Part VI: Grandfathered Health Plans

135. What is a grandfathered health plan?

A grandfathered plan is:

* one continuously in existence since March 23, 2010
* with at least one person (need not be the same person) covered at all times, and
* not changed except as permitted, as discussed hereafter

Grandfathered plans are exempt from many, but not all, health reform rules,[[1]](#footnote-1) described in more detail below, as long as grandfather status is maintained, which can last indefinitely. A self-insured group plan, an insured group plan, and an individual insurance policy may each be grandfathered.

A plan that is grandfathered may permit employees to re-enroll and their family members to enroll after March 23, 2010.[[2]](#footnote-2) While new employees can join the plan, there are restrictions on whether new groups of employees can be transferred to the plan without tainting grandfathered status.[[3]](#footnote-3)

For plan or insurance changes made before March 23, 2010, the changes will be considered to be part of the coverage on March 23, 2010, though they were not in effect on such date, and will not cause the plan to lose grandfathered status, if:

* The changes were effective after March 23, 2010, pursuant to a legally binding contract entered into on or before March 23, 2010,
* The changes were effective pursuant to a filing with the state insurance department that was filed on or before March 23, 2010, or
* The changes were effective after March 23, 2010, pursuant to written amendments to the plan that were adopted on or before March 23, 2010.[[4]](#footnote-4)

Changes that would cause a plan to lose grandfathered status adopted after March 23, 2010, but before June 14, 2010, had to be undone for the first year beginning on or after September 23, 2010, for grandfather status to be maintained.[[5]](#footnote-5)

**135.01 Administrative extension until October 1, 2016 Of Non-ACA compliant individual & small group health insurance policies.**

The administration announced on March 5, 2014 that non-compliant individual health and small group policies can be extended an additional two years for policy years beginning on or before Oct. 1, 2016.[[6]](#footnote-6) As with the original extension, the state insurance regulator must agree to approve such policies, and the health insurance companies must decide to continue offering such policies. States can elect to extend the transitional policy for a shorter period than through October 1, 2016 but may not extend it to policy years beginning after October 1, 2016. Additionally, states may choose to adopt both the November 14, 2013 transitional policy[[7]](#footnote-7) as well as the extended transitional policy through October 1, 2016, or adopt one but not the other. A State may also choose to adopt the transitional relief policy for large businesses that currently purchase insurance in the large group market but that, for policy years beginning on or after January 1, 2016, will be redefined as small businesses purchasing insurance in the small group market.

Insurance departments in 28 states allowed insurers to renew 2013 policies, while 21 states and the District of Columbia prohibited renewals, as shown by the chart below.[[8]](#footnote-8)



Many states also passed their own laws applying some or all of the healthcare reform requirements to coverage issued or renewed in their state on or after January 1, 2014. These market reforms include the coverage of a minimum set of essential health benefits and the ban on preexisting condition exclusions. The existence of such laws may mean that regulators in those states are unable to allow renewals in 2014. HHS estimated that only about 1.5 million non-grandfathered, non-compliant policies were continued in 2014.

Impact On Individual Mandate Penalty. CMS also said that individuals whose non-compliant policies are cancelled will continue to qualify for a “hardship exemption” from individual mandate penalties “if they find other options to be more expensive, and are able to purchase coverage.” CMS spelled out the parameters for the hardship exemption under these circumstances, which now will be available until October 1, 2016, in guidance issued at the end of 2013.[[9]](#footnote-9)

136. How does an employer or other plan sponsor decide whether to maintain grandfathered status?

The sponsor should review the benefits obtained by grandfathered status, i.e., the rules that would otherwise apply that do not apply to grandfathered plans. A plan sponsor should evaluate the relative cost versus the benefit of preserving grandfathered status, including business objectives, such as employee recruitment and retention. In cases in which a collective bargaining agreement or other contract restricts changes that can be made to coverage or contributions, the decision to retain grandfathered status will be relatively easy. Otherwise, the new mandates' increased costs will need to be evaluated. For instance, an employer that already provides rich preventive care benefits should experience less of a cost increase from the preventive care requirements than an employer that provides little or no preventive care coverage. Additionally, an employer that pays the same amount for individual and family coverage for all employees would not be impacted by the new rules preventing discrimination in insured group plans in favor of highly compensated individuals. This analysis will need to be repeated in a year in which changes are contemplated.

137. Has the DOL provided any tools to assist in determining grandfathered status?

The Department of Labor's Employee Benefits Security Administration (EBSA) has published an online self-help tool to enable group health plans, plan sponsors, plan administrators, and health insurance issuers comply with the healthcare reform’s group health plan requirements, namely, the “Self-Compliance Tool for Part 7 of ERISA: Affordable Care Act Provisions.”[[10]](#footnote-10)

It provides a detailed question and answer checklist addressing the various Affordable Care Act (ACA) provisions applicable to group health plans and health insurance issuers. Various questions allow users to assess their plan's compliance with ACA provisions addressing grandfather plan status, extension of dependent coverage to adult children, prohibitions on lifetime limits and restrictions on annual limits, prohibition on preexisting condition exclusions for individuals under 19, summary of benefits and coverage (SBC) and uniform glossary, preventive services, internal claims and appeals, and external review.

138. What are the details for the DOL self-help healthcare reform tool and grandfathered plan checklist?

**Section A. Determining Grandfather Status**[[11]](#footnote-11)

Grandfather status is intended to allow people to keep their coverage as it existed on March 23, 2010, while giving plans some flexibility to make “normal” changes while retaining grandfather status. Grandfathered health plan coverage provides individuals’ protection from significant reductions in coverage, provides for coverage to include numerous protections implemented through the Affordable Care Act, and allows employers the flexibility to manage costs.

The analysis for determining grandfather status applies separately to each benefit package or option. Accordingly, grandfather status might be retained for some benefit packages or options and relinquished for others. By contrast, if an employer relinquished grandfather status for self-only, family, or any other tier within a benefits package, it would relinquish grandfather status for the entire package.[[12]](#footnote-12)

There are transitional rules regarding grandfather status as related to recent changes to plan terms.

* Specifically a plan will not relinquish grandfather status for changes effective after March 23, 2010, pursuant to a legally binding contract entered into on or before March 23, 2010; changes effective after March 23, 2010, pursuant to a filing on or before March 23, 2010, with a State insurance department; or changes effective after March 23, 2010, pursuant to written amendments to a plan that were adopted on or before March 23, 2010.
* If after March 23, 2010, a group health plan or issuer made changes to the terms of the plan or coverage and the changes were adopted prior to June 14, 2010, the changes will not cause the plan or coverage to relinquish grandfather status, if the changes were revoked or modified effective as of the first day of the first plan year beginning on or after September 23, 2010, and the terms of the plan or health insurance coverage on that date, as modified, would not cause the plan or coverage to otherwise cease to be a grandfathered health plan.[[13]](#footnote-13)

If the answer is “yes” to questions 1 and 2 below the group health plan may be a grandfathered health plan.

**Question 1** – Did the plan exist with at least one individual enrolled on March 23, 2010? A grandfathered group health plan must have been in existence with an enrolled individual on March 23, 2010. Any plan that does not meet this requirement is not in grandfathered status.[[14]](#footnote-14)

**Question 2** – Has the plan continuously covered someone (not necessarily the same person) since March 23, 2010? A group health plan will not relinquish its grandfather status merely because one or more (or all) individuals enrolled on March 23, 2010, cease to be covered. However, a grandfathered health plan must continuously cover someone (not necessarily the same person) since March 23, 2010, to maintain its status.[[15]](#footnote-15)

**Question 3** – Has the plan eliminated all or substantially all benefits to diagnose or treat a particular condition? For the purpose of determining grandfather status, 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.[[16]](#footnote-16)

**Question 4** – Has the plan increased a percentage cost-sharing requirement (such as an individual’s coinsurance)? Any increase measured from March 23, 2010, in a percentage cost-sharing requirement causes a plan to relinquish grandfather status.[[17]](#footnote-17)

**Question 5** – Has the plan increased a fixed-amount cost-sharing requirement other than a copayment (such as a deductible or out-of-pocket limit) such that the total percentage increase measured from March 23, 2010 exceeds the maximum percentage increase? The maximum percentage increase is medical inflation, expressed as a percentage, plus 15 percentage points.[[18]](#footnote-18) Medical inflation is 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 Department of Labor using the 1982-1984 base of 100.[[19]](#footnote-19)

**Question 6** – Has the plan increased a fixed-amount copayment such that the increase measured from March 23, 2010 exceeds the greater of: the maximum percentage increase, or an amount equal to $5 plus medical inflation? The maximum percentage increase is medical inflation, expressed as a percentage, plus 15 percentage points.[[20]](#footnote-20) Medical inflation is 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 Department of Labor using the 1982-1984 base of 100.[[21]](#footnote-21)

**Question 7** – Has there been a decrease in the contribution rate by the employer (or employee organization) towards the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010? If the contribution rate is based on a formula, was the decrease in the contribution rate based on a formula by more than 5 percent below the contribution rate for the coverage period that includes March 23, 2010?[[22]](#footnote-22)

If a group health plan modifies the tiers of coverage it had on March 23, 2010 (for example, from self-only and family to a multi-tiered structure of self-only, self-plus-one, self-plus-two, and self-plus-three-or-more), the employer contribution for any new tier would be tested by comparison to the contribution rate for the corresponding tier on March 23, 2010. If the plan adds one or more new coverage tiers without eliminating or modifying any previous tiers and those new coverage tiers cover classes of individuals that were not covered previously under the plan, the new tiers would not be analyzed under the standards of paragraph (g)(1).[[23]](#footnote-23)

In cases of a multiemployer plan that has either a fixed-dollar employee contribution or no employee contribution towards the cost of coverage, if the employer’s contribution rate changes, provided any changes in the coverage terms would not otherwise cause the plan to cease to be grandfathered and there continues to be no employee contribution or no increase in the fixed-dollar employee contribution towards the cost of coverage, the change of the employer’s contribution rate will not, in and of itself, cause a plan that is otherwise a grandfathered health plan to relinquish grandfather status.[[24]](#footnote-24)

**Question 8** – Has the plan added or decreased an overall annual limit on benefits? A plan will relinquish its grandfathered status if it:

* Adds an overall annual limit on the dollar value of all benefits when it did not previously impose an overall annual limit;[[25]](#footnote-25)
* Previously imposed an overall lifetime limit on the dollar value of benefits (but no overall annual limit) and adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010;[[26]](#footnote-26) or
* Decreases the dollar value of the overall annual limit that was in place on March 23, 2010.[[27]](#footnote-27)

If the answer to any of questions 3-8 was “yes”, the plan is NOT a grandfathered plan.

**Question 9** – Did the plan change issuers after March 23, 2010? If the answer to question 9 is “yes”, if the group health plan changed issuers after March 23, 2010, and the change in issuer was effective on or after November 15, 2010, the plan will continue to be a grandfathered plan provided no other changes that would relinquish grandfather status are made.[[28]](#footnote-28)

If a group health plan changed issuers after March 23, 2010, and the change was effective prior to November 15, 2010, the plan will have relinquished grandfather status. The operative date is the effective date of the new contract, not the date the new contract was entered into. Special rules apply for collectively bargained plans.[[29]](#footnote-29)

**Question 10** – Did the plan change from self-insured to fully-insured after March 23, 2010? If the group health plan was self-insured and changed to fully insured after March 23, 2010, and the change was effective on or after November 15, 2010, the plan will continue to be a grandfathered plan provided no other changes are made that would relinquish grandfather status.[[30]](#footnote-30) Proceed to question 11. If a group health plan was self-insured and changed to fully-insured after March 23, 2010, and the change was effective prior to November 15, 2010, the plan will have relinquished grandfather status.

**Question 11** – If the group health plan changed issuers (including a plan that was self-insured and changed to fully insured) and has maintained grandfather status did the plan provide documentation to the new issuer of the plan terms under the prior health coverage sufficient to determine whether any other change was made that would relinquish grandfather status? To maintain status as a grandfathered health plan, the plan must provide to the new issuer (and the new issuer must require) documentation of plan terms (including benefits, cost sharing, employer contributions, and annual limits) under the prior health coverage sufficient to determine whether any other change is being made that would relinquish grandfathered status.[[31]](#footnote-31)

**Question 12** – Does the plan include a statement that it believes it is a grandfathered health plan in any plan materials provided to participants and beneficiaries that describe the benefits provided under the plan? To maintain status as a grandfathered group health plan, the plan must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits under the plan, that the plan believes it is a grandfathered health plan within the meaning of section 1251 of the Affordable Care Act and must provide contact information for questions and complaints. Model language is available.[[32]](#footnote-32)

**Question 13** – Is the plan maintaining records documenting the terms of the plan in connection with the coverage in effect on March 23, 2010, and are these records made available upon request? To maintain status as a grandfathered group health plan the plan must maintain records documenting the terms of the plan in connection with the coverage that was in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan. These records must be maintained for as long as the plan takes the position that it is grandfathered, and must be available for examination upon request.[[33]](#footnote-33)

139. What health reform requirements apply to grandfathered plans?

These seven requirements apply to all health plans, including grandfathered plans.

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| **Health Reform Rules That Apply to All Plans, Including Grandfathered Plans** |
| Pre-existing condition exclusions (PCE) prohibited.[[34]](#footnote-34) Grandfathered individual coverage can continue to apply these exclusions, but group health plans and group health insurance issuers cannot impose PCEs for plan years beginning on or after January 1, 2014. This prohibition took effect for plan years beginning on or after September 23, 2010, (i.e., January 1, 2011, for calendar-year plans) with respect to individuals enrolled in the plan who are younger than nineteen years of age.  |
| Excessive waiting periods of more than ninety days are prohibited for plan years beginning in 2014.[[35]](#footnote-35) |
| Annual/lifetime limits are prohibited for plan years beginning in 2014.[[36]](#footnote-36) These rules apply to grandfathered plans, but the annual limit prohibition does not apply to grandfathered individual coverage. For benefits that are not “essential health benefits,” both lifetime and annual limits are allowed if not prohibited by other federal and state laws.[[37]](#footnote-37) Failure to provide any services for a condition is allowed, but if any benefits are provided for a condition, these prohibitions apply.[[38]](#footnote-38) While grandfathered health plans are not required to offer essential health benefits, they cannot impose either annual or lifetime dollar limits on the essential health benefits they do offer. Individual grandfathered policies may continue annual limits but not lifetime limits. |
| Rescission of policies is prohibited except for fraud or misrepresentation beginning in 2014.[[39]](#footnote-39) |
| Dependent coverage for children under age twenty-six must be offered until 2014, except for adults eligible for coverage through their own employer.[[40]](#footnote-40) |
| SBC Requirement. The requirement to provide at least a four-page summary of benefits and coverage to plan participants applies to grandfathered plans.[[41]](#footnote-41) This is discussed in more detail in Part VII of this publication. |
| Medical Loss Ratio (MLR) reporting and rebates, designed to lower health insurance costs apply to grandfathered plans.[[42]](#footnote-42)  |

140. What health reform requirements do not apply to grandfathered plans and apply only to new plans or plans that lose grandfathered status?

These thirteen requirements do not apply to grandfathered plans. They apply only to new plans or plans that lose grandfathered status.

|  |
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| **Additional Rules Applicable to New and Nongrandfathered Health Plans** |
| Fair health insurance premiums.[[43]](#footnote-43) These are the rules that limit insurers in the individual or small group market as to allowable factors to alter premiums: * coverage category (e.g., whether the coverage is individual versus family coverage);
* rating area (as established by states);
* age (may not vary by more than 3 to 1 for adults); and
* tobacco use (may not vary more than 1.5 to 1).[[44]](#footnote-44)
 |
| Guaranteed-Availability Rules Applicable to Small and Large Group Markets.[[45]](#footnote-45) Healthcare reform makes changes to these requirements. Through December 31, 2013, the guaranteed-availability rules apply to health insurance issuers in the small group market, but not to issuers in the large group market. These rules require a health insurance issuer that actively markets coverage in the small group market to accept every small employer that applies for coverage and to make all products that it actively markets in the small group market available to all small employers. The issuer also must accept for enrollment every eligible individual who applies for coverage when first eligible. Insurers are permitted to impose employer contribution and minimum participation requirements (to the extent consistent with applicable state law), within certain limitations. As of January 1, 2014, the guaranteed-availability rules are significantly expanded. The statutory changes amended and restructured the guaranteed-availability provisions, making these rules applicable to health insurance issuers in the large and small group markets and effecting certain other changes.[[46]](#footnote-46) Each health insurance issuer that offers health insurance coverage in the individual or group market (regardless of whether the coverage is offered in the large or small group market) is required to accept every employer and individual in the state that applies for such coverage. Enrollment may, however, be restricted to open or special enrollment periods.[[47]](#footnote-47)  |
| Guaranteed renewability, which means that an insurer must renew coverage if requested by the plan sponsor..[[48]](#footnote-48) Prior to January 1, 2014, these rules apply to both the small and large group market. They require group insurance issuers in both the small and large group market to renew coverage at the option of the plan sponsor subject to specified exceptions and restrictions (such as nonpayment of premiums, fraud, or violation of certain employer contribution or group participation requirements). |
| Nondiscrimination based on health status. Group health plans and health insurance issuers offering health insurance coverage are prohibited from discriminating against an individual with regard to eligibility or coverage based on a health status factor.[[49]](#footnote-49) Health reform extended these rules, effective January 1, 2014, to health insurance issuers offering individual health insurance coverage.[[50]](#footnote-50) |
| Nondiscrimination against healthcare providers, beginning in 2014 if they act within the scope of their license or certification.[[51]](#footnote-51)  |
| Comprehensive health insurance coverage. Effective for plan years beginning on or after January 1, 2014, health insurance issuers offering coverage in the individual or small group market must ensure that such coverage includes the “essential health benefits package.”[[52]](#footnote-52) A plan must provide essential health benefits,[[53]](#footnote-53) limit cost-sharing,[[54]](#footnote-54) and provide either bronze, silver, gold, or platinum level coverage (benefits that are actuarially equivalent to 60 percent, 70 percent, 80 percent, or 90 percent of the full actuarial benefits provided under the plan), or a catastrophic plan (also known as “young invincibles” coverage).[[55]](#footnote-55) An insurer that offers bronze, silver, gold, or platinum coverage must offer the same level of coverage in a “child-only plan” designed for persons under age twenty-one.[[56]](#footnote-56) |
| No denial of coverage for individuals participating in approved clinical trials.[[57]](#footnote-57)  |
| No cost-sharing (copayments) for preventive and wellness services.[[58]](#footnote-58) |
| Transparency in coverage.[[59]](#footnote-59) A health plan seeking Qualified Health Plan (QHP) certification from an exchange must disclose certain information to the exchange, HHS, and the state insurance commissioner, and make the information available to the public as well as cost-sharing disclosures to participants. |
| Nondiscrimination is prohibited in favor of highly compensated employees by nongrandfathered insured group plans.[[60]](#footnote-60) Those rules are discussed in detail in Part VII of this book. |
| Quality of care reporting requires group health plans and health insurance issuers annually to report to HHS about plan or coverage benefits and provider “reimbursement structures” that may affect the quality of care.[[61]](#footnote-61)  |
| Claims appeals[[62]](#footnote-62) and external review[[63]](#footnote-63) rules.[[64]](#footnote-64) These rules apply in addition to the ERISA claims procedures. Insurers will handle this duty for insured plans. Plan documents, summary plan descriptions (SPDs), existing claims procedures, any forms and notices used to communicate benefit determinations, and service contracts with TPAs and insurers will need to be updated. Non-ERISA self-insured plans not previously subject to the ERISA claims procedure requirement must adopt the existing DOL claims procedures and comply with these new requirements, such as governmental and church plans that have not elected to be subject to ERISA. In March 2011, a grace period for some requirements was extended until plan years beginning on or after January 1, 2012, (with one exception).[[65]](#footnote-65) |
| Patient protections[[66]](#footnote-66) for women to select an OB-GYN and parents to select a pediatrician as their child’s primary care provider. Additionally, for group health plans providing for emergency services, the plan: * may not require preauthorization, including for emergency services provided out-of-network;
* must provide coverage regardless of whether the provider is in- or out-of-network;
* may not impose any administrative requirement or coverage limitation that is more restrictive than would be imposed on in-network emergency services; and
* must comply with cost-sharing requirements.[[67]](#footnote-67)
 |

141. What changes to a plan will not result in loss of grandfather status?

Any change that does not result in loss of grandfathered status will not affect grandfathered status. Changes that are not prohibited do not cause a loss of grandfathered status.[[68]](#footnote-68) Changes to premiums, changes to comply with the law, changes voluntarily to implement healthcare reform changes, and changes by third-party administrators are allowed if they are made without exceeding the standards for changes that terminate grandfather status.[[69]](#footnote-69)

142. Can an insured plan change insurance companies?

The initial regulations provided that if an employer entered into a new policy, certificate, or contract of insurance after March 23, 2010, the new policy, certificate, or contract would not be grandfathered health coverage.[[70]](#footnote-70) This provoked a firestorm of protest because plan sponsors could not improve their plans or decrease costs (in permitted ways) by changing insurers without losing grandfather status. Revised regulations changed this result, but only for changes on or after November 15, 2010.[[71]](#footnote-71) A change entered into prior to November 15, 2010, that is effective thereafter is permitted.[[72]](#footnote-72)

For changes of insurer between March 23, 2010, and June 14, 2010 (when the initial grandfather regulations were issued), changes to group health insurance coverage on or after March 23, 2010, but before June 14, 2010 (the date the regulations were made publicly available), the agencies’ enforcement safe harbor remains in effect for good faith efforts to comply with a reasonable interpretation of the statute.[[73]](#footnote-73) If no prohibited change in costs or coverage was made, such a plan should retain its grandfather status because the regulations, as amended, allow such a change.

The amendment to the regulations applies only to group health plans, not to insurers in the individual market.[[74]](#footnote-74)

143. What documentation is required for an insured grandfathered plan to change insurance companies?

In order to maintain status as a grandfathered plan, a group health plan that enters into a new

An insurance contract or policy must provide to the new insurer (and the new insurer must require) documentation of plan terms (including benefits, cost-sharing, employer contributions, and annual limits) under the prior health coverage sufficient to determine whether any change is being made that would cause a loss of grandfather status. This documentation may include a copy of the policy and any summary plan description.[[75]](#footnote-75)

144. Can a grandfathered insured group plan change to become self-insured or a self-insured plan change to an insured plan without losing grandfathered status?

The regulations do not address the scenario of an insured grandfathered plan becoming self-insured. However, they allow a self-insured grandfathered plan to move to an insured plan but only after November 15, 2010.[[76]](#footnote-76) However, the reasonable good faith compliance standard should be in effect between March 23, 2010, and June 14, 2010.

145. What other changes can be made to a grandfathered self-insured plan without losing grandfather status?

A self-insured plan can change its third party administrator without losing grandfather status.[[77]](#footnote-77)

A self-insured plan also should be able to change its stop-loss insurance without losing grandfather status because it is not health insurance when maintained by a self-insured plan.[[78]](#footnote-78)

146. May enhancements or additions to a grandfathered health plan be made?

Yes. Additions to a grandfathered plan generally will not result in loss of grandfathered status. They are not prohibited changes. Thus, adding domestic partner benefits or a new health coverage option (such as an HMO where employer now only offers a PPO), is allowed, as these are two “benefit packages” and each is analyzed on its own to determine whether it is grandfathered.[[79]](#footnote-79) Thus, the existing PPO option would remain grandfathered.

147. What special rules apply to collectively bargained plans in determining grandfathered plan status?

For insured plans, i.e., health insurance coverage maintained under one or more collective bargaining agreements ratified before March 23, 2010, the coverage will be treated as grandfathered until the last collective bargaining agreement terminates, regardless of whether there is a change that would otherwise destroy grandfathered status.[[80]](#footnote-80) Self-funded collectively bargained plans will be treated the same as non-bargained plans and will need to comply with the grandfathering rules, including the new mandates and the limitations on plan changes, if this date is before the relevant collective bargaining agreement expires.[[81]](#footnote-81)

This collectively bargained plan rule does not provide a delayed effective date for changes required by health reform for collectively bargained plans. Although the grandfather rule allows collectively bargained insured plans to maintain grandfathered plan status during the term of the agreement, they must comply with the rules that apply to grandfathered health plans. Therefore, collectively bargained plans (both insured and self-insured) that are grandfathered plans must comply with all the provisions that apply to grandfathered plans with no extension of any effective dates.[[82]](#footnote-82)

Once the collective bargaining agreement expires, the plan may or may not be a grandfathered health plan. Such status will be determined under the otherwise applicable rules, by comparing the plan in existence at the end of the collective bargaining period with the plan in existence on March 23, 2010.[[83]](#footnote-83) If the plan has made changes that, absent the special collectively bargained rule, would take it out of grandfathered status, then the plan is not a grandfathered plan once the collective bargaining agreement expires.

148. Can new enrollees, including new hires and family members, enroll in a grandfathered health plan?

Yes. An individual who was enrolled in a grandfathered health plan on March 23, 2010, may enroll his or her family members in the grandfathered health plan after March 23, 2010.[[84]](#footnote-84) Additionally, new and existing employees and family members may enroll in a grandfathered health plan.[[85]](#footnote-85) Employees not covered in a grandfathered plan option may move into a grandfathered option at open enrollment without jeopardizing its grandfathered status.[[86]](#footnote-86)

149. Can employees transfer from one grandfathered plan to another?

Yes, and when this is voluntary, no change in the grandfathered status occurs.[[87]](#footnote-87) This is like a newly hired employee enrolling in a grandfathered plan.

150. Are there limits on employees moving from one plan to another?

Yes. The regulations state that transferring employees from one grandfathered plan or benefit package (transferor plan) to a transferee plan will cause the transferee plan to relinquish grandfather status if amending the transferor plan to replicate the terms of the transferee plan would have caused the transferor plan to relinquish grandfather status and there was no bona fide employment-based reason to transfer the employees.[[88]](#footnote-88) There may be many other circumstances in which a benefit package can be eliminated for a bona fide employment-based reason. The term “bona fide employment-based reason” includes a variety of circumstances, such as the following, which is not intended to be an exhaustive list:

* A benefit package is eliminated because the issuer is exiting the market.
* A benefit package is eliminated because the issuer no longer offers the product to the employer (for example, because the employer no longer satisfies the issuer's minimum participation requirement).
* Low or declining participation by plan participants in the benefit package makes it impractical for the plan sponsor to continue to offer the benefit package.
* A benefit package is eliminated from a multiemployer plan as agreed upon as part of the collective bargaining process.
* A benefit package is eliminated for any reason and multiple benefit packages covering a significant portion of other employees remain available to the employees being transferred.[[89]](#footnote-89)
* After a plant closing, the employer transfers employees to a new location, eliminating the option offered only at the closed plant, and the employees enroll in another option.[[90]](#footnote-90)

However, there is no bona fide employment-based reason when there are two or more health plan options and a higher priced option is eliminated to save money, if that amendment would have resulted in a loss of grandfather status. For example, a group health plan may offer two benefit packages, a more generous PPO and a less generous HMO. The employer eliminates the PPO due to its high cost and transfers the employees to the HMO. There is no bona fide employment-based reason for this transfer, and the PPO would have lost its grandfathered status if, instead of being eliminated, its terms had been modified to match the terms of the HMO. Thus, the HMO will lose its grandfathered status. This loss of grandfathered status applies to all enrollees in the HMO, including those in the plan before the employees were transferred from the PPO.[[91]](#footnote-91)

151. What happens to a grandfathered plan after a merger or acquisition?

An anti-abuse rule provides that a plan will lose grandfathered status if it engages in a transaction, such as a merger, acquisition, purchase of assets, etc., for the principal purpose of covering new individuals under a grandfathered health plan.[[92]](#footnote-92)

152. If grandfather status is lost, when is that change effective?

The status is lost on the date a prohibited change becomes effective, rather than the date it is adopted. Thus, if a plan amendment is effective at the beginning of the next plan year, the status is lost for that next plan year.[[93]](#footnote-93)

153. What changes to a health plan will result in a loss of grandfather status?

A change to a health plan effective after March 23, 2010 (unless legally binding prior to that date, as discussed above), can result in loss of grandfathered status. The regulations provide detailed rules for determining if design changes cause a loss of grandfather status. However, only specified changes result in loss of grandfather status.

Any of the six changes discussed in the following section can result in loss of grandfathered plan status:

* Violation of Anti-Abuse Rules (described in Q 151)
* Elimination of benefits
* Any increase in Percentage Cost-Sharing
* Increase in Fixed-Amount Cost-Sharing
* Decrease in Rate of Employer (or Employee Organization) Contributions
* Certain changes to Annual Limits

In addition, as discussed after the questions about these impermissible changes, either of the following failures will cause loss of grandfather status:

* Failure to provide the Annual Grandfather Notice to Participants
* Failure to retain Records of the Plan in Effect on March 23, 2010.

Other changes may be made without loss of grandfather status.[[94]](#footnote-94) Thus, a grandfathered plan can adopt one or more of the requirements that apply to nongrandfathered plans, as listed above in Q 140, and discussed in more detail in Part VII, without losing grandfathered status.

154. What is an impermissible elimination of benefits that terminates grandfathered status?

The elimination of all or substantially all benefits to diagnose or treat a particular condition will cause a group health plan or insurance to lose its grandfathered status. For this purpose, elimination of any element necessary to diagnose or treat the condition is considered elimination of all or substantially all of the benefits for that condition.[[95]](#footnote-95) For example, if a plan decides to no longer cover care for a particular condition, e.g., diabetes, cystic fibrosis, or HIV/AIDS, grandfathered status will be lost when that change is effective. Termination will also occur if one of two necessary treatments needed for a condition is deleted, such as elimination of drugs or counseling for a mental disorder when both are required.[[96]](#footnote-96)

It is not clear whether certain changes in prescription drug benefits will result in loss of grandfathered status. For example, before March 23, 2010, a plan covered a specific brand-name drug that is effective for a medical condition. If the plan changes its prescription drug provider and that specific drug is no longer covered, grandfather status may be jeopardized. However, if another drug that treats the condition is available, then arguably there has not been an elimination of the benefits to treat that condition. Similarly, if elimination of one treatment for a condition is made, but another treatment is substituted, that may not terminate grandfather status.

155. What is an increase in percentage cost-sharing (coinsurance) that terminates grandfather status?

Coinsurance requires a patient to pay a fixed percentage of a charge, such as 20 percent of a hospital bill. Grandfathered plans cannot increase this percentage. An increase after March 23, 2010, in participant percentage cost sharing terminates grandfather status for a group health plan.[[97]](#footnote-97) Thus, an increase in the amount that the insured pays for hospitalization from 10 percent to 15 percent causes the plan to lose its grandfathered status.[[98]](#footnote-98)

If a plan has multiple grandfathered options, and the insured’s coinsurance percentage is increased in only one option, the other options remain grandfathered.[[99]](#footnote-99)

If the owner of an individual policy may elect an option to pay reduced premiums in exchange for higher cost sharing, such an election can be made without affecting the individual policy’s grandfather status.[[100]](#footnote-100)

***Example 1*:** A grandfathered plan includes prescription drug benefits with different cost sharing divided into tiers as follows:

* Tier 1 includes generic drugs only;
* Tier 2 includes brand-name drugs with no generic available;
* Tier 3 includes brand-name drugs with a generic available in Tier 1; and
* Tier 4 includes IV chemotherapy drugs.

A drug was previously classified in Tier 2 as a brand-name drug with no generic available. However, a generic alternative for the drug has just been released and is added to the formulary. The plan moves the brand-name drug into Tier 3 and adds the generic to Tier 1. Does this change terminate the plan’s grandfathered status?

No. The increase in the cost sharing for a brand-name drug where it is replaced by a generic drug with the same or less cost sharing does not terminate grandfathered status.[[101]](#footnote-101)

***Example 2*:** A grandfathered plan covers treatment at 80 percent without any precertification requirement. In 2013, the plan is amended so that it will pay for treatment at 70 percent if an out-of-network provider is used unless the individual obtains precertification, but otherwise will pay 80 percent. Does this change terminate grandfather status? This issue has not been addressed as yet.

156. What is an increase in fixed-amount cost-sharing (coinsurance) that terminates grandfather status?

Frequently, plans require patients to pay a fixed dollar amount for doctor’s office visits and other services. Compared with the required payments in effect on March 23, 2010, grandfathered plans will be able to increase those copays by no more than a percentage equal to percentage medical inflation since 2010 plus 15 percent.[[102]](#footnote-102)

Medical inflation is defined by reference to the overall medical care component (OMCC) of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by the Department of Labor.[[103]](#footnote-103) The change in medical inflation is measured from March 2010 by taking the greatest value of the unadjusted medical index of the CPI-U within twelve months of the date the increase is effective and subtracting the March 2010 medical component of the unadjusted CPI-U. The difference is divided by the March 2010 medical care component of the CPI-U (387.142), which is then added to 15 percent.

While the increase in fixed-amount cost sharing is determined as of the effective date of the increase, the OMCC is computed using any month in the twelve months before the new change is to take effect.[[104]](#footnote-104) Thus, if a change became effective on July 15, 2011, this was evaluated on the OMCC using the month between July 2010 and June 2011 with the “greatest value,” not the OMCC for July 2011.[[105]](#footnote-105)

A plan is allowed a 15 percent cumulative increase, measured from March 23, 2010. Thus, smaller increases may be made annually, but the overall limitation over time is 15 percent.[[106]](#footnote-106)

***Example*:** If medical inflation is 4 percent for 2010 and the copay for 2010 is $30, 4 percent plus 15 percent equals 19 percent. The copay cannot increase more than 19 percent or to a maximum of $35 in 2011.

Beginning in 2012, only medical inflation is added, so assuming medical inflation is again 4 percent, then the 2012 percentage allowed is 23 percent (19 percent plus 4 percent) above the 2010 copay for a maximum copay of $37.

157. How do the fixed-amount cost-sharing limitations apply to HRAs paired with HDHPs?

A health reimbursement arrangement (HRA) is an employer-funded medical expense reimbursement plan, reimbursing specified items not paid by insurance. An HRA may allow unused amounts to carry over into future years. An HRA is sometimes paired with an employer-provided high deductible health plan (HDHP) so that HRA amounts can pay medical expenses not covered by the high deductible plan. The employer HRA contributions likely would be viewed as lowering an otherwise applicable deductible, so long as the HRA balance is available for all expenses subject to the deductible. Similarly, if an employer decreased HRA contributions, this could be treated as an increase in the deductible and subject to the 15 percent limit.

158. How much can a fixed-amount cost-sharing (coinsurance) payment be increased without losing grandfather status?

Some plans have a feature with a fixed-amount cost-sharing requirement, such as a deductible or an out-of-pocket limit, which is based on a percentage-of-compensation. This cost-sharing arrangement will not cause the plan or coverage to cease to be a grandfathered health plan so long as the formula for determining an out-of-pocket limit remains the same as on March 23, 2010.[[107]](#footnote-107) Thus, even if an employee’s compensation increases and the employee faces a higher out-of-pocket limit as a result, that change will not cause the plan to relinquish grandfather status.

Any increase after March 23, 2010, in fixed-amount co-payments above the greater of:

* $5, increased by medical inflation; or
* 15 percent above medical inflation,

will cause a group health plan or insurer to lose its grandfathered status.[[108]](#footnote-108) This limit applies even to copayments that are for a single category of service.[[109]](#footnote-109)

***Example*:** On March 23, 2010, a grandfathered health plan has a copayment of $30 per office visit for specialists. The plan is later amended to increase the copay requirement to $40. Within the twelve-month period before the $40 copay takes effect, the greatest value of the OMCC is 475. The percentage increase in the copayment from $30 to $40 is 33.33 percent.

40 - 30 = 10

10 / 30 = 0.3333 or 33.33 percent

Medical inflation from March 2010 is 0.2269, calculated as follows:

(475 - 387.142 = 87.858

87.858 ¸ 387.142 = 0.2269 or 22.69 percent

The maximum percentage increase permitted is 37.69 percent, calculated as follows:

22.69 percent + 15 percent = 37.69 percent

Because 33.33 percent does not exceed 37.69 percent, the change in the copayment does not cause the plan to cease to be a grandfathered health plan.[[110]](#footnote-110)

159. Are there special rules for value-based insurance design (VBID) copayments?

Yes. A copayment may be imposed for an inpatient treatment for preventive services as a part of value-based insurance design, when there is:

* no increase in copayment for the outpatient treatment for the same condition, and
* a waiver process allowing a waiver of the new hospital inpatient copayment for individuals for whom the outpatient services are medically inappropriate.

***Example 1*:** One healthcare reform FAQ addressed the interaction of value-based insurance design (VBID) and the no cost-sharing preventive care services requirements.[[111]](#footnote-111) In that example, a group health plan did not impose a copayment for colorectal cancer preventive services when performed in an in-network ambulatory surgery center. However, the same preventive service provided at an in-network outpatient hospital setting generally required a $250 copayment, although the copayment was waived for individuals for whom it would be medically inappropriate to have the preventive service provided in the ambulatory setting. The FAQ indicated that this VBID did not cause the plan to fail to comply with the no cost-sharing preventive care requirements.

***Example 2*:** Under another group health plan, since March 23, 2010, similar preventive services are available both at an in-network ambulatory surgery center and at an in-network outpatient hospital setting without a copayment in either setting. If this plan wished to adopt the VBID approach described in Example 1 by imposing a $250 copayment for these preventive services only when performed in the in-network outpatient hospital setting (i.e., not an in-network ambulatory surgery center), and with the same waiver of the copayment for any individuals for whom it would be medically inappropriate to have these preventive services provided in the ambulatory setting, would implementation of that new design now cause the plan to relinquish grandfather status?

No. This increase in the copayment for these preventive services solely in the in-network outpatient hospital setting (subject to the waiver arrangement described above) without any change in the copayment in the in-network ambulatory surgery center setting would not be considered to exceed the thresholds described in the interim final regulations on grandfather status and thus would not cause the plan to relinquish grandfather status.

160. When will a decrease in the rate of plan sponsor contributions terminate grandfather status?

More Than 5 Percentage Point Decrease in Plan Sponsor Contributions. A grandfathered plan will lose its grandfather status if the employer or an employee organization, such as a union, decreases its contribution rate (whether based on a formula or on cost of coverage) for any tier of similarly situated individuals by more than 5 percent below the contribution rate on March 23, 2010.[[112]](#footnote-112) The regulations indicate that a change from, for instance, 90 percent to 85 percent is permitted, because that is a 5 percent reduction, even though the actual number is 4.5 percent (.90 X .05 = 0.45).

For a self-insured plan, the cost of coverage is determined by using the COBRA rate of coverage.[[113]](#footnote-113) Contributions by an employer or employee organization to a self-insured plan are equal to the total cost of coverage minus the employee contributions toward the total cost of coverage.[[114]](#footnote-114) Employee salary reduction deferrals through a cafeteria or premium conversion plan are treated as employee contributions for this purpose.[[115]](#footnote-115)

***Example*** *– S****elf-Insured Plan COBRA Cost of Coverage*:** On March 23, 2010, a self-insured grandfathered health plan has a COBRA premium for the 2010 plan year of $5,000 for self-only coverage and $12,000 for family coverage. The required employee contribution for the coverage is $1,000 for self-only coverage and $4,000 for family coverage. Thus, the contribution rate based on cost of coverage for 2010 is 80 percent for self-only coverage, calculated as follows:

5,000 - 1,000 = 4,000

4,000/5,000 =80 percent

The contribution rate based on cost of coverage for 2010 is 67 percent for family coverage calculated as follows:

12,000 - 4,000 = 8,000

8,000/12,000 = 67 percent

For a subsequent plan year, the COBRA premium is $6,000 for self-only coverage and $15,000 for family coverage. The employee contributions for that plan year are $1,200 for self-only coverage and $5,000 for family coverage. The contribution rate based on cost of coverage remains 80 percent for self-only coverage calculated as follows:

6,000 – 1,200 = 4,800

4,800/6,000 = 80 percent

The contribution rate based on cost of coverage remains 67 percent for family coverage, calculated as follows:

15,000 – 5,000 = 10,000

(10,000/15,000) = 67 percent

There is no change in the employer’s contribution rate based on the COBRA cost of coverage. Therefore, the plan retains its status as a grandfathered health plan.[[116]](#footnote-116)

161. How is this more than 5 percent reduction test applied if there are multiple health packages offered by the plan sponsor?

The test for loss of grandfather status is applied separately to each health package offered by the plan sponsor. It is possible for one package to lose its grandfathering and the others to remain grandfathered.[[117]](#footnote-117)

***Example – Multiple Packages (Options)*:** ABC, Inc. maintains a group health plan that is not maintained pursuant to a collective bargaining agreement. It offered three benefit packages on March 23, 2010. Option F is a self-insured option. Options G and H are insured options. Beginning July 1, 2013, the plan increases employee coinsurance under Option H from 10 percent to 15 percent, which is a reduction in the employer contribution of 5.56 percent. The coverage under Option H loses its grandfather status on the effective date of this change, July 1, 2013. Assuming no other changes to options F and G, they remain grandfathered.[[118]](#footnote-118)

162. What if the employer plan offers several tiers of coverage, such as employee, employee and spouse, and employee and family?

The standards for employer contributions apply on a tier-by-tier basis. The results differ depending on whether tiers are modified or a new tier is added. If a plan modifies its tiers of coverage, such as by changing employee and family to employee, employee and spouse, and employee and family, the employer contribution for any new tier would be tested by comparison to the contribution rate for the corresponding tier on March 23, 2010.[[119]](#footnote-119) All of the tiers for a benefit package must pass the 5 percent test to remain grandfathered.

On the other hand, if the plan merely adds a new tier and does not reduce the sponsor contribution percentage to the existing tier by more than 5 percent, then the existing tier remains grandfathered. The new tier not in existence on March 23, 2010, is not grandfathered, regardless of the contribution rate for the new tier.

***Example – One Coverage Option; Several Tiers (Combinations) of Insureds*:** Prior to March 23, 2010, ABC, Inc. contributed 80 percent of the cost of single and family coverage. Due to premium increases, ABC, Inc. reduces its payment for family coverage from 80 percent to 50 percent, a reduction of 30 percent. The employer payment for single coverage remains at 80 percent. This reduction in employer payments for family coverage is more than 5 percent and causes the entire plan to lose grandfather status.[[120]](#footnote-120)

If ABC, Inc. alters its options to employee coverage, employee-plus-spouse coverage, and family coverage, and the employer payment for any category is less than 75 percent, the grandfather status would be lost.

163. How do the grandfathered plan rules relate to wellness programs?

The final wellness plan rules[[121]](#footnote-121) apply to both grandfathered and nongrandfathered plans. An employer can add a wellness program without losing grandfathered status, but needs to take care to make sure it maintains employer contributions and benefits at the needed levels. Grandfathered plans may continue to provide wellness incentives through, for instance, premium discounts or additional benefits to reward healthy behaviors. But penalties (e.g., increasing the surcharge on premiums for smokers) may implicate the types of changes that defeat grandfather status and may violate other nondiscrimination rules, so they should be implemented carefully.[[122]](#footnote-122)

164. How do plan sponsor fixed dollar amount contributions work for grandfathered plans?

If an employer’s contribution toward the cost of coverage for retirees that is covered by the law is not an excepted benefit (because active employees participate in the same plan) and is a fixed dollar amount multiplied by years of service, subject to a flat dollar cap per retiree, how is the 5 percent threshold for decreases in the rate of employer contributions calculated?

The 5 percent threshold for decreases in employer contributions is not violated so long as the formula for calculating the employer’s contribution remains the same.[[123]](#footnote-123)

165. How do insurers know if the 5 percent sponsor contribution reduction test has been violated?

If insurers follow certain requirements, a plan is treated as a grandfathered plan until the first date the insurer knows that the employer has decreased its contribution rate by more than five percent or until grandfathering is lost for another reason. The steps are as follows:

* Upon renewal, the insurer must require the plan sponsor to make a representation regarding its contribution rate for the plan year covered by the renewal, as well as its contribution rate on March 23, 2010 (if the issuer does not already have it); and
* The issuer’s policies, certificates, or contracts of insurance must disclose in a prominent and effective manner that plan sponsors are required to notify the issuer if the contribution rate changes at any point during the plan year.[[124]](#footnote-124)

An insurer may request additional advance notice of a decrease in contribution rate.[[125]](#footnote-125) The impact of this rule is to avoid penalties that might be imposed, for example, if the plan thought to be grandfathered in fact is not and does not adhere to the new nondiscrimination rules for insured plans.

166. How does the 5 percent reduction rule work for collectively bargained plans?

Multiemployer plans and contributing employers will be provided the same relief as insurers if they follow steps similar to those provided for insurers, described in Q 165. In addition, a decrease in an employer’s rate of contribution does not necessarily mean that the employee’s rate has increased. If there has been no increase in the employee contribution rate, an employer’s decrease will not, in itself, cause a plan to lose its grandfathered status.[[126]](#footnote-126)

167. What if a grandfathered plan imposes an annual or lifetime limit on benefits, or increases an existing limit?

Plans that do not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit, as this change benefits participants. However, the regulations prohibit three other changes regarding annual or lifetime limits:

* A grandfathered plan that did not impose an overall annual or lifetime limit on the value of all benefits on March 23, 2010, will lose its grandfathered status if it imposes an annual limit.[[127]](#footnote-127)
* A plan that had an overall lifetime limit on the value of all benefits but no overall annual limit will lose its grandfathered status if it imposes an overall annual limit on the value of all benefits that is lower than the lifetime limit in place on March 23, 2010.[[128]](#footnote-128)
* For plans with an overall annual limit on the value of all benefits on March 23, 2010, grandfathering is lost if that annual limit is lowered, regardless of whether the plan had a lifetime limit).[[129]](#footnote-129)

The regulations address an “overall limit on the value of all benefits.” It is unclear whether a limit on nonessential benefits would violate this requirement.

168. What is the notice required for grandfathered plans?

The statute (PPACA §1251) has no provision requiring a notice by the plan or the employer or other entity sponsoring the health plan. The regulations (unless they are changed when issued in final form) do impose a notice requirement that is not well known, which in effect could negate the law for most employers and eliminate grandfathered plans for all but that handful of employers who have sophisticated, specialized healthcare reform legal and benefits advisors and were aware of and in fact issued the grandfathered plan notice each year.

The loss of this important statutory provision far outweighs the Department of Labor “goal that the notice encourages plan sponsors and issuers to identify other communications in which disclosure of grandfather status would be appropriate and consistent with the goal of providing participants and beneficiaries information necessary to understand and make informed choices regarding health coverage.”

The regulations issued in 2010 in proposed form[[130]](#footnote-130) require notices to plan participants beginning in the fall of 2010. Failing to distribute the required grandfathered notice will cause a plan to lose its grandfathered status. A plan that intends to maintain grandfathered status must provide, in any plan materials describing benefits for participants or beneficiaries:

1. A statement that the plan or coverage is believed to be a grandfathered plan and

2. Contact information for questions or complaints.

A plan or individual grandfathered policy must provide, in any plan materials describing benefits for participants or beneficiaries, (a) a statement that the plan or coverage is believed to be a grandfathered plan, and (b) contact information for questions or complaints. To maintain grandfather status,[[131]](#footnote-131) group health plans should assume that this requirement applies to enrollment materials, summary plan descriptions, summary of material modifications to an SPD, and perhaps when the SBC (Summary of Benefits & Coverage) is distributed. A grandfathered plan need not provide a disclosure statement regarding its grandfather status every time it sends out a communication, such as an explanation of benefits to participants.[[132]](#footnote-132)

It is not clear when this notice requirement applies. There are a number of possibilities: the first plan year on or after March 23, 2010, or perhaps for the first plan year beginning after June 17, 2010, when the regulations were published in the federal register, or preferably after the regulations are finalized. The latter seems most fair because the law[[133]](#footnote-133) requires no notice of grandfathering and likely most US employers have no knowledge of this notice requirement. Additionally, a plan sponsor may not make the decision on grandfathering until well after March 23, 2010, and perhaps not until subsequent years.

**However, the statute has no notice requirement.**

**PPACA Sec. 1251, Preservation of Right to Maintain Existing Coverage, provides as follows:**

(a) No Changes to Existing Coverage—

(1) In general. Nothing in this Act (or an amendment made by this Act) shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled on the date of enactment of this Act.

(2) CONTINUATION OF COVERAGE. With respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act, this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply to such plan or coverage, regardless of whether the individual renews such coverage after such date of enactment.

(b) Allowance for Family Members to Join Current Coverage. With respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act and which is renewed after such date, family members of such individual shall be permitted to enroll in such plan or coverage if such enrollment is permitted under the terms of the plan in effect as of such date of enactment.

(c) Allowance for New Employees to Join Current Plan. A group health plan that provides coverage on the date of enactment of this Act may provide for the enrolling of new employees (and their families) in such plan, and this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply with respect to such plan and such new employees (and their families).

(d) Effect on Collective Bargaining Agreements. In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before the date of enactment of this Act, the provisions of this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage which amends the coverage solely to conform to any requirement added by this subtitle or subtitle A (or amendments) shall not be treated as a termination of such collective bargaining agreement.

(e) Definition. In this title, the term 'grandfathered health plan' means any group health plan or health insurance coverage to which this section applies.

169. What are the recordkeeping requirements for grandfathered plans?

The plan and coverage terms in effect on March 23, 2010, must be documented. [[134]](#footnote-134) Such documentation, plus any additional documentation needed to verify, explain, or clarify grandfathered health plan status must be retained for so long as the plan or coverage takes the position that it is a grandfathered plan.[[135]](#footnote-135) Such documentation may include intervening and current plan documents, health insurance policies, certificate or contracts of insurance, SPDs, and other cost and cost-sharing documentation.[[136]](#footnote-136)

In addition, the plan or coverage must make those records available for examination upon request.[[137]](#footnote-137) The regulations indicate that a participant, beneficiary, individual policy subscriber, or state or federal agency official may inspect the grandfathered plan documentation.[[138]](#footnote-138)

1. . PHSA §§2701, 2702, 2703, 2705, 2706, 2707, 2709, 2713, 2715A, 2716, 2717, 2719, and 2719A. See also Treas. Reg. §54.9815-1251T(c)(1); DOL Reg. §2590.715-1251(c)(1); HHS Reg. §147.140(c)(1). [↑](#footnote-ref-1)
2. . Treas. Reg. §54.9815-1251T(a)(4). [↑](#footnote-ref-2)
3. . Treas. Reg. §54.9815-1251T(b). [↑](#footnote-ref-3)
4. . Treas. Reg. §54.9815-1251T(g)(2)(i); DOL Reg. §2590.715-1251(g)(2)(i); HHS Reg. §147.140(g)(2)(i). [↑](#footnote-ref-4)
5. . Treas. Reg. §54.9815-1251T(g)(2)(ii); DOL Reg. §2590.715-1251(g)(2)(ii); HHS Reg. §147.140(g)(2)(ii). [↑](#footnote-ref-5)
6. See CMS memo at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf> and <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-03-05-2.html>. [↑](#footnote-ref-6)
7. See CMS letter at <http://www.healthlawyers.org/News/Health%20Lawyers%20Weekly/Documents/111513/commissioner-letter-11-14-2013.PDF>. [↑](#footnote-ref-7)
8. Chart from Commonwealth Fund at <http://www.commonwealthfund.org/Blog/2013/Nov/State-Decisions-on-Policy-Cancellations-Fix.aspx>. [↑](#footnote-ref-8)
9. See CMS memo at <http://www.healthlawyers.org/News/Health%20Lawyers%20Weekly/Documents/122013/cancellation-consumer-options-12-19-2013.pdf> [↑](#footnote-ref-9)
10. . See http://www.dol.gov/ebsa/pdf/part7-2.pdf. [↑](#footnote-ref-10)
11. . See http://www.dol.gov/ebsa/pdf/part7-2.pdf. [↑](#footnote-ref-11)
12. . See 29 CFR 2590.715-1251(a)(1)(i). [↑](#footnote-ref-12)
13. . See 29 CFR 2590.715-1251(g)(2). [↑](#footnote-ref-13)
14. . See 29 CFR 2590.715-1251(a)(1)(i). [↑](#footnote-ref-14)
15. . See 29 CFR 2590.715-1251(a)(1)(i). [↑](#footnote-ref-15)
16. . See 29 CFR 2590.715- 1251(g)(1)(i). [↑](#footnote-ref-16)
17. . See 29 CFR 2590.715-1251(g)(1)(ii). [↑](#footnote-ref-17)
18. . See 29 CFR 2590.715-1251(g)(3)(ii). [↑](#footnote-ref-18)
19. . See 29 CFR 2590.715-1251(g)(3)(i). [↑](#footnote-ref-19)
20. . See 29 CFR 2590.715-1251(g)(3)(ii). [↑](#footnote-ref-20)
21. . See 29 CFR 2590.715-1251(g)(3)(i). [↑](#footnote-ref-21)
22. . See 29 CFR 2590.715-1251(g)(1)(v)(B). [↑](#footnote-ref-22)
23. . See DOL FAQs About the Affordable Care Act Implementation Part II, question 3 at http://www.dol.gov/ebsa/faqs/faq-aca2.html. [↑](#footnote-ref-23)
24. . See DOL FAQs About the Affordable Care Act Implementation Part I, question 4 at http://www.dol.gov/ebsa/faqs/faqaca.html. [↑](#footnote-ref-24)
25. . See 29 CFR 2590.715-1251(g)(1)(vi)(A). [↑](#footnote-ref-25)
26. . See 29 CFR 2590.715-1251(g)(1)(vi)(B). [↑](#footnote-ref-26)
27. . See 29 CFR 2590.715-1251(g)(1)(vi)(C)). [↑](#footnote-ref-27)
28. . See 29 CFR 2590.715-1251(a)(1)(ii), as amended. [↑](#footnote-ref-28)
29. . See 29 CFR 2590.715-1251(f) for collectively bargained plans. [↑](#footnote-ref-29)
30. . See 29 CFR 2590.715-1251(a)(1)(ii), as amended. [↑](#footnote-ref-30)
31. . See 29 CFR 2590.715-1251(a)(3)(ii), as amended. [↑](#footnote-ref-31)
32. . See 29 CFR 2590.715-1251(a)(2). [↑](#footnote-ref-32)
33. . See 29 CFR 2590.715-1251(a)(3)(i)(A) & (i)(B), as amended. [↑](#footnote-ref-33)
34. . PHSA §2704(a), IRC Sec. 9815 & ERISA Sec. 715. [↑](#footnote-ref-34)
35. . PHSA §2708. [↑](#footnote-ref-35)
36. . PHSA §2711. [↑](#footnote-ref-36)
37. . Treas. Reg. §54.9815-2711T(b)(1); DOL Reg. §2590.715-2711(b)(1); HHS Reg. §147.126(b)(2). [↑](#footnote-ref-37)
38. . Treas. Reg. §54.9815-2711T(b)(2); DOL Reg. §2590.715-2711(b)(2); HHS Reg. §147.126(b)(2). [↑](#footnote-ref-38)
39. . PHSA §2712. [↑](#footnote-ref-39)
40. . PHSA §2714. [↑](#footnote-ref-40)
41. . PHSA §2715. [↑](#footnote-ref-41)
42. . PHSA §2718. [↑](#footnote-ref-42)
43. . PHSA §2701. [↑](#footnote-ref-43)
44. . PHSA §2701(a)(1)(A). [↑](#footnote-ref-44)
45. . PHSA §2702. [↑](#footnote-ref-45)
46. . PPACA renumbered PHSA §2711as PHSA §2731; PPACA §1105 included new PHSA §2702(a); and PPACA §1563(c)(8) made changes to PHSA §2731 and renumbered it as PHSA §2702. [↑](#footnote-ref-46)
47. . PHSA §2702(b). [↑](#footnote-ref-47)
48. . PHSA §2703. [↑](#footnote-ref-48)
49. . Health status factors are health status; medical condition (including both physical and mental illnesses); claims experience; receipt of health care; medical history; genetic information; evidence of insurability (EOI) (including conditions arising out of acts of domestic violence); disability; and any other health status-related factor determined appropriate by the Secretary of HHS. IRC Sec. 9802(a)(1); ERISA Sec. 702(a)(1); PHSA §2705(a). The last category was added by health reform. PHSA §2705(a). [↑](#footnote-ref-49)
50. . PHSA §2705. [↑](#footnote-ref-50)
51. . PHSA §2706. [↑](#footnote-ref-51)
52. . PHSA §2707(a). [↑](#footnote-ref-52)
53. . PPACA §1302(b). [↑](#footnote-ref-53)
54. . PPACA §1302(c). [↑](#footnote-ref-54)
55. . PPACA §1302(e). [↑](#footnote-ref-55)
56. . PHSA §2707(c). [↑](#footnote-ref-56)
57. . PHSA §2709. [↑](#footnote-ref-57)
58. . PHSA §2713. [↑](#footnote-ref-58)
59. . PHSA §2715A. [↑](#footnote-ref-59)
60. . PHSA §2716, IRC Sec. 9815 & ERISA Sec. 715. [↑](#footnote-ref-60)
61. . PHSA §2717. [↑](#footnote-ref-61)
62. . DOL Reg. §2590.715-2719(b)(2). [↑](#footnote-ref-62)
63. . DOL Reg. §2590.715-2719(a). [↑](#footnote-ref-63)
64. . PHSA §2719. [↑](#footnote-ref-64)
65. . DOL Technical Release 2011-02. [↑](#footnote-ref-65)
66. . PHSA §2719A. [↑](#footnote-ref-66)
67. . Treas. Reg. §54.9815-2719AT(b)(3)(i); DOL Reg. §2590.715-2719A(b)(3)(i); HHS Reg. §147.138(b)(3)(i). [↑](#footnote-ref-67)
68. . Preamble to Grandfathered Health Plan Regulations, 75 Fed. Reg. 34537 (June 17, 2010); FAQs About the Affordable Care Act Implementation Part II, Q/A-1, available at http://www.dol.gov/ebsa/faqs/faq-aca2.html. [↑](#footnote-ref-68)
69. . Preamble to Grandfathered Health Plan Regulations, 75 Fed. Reg. 34537 (June 17, 2010). [↑](#footnote-ref-69)
70. . Interim Final Treas. Reg. §54.9815-1251T(a)(1)(i) (Mar. 2010); DOL Reg. §2590.715-1251(a)(1)(i) (Mar. 2010); HHS Reg. §147.140(a)(1)(i) (Mar. 2010). [↑](#footnote-ref-70)
71. . Treas. Reg. §54.9815-1251T(a)(1)(i); DOL Reg. §2590.715-1251(a)(1)(i); HHS Reg. §147.140(a)(1)(i). [↑](#footnote-ref-71)
72. . Preamble to the Amendment to the Grandfathered Health Plan Regulations, 75 Fed. Reg. 70114, 70116 (November 17, 2010). [↑](#footnote-ref-72)
73. . Preamble to the Amendment to the Grandfathered Health Plan Regulations, 75 Fed. Reg. 70114, 70116 (November 17, 2010). [↑](#footnote-ref-73)
74. . Preamble to the Amendment to the Grandfathered Health Plan Regulations, 75 Fed. Reg. 70114, 70116 (November 17, 2010). [↑](#footnote-ref-74)
75. . Treas. Reg. §54.9815-1251T(a)(3)(ii); DOL Reg. §2590.715-1251(a)(3)(ii); HHS Reg. §147.140(a)(3)(ii). [↑](#footnote-ref-75)
76. . Treas. Reg. §54.9815-1251T(a)(1)(ii); DOL Reg. §2590.715-1251(a)(1)(ii); HHS Reg. §147.140(a)(1)(ii). [↑](#footnote-ref-76)
77. . Preamble to Grandfathered Health Plan Regulations, 75 Fed. Reg. 34537 (June 17, 2010). [↑](#footnote-ref-77)
78. . Nonbinding comments of Amy Turner, Senior Health Law Specialist, Office of Health Plan Standards and Compliance Assistance of the DOL, Department of Labor Affordable Care Act Compliance Assistance Webcast (September 7, 2010). [↑](#footnote-ref-78)
79. . Treas. Reg. §54.9815-1251T(a)(1)(i); DOL Reg. §2590.715-1251(a)(1)(i); HHS Reg. §147.140(a)(1)(i). [↑](#footnote-ref-79)
80. . Treas. Reg. §54.9815-1251T(f)(1); DOL Reg. §2590.715-1251(f)(1); HHS Reg. §147.140(f)(1). [↑](#footnote-ref-80)
81. . Treas. Reg. §54.9815-1251T(f)(1); DOL Reg. §2590.715-1251(f)(1); HHS Reg. §147.140(f)(1); Preamble to Grandfathered Health Plan Regulations, 75 Fed. Reg. 34537 (June 17, 2010). [↑](#footnote-ref-81)
82. . Preamble to Grandfathered Health Plan Regulations, 75 Fed. Reg. 34537 (June 17, 2010). [↑](#footnote-ref-82)
83. . Treas. Reg. §54.9815-1251T(f)(1); DOL Reg. §2590.715-1251(f)(1); HHS Reg. §147.140(f)(1). [↑](#footnote-ref-83)
84. . Treas. Reg. §54.9815-1251T(a)(4); DOL Reg. §2590.715-1251(a)(4); HHS Reg. §147.140(a)(4). [↑](#footnote-ref-84)
85. . Treas. Reg. §54.9815-1251T(b)(1); DOL Reg. §2590.715-1251(b)(1); HHS Reg. §147.140(b)(1). [↑](#footnote-ref-85)
86. . Treas. Reg. §54.9815-1251T(b)(3), Example 1; DOL Reg. §2590.715-1251(b)(3), Example 1; HHS Reg. §147.140(b)(3), Example 1. [↑](#footnote-ref-86)
87. . Treas. Reg. §54.9815-1251T(b)(3), Example 1; DOL Reg. §2590.715-1251(b)(3), Example 1; HHS Reg. §147.140(b)(3), Example 1. [↑](#footnote-ref-87)
88. . Treas. Reg. §54.9815-1251T(b)(2)(ii); DOL Reg. §2590.715-1251(b)(2)(ii); HHS Reg. §147.140(b)(2)(ii). [↑](#footnote-ref-88)
89. . HHS, DOL, and the Treasury, Frequently Asked Questions (FAQs), Part VI (April 2011 ) at http://www.dol.gov/ebsa/faqs/faq-aca6.html. [↑](#footnote-ref-89)
90. . Treas. Reg. §54.9815-1251T(b)(3), Example 3; DOL Reg. §2590.715-1251(b)(3), Example 3; HHS Reg. §147.140(b)(3), Example 3. [↑](#footnote-ref-90)
91. . Treas. Reg. §54.9815-1251T(b)(3), Example 2; DOL Reg. §2590.715-1251(b)(3), Example 2; HHS Reg. §147.140(b)(3), Example 2. [↑](#footnote-ref-91)
92. . Treas. Reg. §54.9815-1251T(b)(2)(i); DOL Reg. §2590.715-1251(b)(2)(i); HHS Reg. §147.140(b)(2)(i). [↑](#footnote-ref-92)
93. . HHS, DOL & Treasury, FAQs About the Affordable Care Act Implementation Part VI (April 2011) at http://www.dol.gov/ebsa/faqs/faqaca6.html .(as visited Oct. 14, 2011). [↑](#footnote-ref-93)
94. . Preamble to Grandfathered Health Plan Regulations, 75 Fed. Reg. 34537 (June 17, 2010). [↑](#footnote-ref-94)
95. . Treas. Reg. §54.9815-1251T(g)(1)(i); DOL Reg. §2590.715-1251(g)(1)(i); HHS Reg. §147.140(g)(1)(i). [↑](#footnote-ref-95)
96. . Treas. Reg. §54.9815-1251T(g)(4), Example 2; DOL Reg. §2590.715-1251(g)(4), Example 2; HHS Reg. §147.140(g)(4), Example 2. [↑](#footnote-ref-96)
97. . Treas. Reg. §54.9815-1251T(g)(1)(ii); DOL Reg. §2590.715-1251(g)(1)(ii); HHS Reg. §147.140(g)(1)(ii). [↑](#footnote-ref-97)
98. . Treas. Reg. §54.9815-1251T(g)(4), Example 1; DOL Reg. §2590.715-1251(g)(4), Example 1; HHS Reg. §147.140(g)(4), Example 1. [↑](#footnote-ref-98)
99. . Treas. Reg. §54.9815-1251T(g)(4), Example 9; DOL Reg. §2590.715-1251(g)(4), Example 9; HHS Reg. §147.140(g)(4), Example 9. [↑](#footnote-ref-99)
100. . HHS, DOL & Treasury FAQs About the Affordable Care Act Implementation Part IV, Q/A-2 at http://www.dol.gov/ebsa/faqs/faq-aca4.html. [↑](#footnote-ref-100)
101. . HHS, DOL & Treasury, FAQs About the Affordable Care Act Implementation Part VI, Q/A-2, at http://www.dol.gov/ebsa/faqs/faq-aca6.html. [↑](#footnote-ref-101)
102. . Treas. Reg. §54.9815-1251T(g)(1)(iv); Treas. Reg. §54.9815-1251T(g)(1)(iii); DOL Reg. §2590.715-1251(g)(1)(iii); HHS Reg. §147.140(g)(1)(iii). [↑](#footnote-ref-102)
103. . Treas. Reg. §54.9815-1251T(g)(3)(i); DOL Reg. §2590.715-1251(g)(3)(i); HHS Reg. §147.140(g)(3)(i). [↑](#footnote-ref-103)
104. . Treas. Reg. §54.9815-1251T(g)(3)(i); DOL Reg. §2590.715-1251(g)(3)(i); HHS Reg. §147.140(g)(3)(i). [↑](#footnote-ref-104)
105. . Treas. Reg. §§54.9815-1251T(g)(3)(i) and (g)(4), Example (3); DOL Reg. §§2590.715-1251(g)(3)(i) and (g)(4), Example (3); HHS Reg. §§147.140(g)(3)(i) and (g)(4), Example (3). [↑](#footnote-ref-105)
106. . Nonbinding comments of Amy Turner, Senior Health Law Specialist, Office of Health Plan Standards and Compliance Assistance of the DOL, Department of Labor Affordable Care Act Compliance Assistance Webcast (September 7, 2010) at http://www.dol.gov/ebsa/newsroom/webcasts.html. [↑](#footnote-ref-106)
107. . HHS, DOL & TREASURY FAQs About the Affordable Care Act Implementation Part V, Q/A-7 at http://www.dol.gov/ebsa/faqs/faq-aca5.html. [↑](#footnote-ref-107)
108. . Treas. Reg. §54.9815-1251T(g)(1)(iv); DOL Reg. §2590.715-1251(g)(1)(iv); HHS Reg. §147.140(g)(1)(iv). [↑](#footnote-ref-108)
109. . HHS, DOL & TREASURY FAQs About the Affordable Care Act Implementation, Part II, Q/A-4, at http://www.dol.gov/ebsa/faqs/faq-aca2.html. [↑](#footnote-ref-109)
110. . Treas. Reg. §54.9815-1251T (g)(4), Example (3); DOL Reg. §2590.715-1251(g)(4), Example (3); HHS Reg. §147.140(g)(4), Example (3). [↑](#footnote-ref-110)
111. . HHS, DOL & TREASURY FAQs About Affordable Care Act Implementation, Part V Q/A 1 at http://www.dol.gov/ebsa/faqs/faq-aca5.html. [↑](#footnote-ref-111)
112. . Treas. Reg. §54.9815-1251T(g)(1)(v); DOL Reg. §2590.715-1251(g)(1)(v); HHS Reg. §147.140(g)(1)(v). [↑](#footnote-ref-112)
113. . Treas. Reg. §54.9815-1251T(g)(3)(iii)(A); DOL Reg. §2590.715-1251(g)(3)(iii)(A); HHS Reg. §147.140(g)(3)(iii)(A). [↑](#footnote-ref-113)
114. . Treas. Reg. §54.9815-1251T(g)(3)(iii)(A); DOL Reg. §2590.715-1251(g)(3)(iii)(A); HHS Reg. §147.140(g)(3)(iii)(A). [↑](#footnote-ref-114)
115. . Treas. Reg. §54.9815-1251T(g)(4), Example (8); DOL Reg. §2590.715-1251(g)(4), Example (8); HHS Reg. §147.140(g)(4), Example (8). [↑](#footnote-ref-115)
116. . Treas. Reg. §54.9815-1251T(g)(4), Example (8); DOL Reg. §2590.715-1251(g)(4), Example (8); HHS Reg. §147.140(g)(4), Example (8). [↑](#footnote-ref-116)
117. . HHS, DOL & TREASURY, FAQs About the Affordable Care Act Implementation Part II, Q/A 2 at http://www.dol.gov/ebsa/faqs/faq-aca2.html. [↑](#footnote-ref-117)
118. . Treas. Reg. §54.9815-1251T(g)(4), Example (9); DOL Reg. §2590.715-1251(g)(4), Example (9); HHS Reg. §147.140(g)(4), Example (9); HHS, DOL & TREASURY, FAQs About the Affordable Care Act Implementation Part II, Q/A-2 at http://www.dol.gov/ebsa/faqs/faq-aca2.html. [↑](#footnote-ref-118)
119. . HHS, DOL & TREASURY, FAQs About the Affordable Care Act Implementation Part II, Q/A-3 at http://www.dol.gov/ebsa/faqs/faq-aca2.html. [↑](#footnote-ref-119)
120. . Treas. Reg. §54.9815-1251T(g)(4), Example (7); DOL Reg. §2590.715-1251(g)(4), Example (7); HHS Reg. §147.140(g)(4), Example (7). [↑](#footnote-ref-120)
121. Incentives for Nondiscriminatory Wellness Programs in Group Health Plans , 26 CFR Part 54, 29 CFR Part 2590, 45 CFR Parts 146 and 147, 78 Fed. Reg. 33158 (June 3, 2013). [↑](#footnote-ref-121)
122. See FAQs About the Affordable Care Act Implementation Part II, Q/A-5 at <http://www.dol.gov/ebsa/faqs/faq-aca2.html>. [↑](#footnote-ref-122)
123. . See HHS, DOL & TREASURY, FAQs About the Affordable Care Act Implementation Part VI, Q/A-6 at http://www.dol.gov/ebsa/faqs/faq-aca6.html. [↑](#footnote-ref-123)
124. . HHS, DOL & TREASURY, FAQs About the Affordable Care Act Implementation Part I, Q/A-2 at http://www.dol.gov/ebsa/faqs/faq-aca.html. [↑](#footnote-ref-124)
125. . HHS, DOL & TREASURY, FAQs About the Affordable Care Act Implementation Part I, Q/A-2 at http://www.dol.gov/ebsa/faqs/faq-aca.html. [↑](#footnote-ref-125)
126. . HHS, DOL & TREASURY, FAQs About the Affordable Care Act Implementation Part I, Q/A-4, available at http://www.dol.gov/ebsa/faqs/faq-aca.html, stating: “If multiemployer plans and contributing employers follow steps similar to those outlined in Q/A-2 [for insurers], above, the same relief will apply to the multiemployer plan unless or until the multiemployer plan knows that the contribution rate has changed.” [↑](#footnote-ref-126)
127. . Treas. Reg. §54.9815-1251T(g)(1)(vi)(A); DOL Reg. §2590.715-1251(g)(1)(vi)(A); HHS Reg. §147.140(g)(1)(vi)(A). [↑](#footnote-ref-127)
128. . Treas. Reg. §54.9815-1251T(g)(1)(vi)(B); DOL Reg. §2590.715-1251(g)(1)(vi)(B); HHS Reg. §147.140(g)(1)(vi)(B). [↑](#footnote-ref-128)
129. . Treas. Reg. §54.9815-1251T(g)(1)(vi)(C); DOL Reg. §2590.715-1251(g)(1)(vi)(C); HHS Reg. §147.140(g)(1)(vi)(C). [↑](#footnote-ref-129)
130. . Treas. Reg. §54.9815-1251T(c)(1); DOL Reg. §2590.715-1251(c)(1); HHS Reg. §147.140(c)(1). [↑](#footnote-ref-130)
131. . Treas. Reg. §54.9815-1251T(a)(2)(i); DOL Reg. §2590.715-1251(a)(2)(i); HHS Reg. §147.140(a)(2)(i). [↑](#footnote-ref-131)
132. . HHS, DOL & TREASURY, FAQs About the Affordable Care Act Implementation Part IV, Q/A-1, available at http://www.dol.gov/ebsa/faqs/faq-aca4.htm. [↑](#footnote-ref-132)
133. . PPACA §1251. [↑](#footnote-ref-133)
134. . Treas. Reg. §54.9815-1251T(a)(3)(i); DOL Reg. §2590.715-1251(a)(3)(i); HHS Reg. §147.140(a)(3)(i). [↑](#footnote-ref-134)
135. . Treas. Reg. §54.9815-1251T(a)(3)(i); DOL Reg. §2590.715-1251(a)(3)(i); HHS Reg. §147.140(a)(3)(i). [↑](#footnote-ref-135)
136. . Preamble to Grandfathered Health Plan Regulations, 75 Fed. Reg. 34537 (June 17, 2010). [↑](#footnote-ref-136)
137. . Treas. Reg. §54.9815-1251T(a)(3)(ii); DOL Reg. §2590.715-1251(a)(3)(ii); HHS Reg. §147.140(a)(3)(ii). [↑](#footnote-ref-137)
138. . Preamble to Grandfathered Health Plan Regulations, 75 Fed. Reg. 34537 (June 17, 2010). [↑](#footnote-ref-138)