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## HEALTH CARE REFORM CLIENT UPDATE

# Grandfathering: What Employers Need to Know Now

This Client Update is Part One in a series of updates written to help employers understand the effects of the Patient Protection and Affordable Care Act.

Shuttleworth & Ingersoll has put together a multispecialty work group of health, tax, benefit and employment lawyers to analyze the effects of the legislation on you as our clients.



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## ***Introduction***

The Patient Protection and Affordable Care Act (PPACA) and related enactments represent a sea change in the health benefits arena. As a result, employers are faced with significant decisions on their employee health care benefits. As with all major changes, each decision made can and will have consequences. Despite many of the provisions of PPACA having effective dates in the future, employers must be diligent in their decision-making today. Therefore, it is imperative for employers to understand and consider the concept of grandfathering.

## ***What is a Grandfathered Health Plan?***

A health care plan (either fully-insured or self-insured) in existence on March 23, 2010 is “grandfathered.” If an employer enters into a new plan after March 23, 2010, for any reason, including the fact that the previous plan is not being renewed, then that new plan is not grandfathered. Grandfathered health care plans are exempt from most requirements found in PPACA Subtitles A and C, as set out in the list below, but are not exempt from the rest of PPACA. Even grandfathered health care plans must comply with certain requirements, including the employer mandate to offer affordable insurance coverage to full-time employees. The Department of the Treasury released interim final regulations on June 14, 2010, becoming effective upon publication, which provide guidance on many issues regarding grandfathered health care plans.

## ***Grandfathered health care plans are not required to comply with the following provisions:***

- ✓ Coverage of preventive health services
- ✓ Prohibition of discrimination based on salary
- ✓ Ensuring the quality of care
- ✓ Fair health insurance premiums
- ✓ Guaranteed availability of coverage
- ✓ Guaranteed renewability of coverage
- ✓ Prohibiting discrimination against individual participants and beneficiaries based on health status
- ✓ Non-discrimination in health care
- ✓ Comprehensive health insurance coverage

This list is not meant to be exhaustive as there are many other exemptions of interest. However, due to these exemptions, many employers and plan sponsors will want to retain their plan's grandfathered status for as long as that proves to be feasible.

***Grandfathered health care plans are required to comply with the following provisions, regardless of their grandfathered status:***

- ✓ *Notice of Summary of Benefits and Coverage:* Health insurance issuers (insurance companies or HMOs), or employers in the case of a self-insured group health plan, must provide a summary of benefits and coverage explanation to enrollees prior to enrollment or re-enrollment, or to applicants at time of application, not later than March 23, 2012.
- ✓ *Notice of Material Modification:* Health insurance issuers must notify enrollees at least 60 days before making a material modification of health care coverage.
- ✓ *Notice Penalties:* Health insurance issuers or employers that fail to obey the notice requirements are subject to up to a \$1000 fine for each violation, and failures to meet obligations for multiple enrollees count as separate violations.
- ✓ *Premium Revenue Reporting:* Health insurance issuers must report the percent of premium revenue spent on (1) reimbursement for clinical services provided to enrollees; (2) activities that improve health care quality; and (3) all other non-claims costs to the Secretary of Health and Human Services, and must give pro rata rebates to enrollees in amount that premium revenue expended on those three activities exceeds 20% for coverage offered in the group market or 25% for coverage offered in the individual market. The purpose is to incentivize insurers to spend a greater share of premiums on medical care than administrative expenses.
- ✓ *Lifetime and Annual Limits:* Lifetimes limits and unreasonable annual limits on essential health benefits are prohibited for plan years beginning on or after September 23, 2010.
- ✓ *Rescissions:* Rescission is a cancellation or discontinuance of coverage that has retroactive effect. Effective for plan years beginning on or after September 23, 2010, health insurance coverage may not be rescinded unless the enrollee commits an act of fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.
- ✓ *Dependent Care:* Dependent coverage must be extended to children until the individual is

26 years old. This provision is effective for plan years beginning on or after September 23, 2010. Prior to 2014, a child may enroll for dependent coverage on a grandfathered group plan only if the individual is not eligible for employment-based health benefits.

- ✓ *Pre-existing Conditions:* Pre-existing health conditions may not be excluded from coverage. This provision is effective for plan years beginning on or after September 23, 2010 for children under age 19, and January 1, 2014 for everyone else.
- ✓ *Waiting Periods:* Waiting periods (the period of time that must pass before an individual is eligible for benefits) cannot exceed 90 days. This provision is effective beginning on January 1, 2014.

### ***What Actions Will Not Jeopardize an Employer Plan's Grandfathered Status?***

Employees can reenroll in the grandfathered health care plan, and family members can enroll (even if not previously enrolled) as long as the plan's provisions in effect on March 23, 2010 permit such enrollment. New employees and their families can also enroll in the grandfathered health care plans. Each benefit package made available under a group health plan or health insurance coverage is a separate "plan" for determining whether that specific plan is grandfathered, e.g., high deductible plan, PPO, etc.

### ***What Can Employers Do To Prevent Their Plan From Losing its Grandfathered Status?***

To maintain a plan's grandfathered status, the employer must (1) include a statement in any plan materials describing the benefits provided under the plan and that the employer believes that it is a grandfathered health plan, and (2) provide contact information for questions and complaints. Additionally, the employer must maintain records documenting the terms of the plan that were in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered health care plan. The employer must maintain such records and make them available for examination for as long as the employer takes the position that the plan is a grandfathered health care plan.

### ***What Actions Will Terminate Employer Plan's Grandfathered Status?***

If certain changes are made to a grandfathered plan, the plan loses its grandfathered status, according to the interim final regulations. However, if a plan was changed before

June 14, 2010, the changes will not cause the plan to lose its grandfathered status if the changes are revoked or modified effective as of the first day of the plan year beginning after September 23, 2010. Any of the following will cause a health care plan's grandfathered status to be revoked:

- ✓ *Elimination of benefits:* The elimination of 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.
- ✓ *Increase in percentage cost-sharing requirement:* Any increase, measured from March 23, 2010, in a percentage cost-sharing requirement (such as 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 requirement other than a copayment (for example, deductible or out-of-pocket limit), determined as of the effective date of the increase, if the total percentage increase in the cost-sharing requirement measured from March 23, 2010 exceeds medical inflation plus 15%. Medical inflation is the increase in the medical care component of the Consumer Price Index since March 2010.
- ✓ *Increase in a fixed-amount copayment:* Any increase in a fixed-amount copayment, determined as of the effective date of the increase, if the total increase in the copayment measured from March 23, 2010 exceeds the greater of (A) an amount equal to \$5 increased by medical inflation (that is, \$5 times medical inflation, plus \$5), or (B) the medical inflation plus 15%, determined by expressing the total increase in the copayment as a percentage.
- ✓ *Decrease in contribution rate by employers and employee organizations:* Employer decreases its contribution rate based on cost of coverage, or a formula, towards the cost of any tier of coverage for any class of similarly situated individuals by more than 5% below the contribution rate for the coverage period that includes March 23, 2010.
- ✓ *Changes in annual limits:* (A) A plan that on March 23, 2010 did not impose an overall annual or lifetime limit on the dollar value of all benefits if the plan is modified to impose an overall annual limit on the dollar value of benefits. (B) A plan 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 if the plan adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010. (C) A plan that on March 23, 2010 imposed an overall annual limit on the dollar value of all benefits if the plan or health insurance coverage decreases the dollar value of the annual limit (regardless of whether the plan also imposed an overall lifetime limit on March 23, 2010 on the dollar value of all benefits).

- ✓ *Changes in plan eligibility:* If (A) employees are transferred into the plan from a plan under which the employees were covered on March 23, 2010; (B) comparing the terms of the transferee plan with those of the transferor plan (as in effect on March 23, 2010) and treating the transferee plan as if it were an amendment of the transferor plan would cause a loss of grandfather status; and (C) there was no bona fide employment-based reason to transfer the employees into the transferee plan. Changing the terms or cost of coverage is not a bona fide employment-based reason.

Additionally, if the principal purpose of a merger, acquisition, or similar business restructuring is to cover new individuals under a grandfathered health care plan, the plan ceases to be a grandfathered health care plan.

### ***What Should Employers Do?***

Employers should evaluate their current benefit plans to determine whether the benefits of maintaining grandfather status eclipses the restrictions placed upon plan design and cost-sharing changes. The rules regarding grandfathered health care plans are complex. You should consult your attorney concerning your specific situation before acting on the information provided. If you would like further information or assistance, please contact your attorney at S&I or Chair Diane Kutzko, at 319-365-9461 who will refer you to the attorney with the expertise to respond to your questions. Diane can be reached by email at [dhk@shuttleworthlaw.com](mailto:dhk@shuttleworthlaw.com).

**\*\*Note:** This article was prepared by Shuttleworth & Ingersoll's Health Care Reform Workgroup with the assistance of Jennifer Hennessy, summer associate.