

# SAVITZ ADVISORY

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July 2010

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## Grandfathered Health Plans

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Since health care reform legislation was passed in the spring, plan sponsors have been waiting for guidance on a wide variety of legislative mandates. For the 2011 plan year, several of the biggest questions have been “What do I need to do to maintain my plan’s grandfathered status?” and “Is it even worth it to try to maintain grandfathered status?” Interim final regulations were published in the Federal Register on June 17th outlining what employers can and can not do if they want their plan to remain grandfathered. While comments are being solicited through August of this year, the guidance adds significant clarification for plan sponsors who want to work on their plan designs for 2011.

What is a grandfathered plan and why should a plan sponsor care about maintaining grandfathered status? The simplest explanation of a grandfathered plan is that it is a health plan that was in place on March 23, 2010, had enrolled participants on that date and has not made changes to the plan since that date. The grandfathered status of a plan exempts it from many of the mandates of reform legislation. The most significant relief includes:

- exemption from including dependents to age 26 who have coverage through their own employer plan into the company’s health plan;
- no limitations on having co-pays, deductibles or coinsurance attached to preventive care and immunizations;
- no requirements to allow an OB/Gyn or pediatrician to be the primary physician without a referral;
- no requirement to allow emergency services without pre-authorization or to treat them as in-network benefits;
- no requirement to provide an internal appeals and external review process; and
- for insured arrangements, no limitations on discriminating in favor of highly compensated individuals.

There are also some mandates that grandfathered plans are *not exempt* from and they *must comply* with:

- no overall lifetime limits – benefit maximums or dollar limits – on essential benefits;
- annual limit restrictions for essential benefits – to be defined by Health and Human Services (HHS);
- extension of coverage to dependent children if they do not have employer-sponsored coverage (before 2014);
- no pre-existing condition exclusions for children under 19 (2010/2011);
- no waiting period longer than 90 days (2014 and later); and
- uniform explanation of coverage required (2012).

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The guidance released in June 2010 clarifies what changes you can make to your health plan and **not** lose grandfather status. Employers may:

- change the premium amounts, as long as employee contributions don't increase by greater than 5%, as adjusted for medical inflation;
- change third party administrators (TPAs), but not insurers if your plan is fully insured;
- change your plan to comply with federal or state law; and
- make voluntary plan changes to comply with PPACA mandates.

If the plan sponsor chooses to maintain grandfathered status, then the health plan must maintain records that document the plan in effect on the grandfather date plus any other documentation needed to verify the plan's grandfathered health plan status. All records must be available to plan participants, beneficiaries, and state and federal agencies upon request and must be maintained as long as the plan claims to be grandfathered.

Also, health plan information provided to plan participants or beneficiaries that describes the benefits offered by the plan must include a statement that the plan believes it is a grandfathered health plan as well as contact information for questions and comments. (The interim final regulations contain a model statement for employers to use that will satisfy the disclosure requirement.)

More importantly, the guidance tells you what **will** cause your plan to lose grandfather status. Employers may **not**:

- obtain a new policy, certificate or contract of insurance (e.g., if a policy, certificate, or contract of insurance is not renewed);
- eliminate benefits for particular conditions such as diabetes;
- add or decrease an overall annual dollar limit on a benefit;
- increase the coinsurance percentage on the plan by any amount;
- increase deductibles or the plan out-of-pocket maximum by more than 15%, adjusted for medical inflation;
- increase co-pays by more than greater of \$5 or 15%, adjusted for medical inflation; and
- decrease the employer contribution rate by more than 5%.

Although the guidance helps for 2011 planning, there are still areas of uncertainty that need to be defined including what will happen to your grandfather status if the employer:

- makes changes to the plan's structure such as switching from an insured plan to a self-funded arrangement;
- makes changes to the plan's provider network; or
- changes the prescription drug formulary.

Many plan sponsors are making the assumption that these modifications will trigger a loss of status and are evaluating their plan design changes in this context.



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Of course, there are transition rules that plan sponsors can apply if maintaining a plan's grandfather status is important to their organization:

- **Grace period for revoking changes** – If you amended your plan after March 23, 2010 but prior to issuance of the interim final regulations, you may revoke these amendments prior to the beginning of plan year commencing on or after September 23, 2010 and retain your grandfather status
- **Good faith compliance standards** – Where plans already have made changes that “only modestly exceed” permitted changes, the agencies governing health care reform may apply “good faith” standards in determining if a plan retains grandfather status.

Also, there are special rules regarding fully-insured collectively bargained plans. They are considered to be grandfathered if the plans were in place prior to March 23, 2010 and will keep their grandfathered status until the date of termination of the final collective bargaining agreement (CBA) that was in place at that time.

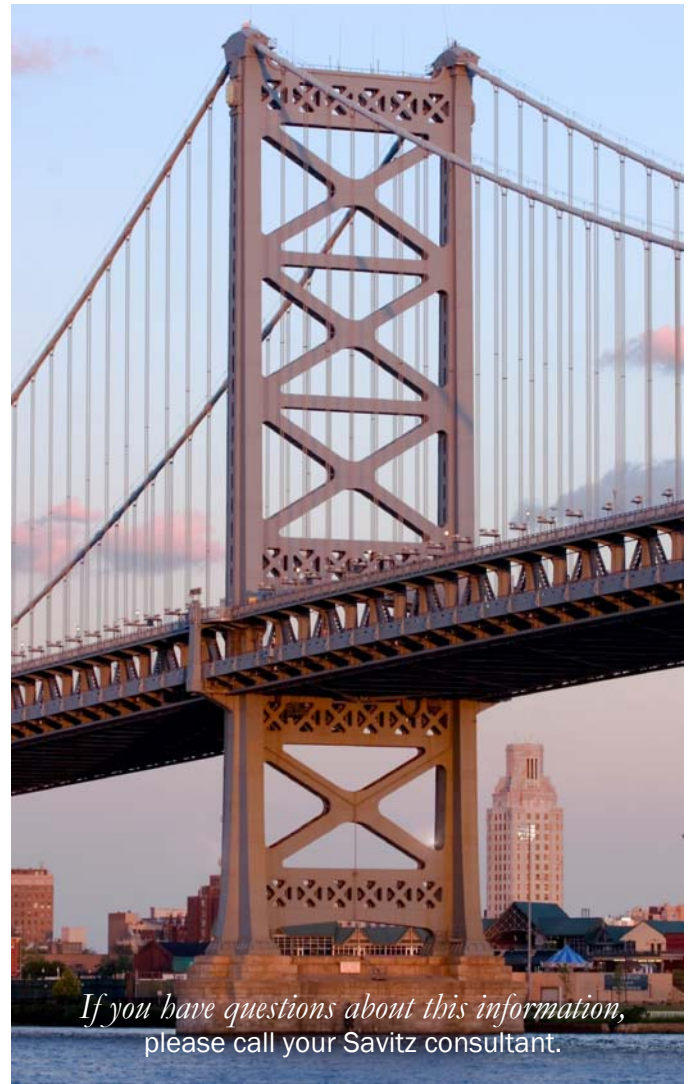
Additionally:

- A plan amendment made to conform to a health care reform law is not considered termination of the CBA
- Unlike other grandfathered plans, changing insurers will not cause the plan to lose its grandfathered status
- After the termination date of the last CBA, the plan remains grandfathered until it implements one or more of the changes that cause all grandfathered plans to lose that status (i.e., obtain a new policy or eliminate benefits for a certain condition)
- Changes made during the period of a CBA could cause the plan to lose the grandfathered status immediately on the termination date.

There are no special provisions for self-insured collectively bargained plans. Therefore, they are treated just like non-collectively bargained plans.

All grandfathered collectively bargained plans (fully-insured or self-insured) are subject to the same requirements as other grandfathered plans. For instance, they must comply with the rules regarding no lifetime limits on benefits.

*After reviewing the guidance on grandfathered plans, plan sponsors need to weigh the advantages of retaining grandfathered status for their health plans versus the possible disadvantages of giving up their freedom to change plan design and cost sharing arrangements that meet their current business needs.*



*If you have questions about this information, please call your Savitz consultant.*