Health Reform Update

Health Care Reform Grandfathering Rules Require Careful Scrutiny by Plan Sponsors

Since the enactment of the Patient Protection and Affordable Care Act,1 as amended by the Health Care and Education Reconciliation Act2 (collectively, the “Act”), plan sponsors have been concerned that a relatively minor amendment to a group health plan could result in the loss of the plan’s grandfather status under the Act. The interim final rules (the “Grandfathering Rules”) issued on June 14, 2010 by the Departments of Health and Human Services (“HHS”), Labor and Treasury (collectively, the “Departments”) address, and in some cases confirm, this concern and suggest an intent to reduce the number of grandfathered plans.3 The Grandfathering Rules are effective immediately.

The Grandfathering Rules generally provide that amendments or changes to a group health plan that decrease benefits or increase participant costs above a permitted threshold will jeopardize the plan’s grandfather status. Additionally, certain changes in a plan’s eligibility requirements could result in a loss of grandfather status. This client publication provides additional information on the types of changes that will cause a loss of grandfather status under the Grandfathering Rules and also on the additional obligations that will be imposed on the plan sponsor as a result of that loss.

The new interim final rules have implications beyond grandfathered plans. In the new rules, the Departments clarify that certain provisions of the Act, including the amendments to Title XXVII of the Public Health Services Act (the “PHSA”) requiring group health plans to cover adult children dependents until age 26, do not apply to

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3 “Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Plan Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule” at http://edocket.access.gpo.gov/2010/pdf/2010-14488.pdf. The Grandfathering Rules also include a warning by the Departments that they may issue additional guidance, as necessary, to address “unanticipated changes by plans and issuers to ensure that individuals benefit from the Act while preserving the right to maintain coverage in effect on March 23, 2010”.

HHS has stated that it expects that by the time the health insurance exchanges are established in 2014, fewer large employer plans will have grandfather status, while noting that such assumed market changes depend on choices made by large employers. See “Questions and Answers: Keeping the Health Plans You Have: The Affordable Care Act and Grandfathered Health Plans” at http://healthreform.gov/about/grandfathering.html.
retiree-only plans. Additionally, the Departments use the Grandfathering Rules to suggest that the Departments will not apply certain substantive provisions of the Act to retiree-only health care plans sponsored by non-U.S. governments (i.e., state-sponsored plans), even though the Act could arguably be read to apply the amendments to the PHSA to these plans.

Background

The Act defines a “grandfathered plan” as a group health plan (both insured and self-insured) that was in existence as of March 23, 2010, the date on which the Act was enacted. Grandfather status will continue even if some or all of the plan participants drop out of the plan, as long as the plan’s coverage is continuous as of March 23, 2010. The Act permits the enrollment of new participants in a grandfathered plan, including a participant’s family members, even if enrolled after March 23, 2010.

Plan Changes Resulting in Loss of Grandfather Status

Under the Grandfathering Rules, the following changes to a group health plan in existence on March 23, 2010 will cause that plan to lose its grandfather status, unless transition relief is available or the plan is collectively-bargained, as described below:

- Entering into a new policy, certificate or contract of insurance after March 23, 2010, such as changing insurers for an insured plan or converting a self-insured plan to an insured plan, even if the benefits provided under the plan do not change.
- Eliminating all or substantially all of the benefits to treat or diagnose a particular condition. This type of change includes the elimination of any one element required to treat or diagnose a particular condition. The new rules give the example of the elimination of coverage for counseling, if the treatment for a particular mental condition is a combination of prescription drugs and counseling.
- Increasing the percentage cost-sharing borne by participants, such as an increase in participants’ coinsurance from 10% to 20%.
- Increasing the fixed-amount cost-sharing requirement, other than a co-payment, by more than the rate of medical inflation plus 15 percentage points. A plan’s deductibles and out-of-pocket limits are examples of fixed-amount cost-sharing requirements.
- Increasing a fixed-amount co-payment by more than the greater of (i) $5, increased for medical inflation and (ii) the rate of medical inflation plus 15 percentage points.
- For any class of similarly situated individuals, (i) decreasing the employer’s contribution rate based

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4 The Public Health Service Act is the federal legislation governing public health. The Act amends the provisions of the PHSA that relate to group health plans and health insurance issuers. The Grandfathering Rules provide that the Act’s amendments to the PHSA, such as the requirement to cover adult child dependents until age 26, do not apply to ERISA plans that cover only retirees. The Department’s position relies on the Act’s addition of Section 715(a)(1) to ERISA and Section 9815(a)(1) to the Internal Revenue Code of 1986, as amended (the “Code”). These new sections incorporate the provisions of the PHSA into ERISA and the Code, respectively. The Act also adds Section 715(a)(2) to ERISA, which provides that, to the extent that any provision of part 7 of Title I ERISA conflicts with the PHSA, the latter will apply. Section 732(a) of ERISA provides that part 7 of Title I ERISA does not apply to group health plans that have less than 2 active employees as participants. Accordingly, under pre-Act law, part 7 of Title I of ERISA did not apply to stand-alone retiree-only plans. Since nothing in the Act conflicts with Section 732(a) of ERISA, part 7 of Title I of ERISA, as amended by the Act, continues not to apply to retiree-only plans.

5 HHS makes this recommendation, while conceding that the States have primary authority to enforce the PHSA with respect to health insurance issuers, as well as the authority to impose requirements that are more protective than the federal provisions. The purpose of the HHS recommendation is to avoid the confusion that would be created if insurance issuers had to distinguish between group health plans subject to ERISA and those subject only to the PHSA, such as group health plans of state governments.

6 The Grandfathering Rules provide that medical inflation is based upon the overall medical care component of the Consumer Price Index for All Urban Consumers, unadjusted, published by the Department of Labor.
on the cost of coverage by more than five percentage points below the contribution rate in effect on March 23, 2010\(^7\) or (ii) decreasing the employer’s contribution rate based on a formula by more than five percent below the contribution rate for the coverage period that includes March 23, 2010.\(^8\)

- Changing a plan’s annual limits by:
  - imposing an overall annual limit on the dollar value of benefits, if, on March 23, 2010, the plan did not impose an overall annual or lifetime limit;
  - adopting an overall annual limit on benefits at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010, if on that date, the plan imposed an overall lifetime limit on the dollar value of benefits, but no annual limit on the dollar value of benefits; or
  - decreasing the dollar value of the annual limit on benefits (regardless of whether the plan also imposed an overall lifetime limit on March 23, 2010), if on March 23, 2010, the plan imposed an overall annual limit on the dollar value of all benefits.

The changes summarized above are not the only way a plan may lose its grandfather status. A group health plan will lose grandfather status if, without a bona fide employment-based reason, the sponsor transfers participants to another grandfathered group health plan and that transfer results in a reduction in benefits or an increase in cost-sharing to the participant that would trigger a loss of grandfather status under the Grandfathering Rules. Additionally, a plan could lose its grandfather status if the principal purpose of merger, acquisition or similar business restructuring is to cover new individuals under a grandfathered plan.\(^9\)

### Transition Rules and Special Rules for Collectively Bargained Plans

The Grandfathering Rules provide some flexibility for certain changes adopted after March 23, 2010 to a grandfathered plan. If a plan sponsor made changes to a grandfathered plan pursuant to a contract entered into, or written plan amendments adopted after March 23, 2010 and before June 14, 2010, these changes will not cause the plan to lose its grandfather status, if the changes are revoked or modified effective as of the first day of the plan year beginning after September 23, 2010.\(^10\)

The preamble to the Grandfathering Rules further states that the Departments will take into account good-faith efforts to comply with a reasonable interpretation of the statutory requirements and may disregard changes to plan terms that only modestly exceed the changes described in the Grandfathering Rules and were adopted before June 14, 2010. Unfortunately, the Grandfathering

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\(^7\) The contribution rate based on cost of coverage is the amount (expressed as a percentage) of contributions made by an employer compared to the total cost of coverage. The total cost of coverage is determined in the same manner as the applicable premium is calculated for purposes of COBRA. For a self-insured plan, employer contributions are equal to the total cost of coverage minus the employee contributions toward the cost of coverage. The determination of similarly situated individuals is made in accordance with Treas. Reg. 54.9802-1(d), which generally provides that a plan may treat (i) participants as two or more distinct groups of similarly-situated individuals if the distinction between the groups is based on a bona fide employment-based classification consistent with the employer’s usual business practice and (ii) beneficiaries as two or more distinct groups of similarly situated individuals if the distinction between the groups is based on any of the following factors: a bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage, relationship to the participant, marital status, age or student status (with respect to children of a participant) or any other factor that is not a health factor.

\(^8\) The contribution rate based on a formula means the formula used to determine contributions, such as hours worked.

\(^9\) The Grandfathering Rules indicate that the following types of changes will not cause a plan to lose its grandfather status: changes to premiums, changes to comply with legal requirements, including the Act, cost adjustments to keep up with medical inflation, and changes to third-party administrators, as long as these changes do not exceed the standards outlined above.

\(^10\) The transition rules distinguish between changes made to a plan prior to March 23, 2010, and those changes made after March 23, 2010 and adopted prior to the issuance of the Grandfathering Rules on June 14, 2010. Certain changes made to the plan before March 23, 2010, even if not yet in effect, will be considered as terms of the plan that were in effect on March 23, 2010 for grandfathering purposes.
Rules offer no guidance on the types of changes that the Departments would consider “modest”.

Special rules apply to an insured collectively bargained plan under one or more agreements that was ratified before March 23, 2010. In that case, the plan will retain its grandfather status until the underlying collective bargaining agreement(s) terminate. At that point, the determination of whether the plan retains its grandfather status will be based on the Grandfathering Rules described above. These special rules do not apply to a self-insured collectively bargained plan.

**Documentary Requirements to Maintain Grandfather Status**

Plan sponsors intending to maintain the grandfather status of their group health plan must comply with the following documentary requirements of the Grandfathering Rules:

- maintain records documenting the terms of the plan in effect as of March 23, 2010 and make these records available for examination on request; and

- include a statement in any plan materials provided to participants describing the plan’s benefits and noting that the plan believes is it a grandfathered health plan within the meaning of the Act.11 While it appears that this statement must appear in summary plan descriptions and summaries of material modifications, it is not clear what other plan documents must include this language.

**Impact of Loss of Grandfathering Status**

If a group health plan loses its grandfather status, it becomes subject to the requirements of the Act applicable to plans that are not grandfathered. Loss of a plan’s grandfather status may, depending on the coverage provided under the plan prior to loss of its grandfather status, impose additional costs and obligations on the plan sponsor and result in additional benefits to participants.12

The more significant of the requirements under the Act applicable to a plan that has lost its grandfather status are:

- The requirement, effective for plan years beginning after September 23, 2010, to extend the plan’s

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11 The Grandfathering Rules include the following model statement that plan sponsors may use to satisfy the disclosure requirement: “This group health plan believes this plan 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 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.

12 The impact on plan sponsors of the loss of grandfather status under the Act differs from the impact under Section 409A of the Code. Under Section 409A of the Code, loss of a plan’s grandfather status generally simplifies plan administration for the sponsor and could subject the participant to additional tax liability under Section 409A of the Code. While loss of grandfather status under the Act could require a plan to provide additional benefits to participants, such loss could also cause a participant to fail to satisfy the individual mandate under the Act to maintain minimum essential coverage, as a grandfathered plan, by definition, provides minimum essential coverage, but a non-grandfathered plan may not. For additional information, you may wish to refer to the Shearman & Sterling LLP client publication entitled “Self-Insured Medical Plans After Health Reform” at http://www.shearman.com/self-insured-medical-plans-after-health-reform-04-29-2010/.

“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]. 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.”
dependent coverage to adult children of covered employees until the children attain age 26;\(^{13}\)

- The requirement to cover, without imposing cost-sharing, certain preventative health services such as immunizations and preventative care and screenings for infants, children, adolescents and women (such as mammography);

- The requirement that an insured group health plan comply with the non-discrimination requirements imposed by the Code. If a plan does not satisfy those requirements, the plan sponsor will be subject to an excise tax;\(^{14}\)

- The requirement to incorporate an external review in the benefit claims and appeal process;

- For self-insured plans, the requirement to comply with “cost-sharing” restrictions that arguably apply to non-grandfathered self-insured group health plans, in addition to insured group health plans; and

- For insured plans, the requirement to disclose to HHS, the state insurance commissioner and participants, claim payment policies and practices, financial information, enrollment and disenrollment data, claim denials, rating practices, cost-sharing and participant rights.\(^{15}\)

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\(^{13}\) The Act permits a grandfathered plan to postpone extending coverage to adult children until plan years beginning on or after January 1, 2014 as long as the adult child is eligible for other employer-sponsored group health care (other than coverage available through a plan of a parent). For additional information, on the Act’s requirements for dependent coverage, you may wish to refer to the Shearman & Sterling LLP client publication entitled “Mandate to Cover Adult Children: 2010 Plan Amendment May Be Required” at [http://www.shearman.com/health-reform-update---mandate-to-cover-adult-children--2010-plan-amendment-may-be-required-06-07-2010/](http://www.shearman.com/health-reform-update---mandate-to-cover-adult-children--2010-plan-amendment-may-be-required-06-07-2010/).

\(^{14}\) All self-insured group health plans are subject to the Code’s non-discrimination requirements. If a self-insured plan fails to satisfy those requirements, highly compensated employees must include as taxable income some or all of the value of the benefits received under the plan.


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### Next Steps for Plan Sponsors

Plan sponsors should review the Grandfathering Rules in light of the upcoming open enrollment. Before making any changes to a group health plan as part of the open enrollment process, plan sponsors will need to understand the potential impact of the change under the Grandfathering Rules on the sponsor and plan participants. Since the decision to amend a plan is a settlor decision (rather than a fiduciary decision), plan sponsors are not obligated to amend a plan for the benefit of participants.

Additionally, plan sponsors that:

- elect to maintain the grandfather status of their plan should add the required disclosure to the plan documents as soon as practicable, since the Grandfathering Rules are currently in effect and do not include a specific deadline for compliance; and

- wish to rely on the exemption for retiree-only plans from compliance with the Act’s amendments to ERISA, such as the requirement to cover adult children dependents, should confirm that their retiree plan is eligible for this exemption.

While the Grandfathering Rules may result in the loss of grandfather status for many group health plans, plan sponsors should find these rules helpful as they fairly clearly delineate the types of changes that will cause such loss.
This memorandum is intended only as a general discussion of these issues. It should not be regarded as legal advice. We would be pleased to provide additional details or advice about specific situations if desired.

If you wish to receive more information on the topics covered in this memorandum, you may contact your regular Shearman & Sterling contact person or any of the following:

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