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Healthcare Reform: Is It Really Advantageous to Maintain a Grandfathered Group Health Plan?

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The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (together, the “Act”), popularly known as “healthcare reform,” significantly alters employer and insurer responsibilities with respect to providing group health plan coverage to employees.¹ However, certain group health plans and health insurance coverage existing as of March 23, 2010 (the date of enactment) are subject only to certain provisions of the Act. These plans and health insurance coverage are referred to as “grandfathered health plans.” As enacted, the Act does not provide any guidance regarding what might cause a plan to lose its grandfathered status or if there is a limit on the duration of such grandfathered status. Accordingly, as plan design changes were contemplated for open enrollment, employers were wary to make any changes to any existing group health plans for fear of losing grandfathered health plan status. It is important to remember that grandfathered status does not eliminate all of the Act’s requirements and it only

delays the application of some of the Act’s requirements until grandfathered status is lost.

On June 14, 2010, the U.S. Departments of Treasury, Labor (“DOL”), and Health and Human Services (“HHS”) issued new regulations that provide guidance to these employers as to what might cause a group health plan or health insurance coverage to lose its grandfathered status (the “Grandfather Regulations”).² This article explains the Grandfather Regulations, including (1) the benefits of maintaining a grandfathered health plan, (2) what changes cause a grandfathered plan to lose grandfathered status, and (3) what changes do not cause a grandfathered plan to lose grandfathered status. It is important to remember that grandfathered status does not protect a plan from complying with the prohibition on lifetime dollar limits on essential health benefits or annual dollar limits on essential health benefits, a potentially very costly requirement in the Act.³

Grandfathered status is not determined on a “plan” basis, but on a “benefit package” basis.⁴ Thus, the changes to each benefit package must be compared to the benefit package as it was offered on March 23, 2010. There cannot be a change in one benefit package that is offset by a change in another benefit package in the same plan that permits both benefit packages to retain grandfathered status; rather, the analysis of whether

¹ Pub. L. No. 111-148.

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² 75 Fed. Reg. 34,538 (June 17, 2010).

³ Public Health Service Act (“PHSA”) § 2711, Act § 1001.1251.

⁴ Interim Final Temp. Treas. Reg. § 54.9815-1251T(a)(1); Interim Final Reg. 29 C.F.R. § 2590.715-1251(a)(1); 45 C.F.R. § 147.140(a)(1).

the changes impact such status are made on a benefit package by benefit package basis.

A. Advantage of Grandfathered Status

The Act requires group health plans and health insurance coverage to comply with several new mandates, implemented in two phases: (1) the first set of requirements become effective beginning with the first plan year beginning on or after Sept. 23, 2010, (the “**2011 Requirements**”), and (2) the second set of requirements become effective beginning Jan. 1, 2014 (the “**2014 Requirements**”). Grandfathered health benefit packages are not subject to several of these requirements as long as grandfathered status is maintained. The determination of grandfathered status is made on a benefit package basis and must be tested separately for each benefit package. In oral discussions, a representative from the governing agencies indicated that a “benefit package” would be the total option an employee could elect to participate and enroll in, such as enrolling in the Preferred Provider option or the HMO option for medical benefits and it would include all benefits covered by such election.

1. *2011 Requirements.* If a group health benefit package is grandfathered, it is **not** subject to the following 2011 Requirements:

(a) *Coverage of Preventive Care.* A nongrandfathered group health benefit package must provide coverage (without cost-sharing requirements) for certain immunizations and other preventive care recommended by the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration.⁵ The preventive care proscribed by the statute and currently in published guidance from the first two organizations include a number of different diagnostic tests, some of which are not covered by even very generous plans and a number of which are frequently billed on a bundled basis with other services and as such may be subject to a copayment or co-insurance requirement that cannot be imposed if the benefit package loses grandfathered status.⁶

(b) *Coverage of Dependents Eligible for Other Employer Plans.* A nongrandfathered group health benefit package must provide coverage to children until age 26, regardless of whether the child is eligible for other employer-sponsored health coverage.⁷

(c) *Nondiscrimination.* Nongrandfathered fully-insured group health benefit packages are subject to the nondiscrimination requirements of Section 105(h)(2) of the Internal Revenue Code of 1986, as amended (the “**Code**”) that are already applicable to self-insured group health plans. Under Code Section 105(h)(2), a plan cannot discriminate in favor of highly compensated employees (“**HCEs**”) with re-

spect to either eligibility to participate in the plan or the benefits provided under the plan. If a nongrandfathered fully-insured plan violates the nondiscrimination requirements, the penalty is an excise tax imposed on the employer.⁸

(d) *Appeals Process.* A nongrandfathered group health benefit package must (1) have an internal claims and appeal process that incorporates ERISA claims and appeal procedures, as updated by the DOL, (2) provide notice to participants of available internal and external claims processes and assistance of the office of health insurance consumer assistance or ombudsman, (3) allow participants to review their files, present evidence and testimony as part of the appeals process, and receive continued coverage during the appeals process, and (4) implement an external review process that meets state or HHS standards.⁹ The extent of the requirement to provide continued coverage during the pendency of a claim and an appeal could be very costly for a group health plan when considering that the interim final regulations defining what constitutes a prohibited rescission includes “a cancellation or discontinuance of coverage that has retroactive effect.”¹⁰ Thus, a retroactive attempt to recoup the costs of coverage provided during an appeal of a claim might be viewed as a rescission of coverage, and would therefore be precluded. This would result in a plan being prevented from recovering amounts paid to cover the claim while the appeal was in process, and could be a costly requirement for some claims and appeals with no way to recover the amounts paid during the claims and appeals process. We will need to see what the reopening and revision of the claims and appeal process regulations in light of the Act brings.

Of all of the requirements for nongrandfathered group health benefit packages, the requirement that the benefit package continue coverage for participants during the appeals process will likely be very costly for many benefit packages.

(e) *Access to Care.* The Act requires nongrandfathered group health benefit packages to comply with various requirements relating to protection of an individual’s right to select his or her primary care physician. First, a group health benefit package that requires or provides for the designation by participants, beneficiaries, or enrollees of a participating primary care provider must permit each participant, beneficiary, or enrollee to designate any available participating primary care provider. Second, if a group health benefit package requires or provides for the designation of a participating primary care provider for a child, the benefit package must permit the participant to designate an in-network physician who specializes in pediatrics as the child’s primary care provider. Finally, if a group health benefit package (1) provides coverage for obstetric or gynecologic care and (2) requires the designation of a participating primary care provider, the group health benefit package may not require authorization or re-

⁵ Public Health Service Act (PHSA) § 2713; Act § 1001, 1251.

⁶ See Appendix A for a list of preventive services. Regulations on the preventive care requirements were delivered to the Office of Management and Budget for review on June 29, 2010. <http://www.reginfo.gov/public/sp/EO/eoDashboard.jsp>.

⁷ PHSA § 2714; Act § 1001, 1251; 29 C.F.R. § 2590.715-2714.

⁸ PHSA § 2716; Act § 1001, 1251.

⁹ PHSA § 2719; Act § 1001, 1251.

¹⁰ Interim Final Temp. Treas. Reg. § 54.9815-2712T(a)(2); Interim Final Reg. 29 C.F.R. § 2590.715-2712(a)(2); 45 C.F.R. § 147.128(a)(2).

ferral with respect to a female enrollee who seeks coverage for obstetrical or gynecological care, so long as such care is provided by a participating health care professional who agrees to adhere to the benefit package's policies and procedures. The group health benefit package must treat such services as having been authorized by a primary care physician.

In addition to protection of an individuals' right to select his or her primary care physician, the Act also protects an individual's right to receive emergency care. If a nongrandfathered group health benefit package provides or covers any benefits with respect to emergency services in a hospital, the plan must cover such services: (1) without the need for any prior authorization; (2) without regard to whether the health care provider furnishing the services is a participating provider; (3) in a manner that if such services are provided by a non-participating provider, the limits on coverage are not more restrictive than those applied to participating providers; , and (4) in a manner that if any services are provided out-of-network, any limits on cost-sharing are not more restrictive than those applied to in-network services.¹¹ Here, the cost sharing limit calculation will present the plans with a challenge because the interim final regulations consider the co-insurance, copayment, or deductible, and also the impact of balance billing by including a mandate regarding how to calculate the out-of-network emergency services.¹²

Insured benefit packages requiring the designation of a primary care provider may already be in compliance with the pediatrician and obstetrical and gynecological service mandates for access to care provisions as a result of maintaining compliance with applicable state insurance laws; however, the calculation of the emergency services mandated coverage cost sharing limit will present a number of new challenges and questions.

(f) *Reports to HHS.* Nongrandfathered health benefit packages are required to submit information to the insurance commissioner and the Secretary of HHS (the "**Secretary**") each year regarding claims payment policies and practices, financial disclosures, data on enrollment and disenrollment, data on the number of claims denied, data on rating practices, information on cost-sharing and payments to any out-of-network coverage, information on participant rights and other information determined by the Secretary.¹³

In addition, nongrandfathered health benefit packages must report annually to the Secretary and enrollees regarding whether the benefits under a group health benefit package satisfy certain standards relating to: (1) improving health outcomes through quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives; (2) activities to prevent hospital readmissions (including through education and counseling; (3) ac-

tivities to improve patient safety and reduce medical errors through the use of best clinical practices, evidence based medicine, and health information technology; and (4) wellness and health promotion activities. The Secretary must develop guidelines for group health plans to use in providing this report by March 23, 2012.¹⁴ Until such guidelines are issued, no reports can be required.

(2) *2014 Requirements.* If a group health benefit package is grandfathered, it is **not** subject to the following 2014 requirements:

(a) *Participation in Clinical Trials.* Nongrandfathered group health benefit packages may not deny an individual participation in certain clinical trials (relating to cancer or other life threatening diseases), or deny coverage for (or limit or impose additional conditions on) routine patient costs for items and services furnished in connection with participation. This provision does not require that a benefit package provide benefits for routine patient services provided outside of the benefit package's health care provider network unless out-of-network benefits are otherwise provided under the benefit package.¹⁵ There can be significant medical costs for hospitalization that would not be covered by the cost of the clinical trial of a new drug that currently would be excluded from coverage for many benefit packages.

(b) *Annual Out-of-Pocket Costs.* Annual out-of-pocket costs cannot exceed the limits for high deductible health plans (currently \$5,950 for individuals, \$11,900 for families). Out-of-pocket costs include deductibles, co-insurance, copayments, and any other expenditure required by a participant for a qualified medical expense with respect to essential health benefits covered under the benefit package.¹⁶

(c) *Nondiscrimination in Health Care Providers.* A nongrandfathered group health benefit package may not discriminate with respect to participation under the benefit package against any health care provider who is acting within the scope of that provider's license or certification under applicable state law. However, this provision does not require a group health benefit package to contract with any health care provider willing to abide by the terms and conditions for participation established by the "plan."¹⁷ However, it is unclear what this provision actually does because the second sentence appears to cut back on the any willing provider requirement in the first sentence; however, the cutback only indicates that a "plan" is not required to contract with any particular provider with any particular provider. In fact, most providers contract with a managed care organization such as a preferred provider organization or an insurer; very few plans contract directly with health care providers to create their own network. This fact makes the second sentence's relief unuseful to most group health plans since most group health plans do not contract directly with any health care provider.

¹¹ PHSa § 2719A; Act § 10101, 10103.

¹² Interim Final Temp. Treas. Reg. § 54.9815-2719AT(b)(3); Interim Final 29 C.F.R. § 2590.715-2719AT(b)(3); 45 C.F.R. § 147.138(b)(3).

¹³ PHSa § 2715A; Act § 10101, 10103.

¹⁴ PHSa § 2717; Act § 1001, 1251.

¹⁵ PHSa § 2709; Act § 10103.

¹⁶ PHSa § 2707; Act § 1201, 1251.

¹⁷ PHSa § 2706; Act § 1201.

B. How to Lose Grandfathered Status

In general, a group health benefit package is grandfathered if it had participants on March 23, 2010. Grandfathered status is determined on a benefit package basis. That means that, if a group health plan offers more than one benefit package (for instance, an HMO and a PPO), one benefit package may be grandfathered and the other benefit package may not be grandfathered even though both benefit packages are offered under the same group health plan.¹⁸ **If a benefit package desires to be grandfathered in addition to not making any change that violates one of the restrictions discussed below it must also comply with the following requirements:**

(1) *Statement of Grandfathered Status.* A group health plan must include a statement of grandfathered status in all plan materials provided to a participant or beneficiary describing the benefits provided thereunder. The Grandfather Regulations contain model language that may be used.¹⁹

(2) *Maintain Records.* A group health plan must retain records documenting the terms of the plan in effect on March 23, 2010, and for each subsequent year showing how changes comply with the restrictions in the Grandfather Regulations and any subsequent guidance. The plan seeking to maintain grandfathered status must make such records available for examination upon request.²⁰

Below is a list of the actions that **will** cause a benefit package to lose its grandfathered status. Any proposed change to a benefit package that desires to maintain grandfathered status must be analyzed to determine if the change violates any of the rules below or if it might be viewed as an attempt to avoid one of the restrictions described below:

(1) *New Policy, Certificate, or Contract of Insurance.* A group health benefit package will lose grandfathered status if it enters into a new policy, certificate, or contract of insurance. For instance, assume a group health benefit package provides coverage through a group health insurance policy from Issuer X on March 23, 2010. If the plan enters into a new policy with Issuer Z for the plan year beginning Jan. 1, 2012, the group health insurance coverage issued by Z would not be a grandfathered health benefit package because Z did not provide coverage on March 23, 2010.²¹ This does not apply to collectively bargained insurance coverage. This rule was driven in part by the fact that the Act precludes an insurer from issuing a new policy that does not comply with the Act's requirements after Sept. 23, 2010, and thus if a group plan benefit package changed to a new insurer any new policy must comply with the Act's provisions because the insurer can only issue policies in compliance with the Act's requirements.

(2) *Elimination of Benefits.* A group health benefit package will lose its grandfathered status if it eliminates all or substantially all benefits to diagnose or treat

a particular condition. This includes the elimination of any element that is necessary to diagnose or treat a condition. For instance, if a benefit package provides benefits for a particular mental health condition, the treatment for which is a combination of counseling and prescription drugs, and subsequently eliminates benefits for counseling, the benefit package is treated as having eliminated all or substantially all benefits for that mental health condition.²² Every change to a benefit package/plan's definitions or exclusions must be analyzed to determine if the change potentially violates the prohibition on the elimination of all benefits for treatment of a particular condition.

(3) *Increase in Percentage Cost-Sharing or Co-Insurance Requirement.* Any increase in a percentage cost-sharing requirement causes a group health benefit package to lose its grandfathered status. For instance, if a group health benefit package increased its co-insurance percentage from 20 percent to 25 percent, the amendment would cause the plan to lose its grandfathered status.²³ This is because co-insurance by its very nature self-adjusts for inflationary adjustments in the cost of the medical services by applying the percentage to the new increased charge.

(4) *Increase in Fixed-Amount Cost-Sharing Requirement.* Any increase in a fixed amount cost-sharing requirement other than a copayment, such as a deductible or out-of-pocket limit, by more than "medical inflation"²⁴ plus 15 percent causes a group health benefit package to lose grandfathered status.²⁵ The calculation of the medical inflation adjustment requires careful review of the examples in the regulation and use of the CPI-U for medical services to specific persons specified in the Grandfather Regulations.

(5) *Increase in Copayment Requirement.* Any increase in a copayment causes a group health benefit package to lose grandfathered status, if the total increase in the copayment, measured from March 23, 2010, exceeds the greater of: (a) \$5 increased for medical inflation (the \$5 increment is increased for medical inflation, not the copayment plus the \$5 increment; or (b) medical inflation plus 15 percent. For instance, assume a grandfathered health plan has a copayment requirement of \$30 per office visit for specialists. The plan is subsequently amended to increase this copayment requirement to \$40. Within the 12-month period before the \$40 copayment takes effect, the greatest value of the overall medical care component of the CPI-U (unadjusted) is 475. In this example, the increase in the co-

²² 26 C.F.R. § 54.9815-1251T(g)(1)(i); 29 C.F.R. § 2590.715-1251(g)(1)(i); 45 C.F.R. § 147.140(g)(1)(i).

²³ 26 C.F.R. § 54.9815-1251T(g)(1)(ii); 29 C.F.R. § 2590.715-1251(g)(1)(ii); 45 C.F.R. § 147.140(g)(1)(ii).

²⁴ Medical inflation is defined as the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by the DOL using the 1982 - 1984 base of 100. For this purpose, the increase in the overall medical care component is computed by subtracting 387.142 (the overall medical care component of the CPI-U (unadjusted) published by the DOL for March 2010, using the 1982 - 1984 base of 100) from the index amount for any month in the twelve months before the new change is to take effect and then dividing that amount by 387.142. 26 C.F.R. § 54.9815-1251T(g)(3)(i); 29 C.F.R. § 2590.715-1251(g)(3)(i); 45 C.F.R. § 147.140(g)(3)(i).

²⁵ 26 C.F.R. § 54.9815-1251T(g)(1)(iii); 29 C.F.R. § 2590.715-1251(g)(1)(iii); 45 C.F.R. § 147.140(g)(1)(iii).

¹⁸ 26 C.F.R. § 54.9815-1251T(a)(1)(i); 29 C.F.R. § 2590.715-1251(a)(1)(i); 45 C.F.R. § 147.140(a)(1)(i).

¹⁹ 26 C.F.R. § 54.9815-1251T(a)(2); 29 C.F.R. § 2590.715-1251(a)(2); 45 C.F.R. § 147.140(a)(2).

²⁰ 26 C.F.R. § 54.9815-1251T(a)(3); 29 C.F.R. § 2590.715-1251(a)(3); 45 C.F.R. § 147.140(a)(3).

²¹ 26 C.F.R. § 54.9815-1251T(a)(1)(ii); 29 C.F.R. § 2590.715-1251(a)(1)(ii); 45 C.F.R. § 147.140(a)(1)(ii).

payment from \$30 to \$40, expressed as a percentage, is 33.33 percent. Medical inflation from March 2010 is 0.2269 ([475-387.142]/387.142). (387.142 is the permanent base number for calculation of medical inflation under the Grandfather Regulations. Note the CPI-U has not actually increased to 475 as of the time this was written.) Therefore, the maximum percentage increase permitted is 37.69 percent (22.69 percent plus 15 percent = 37.69 percent). Because 33.33 percent does not exceed 37.69 percent, the change in the copayment requirement does not cause the benefit package to lose its grandfathered status.²⁶

(6) *Decrease in Employer Contribution Rate.* Any decrease in an employer's contribution rate based on the cost of coverage toward the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percent causes a benefit package to lose its grandfathered status. For instance, assume a group health benefit package provides two tiers of coverage – self-only and family. The employer contributes 80 percent of the total cost of coverage for self-only and 60 percent of the total cost of coverage for family. If the employer reduces the contribution to 50 percent for family coverage, the group health benefit package loses its grandfathered status, even though the plan keeps the same contribution rate for self-only coverage.²⁷

(7) *Changes in Annual Limits.* A group health benefit package loses its grandfathered status if it makes one of the following changes with respect to an overall annual limit on the dollar value of all essential health benefits (an “annual dollar limit”).²⁸ This occurs even if the change in the annual limit is permitted under the guidance on annual and lifetime limits that was issued after the Grandfather Regulations.²⁹

(a) *No Limit.* If the benefit package did not have an annual or lifetime dollar limit on March 23, 2010, the benefit package loses its grandfathered status if it adopts an annual dollar limit.

(b) *Lifetime Limit in Effect.* If the benefit package had a lifetime limit on the dollar value of essential health benefits, but not an annual dollar limit, on March 23, 2010, the benefit package loses its grandfathered status if it adopts an annual dollar limit that is less than the lifetime limit in effect on March 23, 2010.

(c) *Annual Limit in Effect.* If the benefit package had an annual dollar limit on March 23, 2010, the benefit package loses its grandfathered status if it decreases the annual limit in effect on March 23, 2010.

If a change is not prohibited by one of the above restrictions and it is not a change designed to avoid or circumvent one of the above restrictions, then it is not currently prohibited, and any change to increase the restrictions above will only be effective prospectively.³⁰ However, a change made in good faith compliance with a reasonable interpretation of the regulations will be considered by the enforcement agencies and plans must

²⁶ 26 C.F.R. § 54.9815-1251T(g)(1)(iv); 29 C.F.R. § 2590.715-1251(g)(1)(iv); 45 C.F.R. § 147.140(g)(1)(iv).

²⁷ 26 C.F.R. § 54.9815-1251T(g)(1)(v); 29 C.F.R. § 2590.715-1251(g)(1)(v); 45 C.F.R. § 147.140(g)(1)(v).

²⁸ 26 C.F.R. § 54.9815-1251T(g)(1)(vi); 29 C.F.R. § 2590.715-1251(g)(1)(vi); 45 C.F.R. § 147.140(g)(1)(vi).

²⁹ 75 Fed. Reg. 37188 (June 28, 2010).

³⁰ 75 Fed. Reg. 34538, 34544 (June 17, 2010).

consider use of the transition rule if a change exceeds the Grandfather Regulation limits (see Section D, below, for the transition rules).

C. How to Maintain Grandfathered Status

Despite the long list of actions that cause a benefit package to lose its grandfather status, plan sponsors do have some flexibility to make amendments without losing grandfathered status, including the following actions:

(1) *Existing Enrollees Renew Coverage or Add Dependents.* A grandfathered health benefit package will not lose its status if an individual who was enrolled in the benefit package on March 23, 2010, renews coverage or enrolls family members, as long as the plan provided dependent coverage on March 23, 2010.³¹

(2) *New Enrollees.* A grandfathered benefit package will not lose its status if the benefit package enrolls new employees (and their families) in the plan. However, the Grandfather Regulations contain an anti-abuse rule that prohibits business restructuring for the purpose of covering new individuals under a grandfathered benefit package. In addition, a grandfathered benefit package will lose its status if: (1) employees are transferred to the grandfathered benefit package from another benefit package, (2) amending the other benefit package to match the terms of the grandfathered benefit package would cause the other benefit package to lose grandfathered status, and (3) there is no bona fide employment-based reason to transfer the employees.³²

(3) *Change Premiums.* The preamble to the Grandfather Regulations provides that a grandfathered health benefit package may change premiums without losing grandfathered status.

(4) *Comply With Applicable Law.* The preamble to the Grandfather Regulations provides that a grandfathered health benefit package will not lose grandfathered status if it is amended to comply with federal or state legal requirements or voluntarily comply with the Act. Thus, changes to effect compliance with the regulations under the Mental Health Parity and Addiction Equity Act³³ will not alone cause loss of grandfathered status.

(5) *Change Third-Party Administrators.* The preamble to the Grandfather Regulations provides that a grandfathered health benefit package may change third-party administrators without losing grandfathered status.

(6) *Other Changes.* The preamble to the Grandfather Regulations clarifies that any changes, other than the changes listed in Section B above, will not cause a plan to cease to be a grandfathered health plan. However, the agencies issuing the Grandfather Regulations also indicated that any changes in the restrictions will be prospective and that they are considering additional issues.³⁴

³¹ 26 C.F.R. § 54.9815-1251T(a)(4); 29 C.F.R. § 2590.715-1251(a)(4); 45 C.F.R. § 147.140(a)(4).

³² 26 C.F.R. § 54.9815-1251T(b); 29 C.F.R. § 2590.715-1251(b); 45 C.F.R. § 147.140(b).

³³ Pub. L. No. 110-343.

³⁴ 75 Fed. Reg. 34,538, 34,544 (June 17, 2010).

D. Transition Rules

Generally, the Grandfather Regulations become effective on the first plan year beginning on or after Sept. 23, 2010. However, the Grandfather Regulations contain a number of transition provisions providing that the following do not cause a loss of grandfathered status:

(1) *Changes Adopted Prior to March 23, 2010, With Later Effective Date.* The Grandfather Regulations provide that if a group health plan made changes that were effective after March 23, 2010, but were adopted on or prior to March 23, 2010, such changes are considered part of the plan terms on March 23, 2010. Accordingly, such changes will not cause a benefit package to lose grandfathered status.³⁵ This may be helpful for plans with fiscal years that had adopted benefit changes by March 23, 2010, even if the new plan year had not yet started.

(2) *Changes Adopted Between March 23, 2010, and June 14, 2010.* If a plan sponsor made changes to its group health benefit package prior to the issuance of the Grandfather Regulations, and such changes were made in a good faith effort to comply with the Act, the benefit package will maintain its grandfathered status, so long as such amendments only modestly exceed those changes permitted in Section B above.³⁶

(3) *Revoking Changes.* The Grandfather Regulations provide employers with a grace period within which to revoke or modify any changes adopted prior to June 14, 2010, if the changes made would cause the benefit package to lose its grandfathered status. If the changes are revoked or modified, effective as of the first plan year beginning on or after Sept. 23, 2010, to bring the terms within the limits for retaining grandfathered status, the benefit package will maintain its grandfathered status.³⁷

E. Application of the Act

The Grandfather Regulations clarify the application of the Act to certain plans. The preamble to the Grandfather Regulations provides that the Act does not apply to: (1) plans with less than two participants who are current employees (including retiree-only plans), and (2) excepted benefits (as defined in the Public Health Service Act).³⁸ This statement in the preamble clarified

³⁵ 26 C.F.R. § 54.9815-1251T(g)(2)(i); 29 C.F.R. § 2590.715-1251(g)(2)(i); 45 C.F.R. § 147.140(g)(2)(i).

³⁶ The Grandfather Regulations do not provide any guidance on what it means to “modestly exceed” the changes permitted by the Grandfather Regulations.

³⁷ 26 C.F.R. § 54.9815-1251T(g)(2)(ii); 29 C.F.R. § 2590.715-1251(g)(2)(ii); 45 C.F.R. § 147.140(g)(2)(ii).

³⁸ 75 Fed. Reg. 34,538, 34,539 (June 17, 2010); “Excepted benefits” include coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers’ compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination

a discrepancy caused by a “conforming change” in the Act which repealed the exemption only for nonfederal governmental plans, yet did not repeal it for plans subject to ERISA or the Code. This is a significant clarification because it relieves retiree only plans from compliance with any portion of the Act and does not merely delay portions of compliance while grandfathered status is maintained.

In addition, the Grandfather Regulations clarify that collectively-bargained self-funded plans will lose their grandfathered status for any of the reasons listed in Section B above (i.e., they are treated the same as all other grandfathered plans) and are not entitled to any delayed effective date beyond that provided by grandfathered status. However, collectively bargained fully-insured plans will not lose their grandfathered status for taking one of the actions listed above until the applicable collective bargaining agreement terminates.³⁹ While this clarifies this provision, it also limits its usefulness for collectively bargained plans as a whole since it only applies to collectively bargained insurance coverage.

F. Conclusion

Because grandfathered group health benefit packages are not subject to several of the requirements of the Act, it may be advantageous for a benefit package to maintain grandfathered status. The determination of whether to maintain grandfathered status must be made for each benefit package separately. However, due to the number of ways a benefit package may lose grandfathered status, the administrative costs in maintaining grandfathered status may be significant. In determining the best course of action for each of its group health benefit packages, plan sponsors need to weigh the costs of implementing the requirements applicable to nongrandfathered health plans versus the costs of maintaining grandfathered status. Currently pending at the Office of Management and Budget are regulations on preventive care requirements and these may influence plan sponsors’ decisions on maintaining grandfathered status.

APPENDIX A

*U.S. Preventive Services Task Force Clinical Preventive Services for PPACA Required Wellness Services*⁴⁰

thereof; coverage only for a specified disease or illness; and hospital indemnity or other fixed indemnity insurance.

³⁹ 26 C.F.R. § 54.9815-1251T(f).

⁴⁰ The USPSTF grades its recommendations according to one of five classifications (A, B, C, D, E, I), reflecting the strength of evidence and magnitude of net benefit (benefit minus harms). “A” recommendations are services that the USPSTF strongly recommends that clinicians provide to eligible patients. *The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.* “B” recommendations are services that the USPSTF recommends that clinicians provide to eligible patients. *The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.*

Type of Screening	Summary of Recommendations with a Grade of A or B
Genetic Risk Assessment and BRCA Mutation Testing for Breast and Ovarian Cancer Susceptibility	The U.S. Preventive Services Task Force Clinical Preventive Services (USPSTF) recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing. <i>Grade: B Recommendation.</i>
Screening for Breast Cancer	The USPSTF recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women aged 40 and older. <i>Grade: B Recommendation.</i>
Screening for Cervical Cancer	The USPSTF strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix. <i>Grade: A Recommendation.</i>
Screening for Colorectal Cancer	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods may vary. <i>Grade: A Recommendation.</i>
Heart, Vascular, and Respiratory Diseases	The USPSTF recommends one-time screening for abdominal aortic aneurysm (AAA) by ultrasonography in men aged 65 to 75 who have ever smoked. <i>Grade: B Recommendation.</i>
Aspirin for the Prevention of Cardiovascular Disease	The USPSTF recommends the use of aspirin for men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage. <i>Grade: A Recommendation.</i> The USPSTF recommends the use of aspirin for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm due to an increase in gastrointestinal hemorrhage. <i>Grade: A Recommendation.</i>
Screening for High Blood Pressure	The USPSTF recommends screening for high blood pressure in adults aged 18 and older. <i>Grade: A Recommendation.</i>
Screening for Lipid Disorders in Adults	The USPSTF strongly recommends screening men aged 35 and older for lipid disorders. <i>Grade: A Recommendation.</i> The USPSTF recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease. <i>Grade: B Recommendation.</i> The USPSTF strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease. <i>Grade: A Recommendation.</i> The USPSTF recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease. <i>Grade: B Recommendation.</i>
Screening for Asymptomatic Bacteriuria	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later. <i>Grade: A Recommendation.</i>

Screening for Chlamydial Infection	The USPSTF recommends screening for chlamydial infection for all sexually active nonpregnant young women aged 24 and younger and for older nonpregnant women who are at increased risk. <i>Grade: A Recommendation.</i> The USPSTF recommends screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk. <i>Grade: B Recommendation.</i>
Screening for Gonorrhea	The USPSTF recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors; go to Clinical Considerations for discussion of risk factors). <i>Grade: B Recommendation.</i> The USPSTF strongly recommends prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum. <i>Grade: A Recommendation.</i>
Screening for Hepatitis B Virus Infection	The USPSTF strongly recommends screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit. <i>Grade: A Recommendation.</i>
Screening for HIV	The USPSTF strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection. <i>Grade: A Recommendation.</i> The USPSTF recommends that clinicians screen all pregnant women for HIV. <i>Grade: A Recommendation.</i>
Behavioral Counseling to Prevent Sexually Transmitted Infections	The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs. <i>Grade: B Recommendation.</i>
Screening for Syphilis Infection	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection. <i>Grade: A Recommendation.</i> The USPSTF strongly recommends that clinicians screen all pregnant women for syphilis infection. <i>Grade: A Recommendation.</i>
Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse	The USPSTF recommends screening and behavioral counseling interventions to reduce alcohol misuse (go to Clinical Considerations) by adults, including pregnant women, in primary care settings. <i>Grade: B Recommendation.</i>
Screening for Depression in Adults	The USPSTF recommends screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow up. <i>Grade: B Recommendation.</i>
Counseling to Prevent Tobacco Use and Tobacco-Caused Disease	The USPSTF strongly recommends that clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products. <i>Grade: A Recommendation.</i> The USPSTF strongly recommends that clinicians screen all pregnant women for tobacco use and provide augmented pregnancy-tailored counseling to those who smoke. <i>Grade: A Recommendation.</i>

Metabolic, Nutritional, and Endocrine Conditions

Behavioral Counseling in Primary Care to Promote a Healthy Diet	The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians. <i>Grade: B Recommendation.</i>
Screening for Iron Deficiency Anemia—Including Iron Supplementation for Children and Pregnant Women	The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women. <i>Grade: B Recommendation.</i> The USPSTF recommends routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia (see Clinical Considerations for a discussion of increased risk). <i>Grade: B Recommendation.</i>
Screening for Obesity in Adults	The USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. <i>Grade: B Recommendation.</i>
Screening for Type 2 Diabetes Mellitus in Adults	The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg. <i>Grade: B Recommendation.</i>
Screening for Osteoporosis in Postmenopausal Women	The USPSTF recommends that women aged 65 and older be screened routinely for osteoporosis. The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures (see Clinical Considerations for discussion of women at increased risk). <i>Grade: B Recommendation.</i>
Primary Care Interventions to Promote Breastfeeding	The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding. <i>Grade: B Recommendation.</i>
Screening for Rh (D) Incompatibility	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care. <i>Grade: A Recommendation.</i> The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D)-negative. <i>Grade: B Recommendation.</i>

Section 3. Recommendations for Children and Adolescents

Screening for Congenital Hypothyroidism	The USPSTF recommends screening for congenital hypothyroidism (CH) in newborns. <i>Grade: A Recommendation.</i>
Prevention of Dental Caries in Preschool Children	The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride. <i>Grade: B Recommendation.</i>

Screening and Treatment for Major Depressive Disorder in Children and Adolescents	The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up. <i>Grade: B Recommendation.</i>
Universal Screening for Hearing Loss in Newborns	The USPSTF recommends screening for hearing loss in all newborn infants. <i>Grade: B Recommendation.</i>
Screening for Phenylketonuria	The USPSTF recommends screening for phenylketonuria (PKU) in newborns. <i>Grade: A Recommendation.</i>
Screening for Sickle Cell Disease	The USPSTF recommends screening for sickle cell disease in newborns. <i>Grade: A Recommendation.</i>
Screening for Visual Impairment in Children Younger Than Age 5 Years	The USPSTF recommends screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5 years. <i>Grade: B Recommendation.</i>

Immunizations Recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services

Vaccine and dose no.	Recommended age for this dose	Minimum age for this dose	Recommended interval to next dose	Minimum interval to next dose
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Hepatitis B (HepB)-1	Birth	Birth	1-4 months	4 weeks
HepB-2	1-2 months	4 weeks	2-17 months	8 weeks
HepB-3	6-18 months	24 weeks	—	—
Diphtheria-tetanus-acellular pertussis (DTaP)-1	2 months	6 weeks	2 months	4 weeks
DTaP-2	4 months	10 weeks	2 months	4 weeks
DTaP-3	6 months	14 weeks	6-12 months	6 months
DTaP-4	15-18 months	12 months	3 years	6 months
DTaP-5	4-6 years	4 years	—	—
Haemophilus influenzae type b (Hib)-1	2 months	6 weeks	2 months	4 weeks
Hib-2	4 months	10 weeks	2 months	4 weeks
Hib-3	6 months	14 weeks	6-9 months	8 weeks
Hib-4	12-15 months	12 months	—	—
Inactivated poliovirus (IPV)-1	2 months	6 weeks	2 months	4 weeks
IPV-2	4 months	10 weeks	2-14 months	4 weeks
IPV-3	6-18 months	14 weeks	3-5 years	4 weeks
IPV-4	4-6 years	18 weeks	—	—
Pneumococcal conjugate (PCV)-1	2 months	6 weeks	2 months	4 weeks
PCV-2	4 months	10 weeks	2 months	4 weeks
PCV-3	6 months	14 weeks	6 months	8 weeks
PCV-4	12-15 months	12 months	—	—
Measles-mumps-rubella (MMR)-1	12-15 months	12 months	3-5 years	4 weeks
MMR-2	4-6 years	13 months	—	—
Varicella (Var)-1	12-15 months	12 months	3-5 years	12 weeks
Var-2	4-6 years	15 months	—	—
Hepatitis A (HepA)-1	12-23 months	12 months	6-18 months	6 months
HepA-2	18-41 months	18 months	—	—
Influenza inactivated	6-59 months	6 months	1 month	4 weeks
Influenza live attenuated	—	5 years	6-10 weeks	6 weeks

Meningococcal conjugate	11–12 years	11 years	—	—
Meningococcal polysaccharide (MPSV)-1	—	2 years	5 years	5 years
MPSV-2	—	7 years	—	—
Tetanus-diphtheria	11–12 years	7 years	10 years	5 years
Tetanus-diphtheria acellular pertussis (Tdap)	> 11 years	10 years	—	—
Pneumococcal polysaccharide (PPV)-1	—	2 years	5 years	5 years
PPV-2	—	7 years	—	—
Human papillomavirus (HPV)-1	11–12 years	9 years	2 months	4 weeks
HPV-2	11–12 years (+2 months)	109 months	4 months	12 weeks
HPV-3	11–12 years (+6 months)	112 months	—	—
Rotavirus (RV)-1	2 months	6 weeks	2 months	4 weeks
RV-2	4 months	10 weeks	2 months	4 weeks
RV-3	6 months	14 weeks	—	—