purpose. It is unclear whether a formal prescription is required or if a letter of recommendation is sufficient. Many cafeteria plans use plan years other than calendar years. Plan administrators for such plans should inform participants that this change in law will affect the plan year that starts in 2010 and ends in 2011 in order to allow participants to plan accordingly.
- **Establishment of Simple Cafeteria Plans for Small Businesses** - Employers with an average of 100 or fewer employees in either of the past two years that maintain a “simple cafeteria plan” will not violate nondiscrimination requirements if certain minimum eligibility and participation requirements are satisfied.

- **Closing the Medicare Part D “Donut Hole” Part II** - In order for a drug to be covered under Medicare Part D, drug manufacturers must participate in the soon-to-be-established Medicare gap discount program. Under the program, drug manufacturers must provide Part D beneficiaries with a 50 percent discount on brand name drugs purchased during the coverage gap. Coinsurance is also provided for brand name and generic drugs purchased in the coverage gap. The amount of coinsurance is increased each year such that by 2020 Medicare Part D beneficiaries will only be responsible for 25 percent of the cost of drugs purchased in the coverage gap.

Effective 1/1/2013

- **Additional Hospital Insurance Tax on High Income Taxpayers** - The hospital insurance (Medicare) tax portion of FICA will increase by 0.9 percent on individuals earning over \$200,000 and married couples earning over \$250,000. This will affect employer withholding.
- **Limitation on Health Flexible Spending Arrangements under Cafeteria Plans** - Salary contributions to health flexible spending arrangements under cafeteria plans will be limited to \$2,500. This amount will be adjusted in subsequent years to account for inflation using the Consumer Price Index for All Urban Consumers.
- **Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy** - Employers who maintain prescription drug plans for Medicare Part D retirees will no longer be able to deduct the subsidized costs.

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Effective 3/1/2013

- **Employer Requirement to Inform Employees of Coverage Options** - Employers must notify each employee when hired: (1) of the existence of the Exchange, (2) that the employee may be eligible for a premium assistance tax credit and cost-sharing reduction if the employer pays less than 60 percent of the cost of benefits, and (3) that the employee will lose the employer's contribution to health benefits if he purchases a policy through the Exchange.

Effective 1/1/2014

- **Automatic Enrollment for Employees of Large Employers** - Employers with 200 or more full time employees that offer at least one health benefit plan to employees must automatically enroll new employees in one of the plans and continue the enrollment of current employees. Employees who are automatically enrolled must receive notice of the ability to select another coverage option offered by the employer or to opt out of coverage.
- **Prohibition on Excessive Waiting Periods** - Waiting periods for group coverage may not exceed 90 days.
- **Shared Responsibility for Employers** - The “Employer Mandate”
 - Employers with 50 or more full time employees (“Large Employers”) that do not offer coverage and have at least one employee who receives a tax credit to buy into the Exchange must pay a fee of \$166.67 per month (\$2,000 per year) for each employee. The first 30 employees will be excluded from the fee.

- Large Employers that offer coverage to employees, but have employees that receive a credit to enroll in the Exchange, and enroll in the Exchange, must pay \$250 per month (\$3,000 per year) for each employee enrolled in the Exchange up to an aggregate amount of \$2,000 multiplied by the total number of full-time employees.

- **Free Choice Vouchers** - Employers that offer employees minimum essential coverage and pay for a portion of the cost of such coverage must provide free choice vouchers to qualified employees to purchase coverage from the Exchange. The voucher must equal the portion of costs the employer would have paid for the employee to be covered under its own plan. Failure to provide the vouchers will subject the employer to the “Shared Responsibility for Employers” payments described above.
- **Small Business Tax Credit Part II** - The amount of the small business tax credit will increase to 50 percent of contributions made on behalf of employees. For tax-exempt small businesses, the amount of the credit will increase to 35 percent.
- **Freedom not to Participate in Federal Health Insurance Programs** - Businesses offering group or individual health insurance coverage are not required to participate in any health insurance program created under the Act.

Effective 1/1/2016

- **Employer Small Group Definition** - After this date, states will no longer have the option to treat employers with 51-100 employees as large employers. Instead, only employers with more than 100 employees can be treated as

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large employers. This will affect a number of provisions in the legislation including the small business tax credit described above.

Effective 1/1/2018

- **Excise Tax on High Cost Employer- Sponsored Health Coverage (“Cadillac Plans”)** - A non-deductible 40 percent excise tax will be imposed on employer sponsored health coverage if the value of such coverage exceeds \$10,200 per year for individuals or \$27,500 for families. The threshold will increase before 2018 if health care costs rise more than anticipated, and will be adjusted after 2018 using the Consumer Price Index. Employers are responsible for calculating the tax and notifying the party responsible for payment. The tax will be paid by health insurers in fully insured plans, by employers making contributions to HSAs, and third party administrators in self-insured plans.

Saul Ewing stands ready to assist you to navigate the complex array of challenges presented by healthcare reform legislation.

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