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Compliance Checklist for Determining Grandfathered Status

The Affordable Care Act (ACA) contains many provisions that affect the health coverage you provide for your employees. The extent of the law's effect depends, in part, on whether you maintain a "grandfathered" health plan. Insured and self-funded group health plans of all sizes may qualify for grandfathered status under ACA.

Grandfathered plans are not subject to a number of ACA's reforms. For example, grandfathered plans are not required to cover preventive care services without cost sharing and these plans are not subject to ACA's cost-sharing limits on essential health benefits.

A plan may maintain its grandfathered status for 2014 and beyond, when many of ACA's major reforms become effective. A plan will lose its grandfathered status if significant changes are made that reduce plan benefits or increase plan costs for participants. Once a plan relinquishes its grandfathered status, it cannot be regained and the plan must comply with additional reforms under ACA.

The Department of Labor (DOL) issued the following compliance checklist to assist plans and issuers determine their grandfathered status under ACA.

	Yes	No	N/A
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. *29 CFR 2590.715-1251(a)(1)(i).*			
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. *29 CFR 2590.715-1251(a)(1)(i).* **If the answers to questions 1 and 2 are "yes," complete questions 3-11. If the answer is "no" to either question 1 or 2, the group health plan cannot claim grandfather status.**			

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TIP Provided changes are made without exceeding the other standards that cause a plan to relinquish grandfather status, changes that generally will not cause plans to relinquish grandfather status include changes to: premiums; comply with federal or state legal requirements; voluntarily comply with provisions of the ACA; third party administrators; network plan's provider network; and a prescription drug formulary.			
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. *29 CFR 2590.715-1251(g)(1)(i).*			
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. *29 CFR 2590.715-1251(g)(1)(ii).*			
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. *29 CFR 2590.715-1251(g)(3)(ii).* 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. *29 CFR 2590.715-1251(g)(3)(i).*			
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. *29 CFR 2590.715-1251(g)(3)(ii).* 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. *29 CFR 2590.715-251(g)(3)(i).*			
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? *29 CFR 2590.715-1251(g)(1)(v)(B).* **TIP** 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). *See DOL FAQs About the Affordable Care Act Implementation Part II, question 3* at *http://www.dol.gov/ebsa/faqs/faq-aca2.html.* 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. *See DOL FAQs About the Affordable Care Act Implementation Part I, question 4 at http://www.dol.gov/ebsa/faqs/faqacaa/html.*			
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 (*29 CFR 2590.715-1251(g)(1)(vi)(A)*); • 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 (*29 CFR 2590.715-1251(g)(1)(vi)(B)*); or • Decreases the dollar value of the overall annual limit that was in place on March 23, 2010 (*29 CFR 2590.715-1251(g)(1)(vi)(C)*). **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 Nov. 15, 2010, the plan will continue to be a grandfathered plan provided no other changes that would relinquish grandfather status are made. *29 CFR 2590.715-1251(a)(1)(ii), as amended.* Proceed to question 10. **If a group health plan changed issuers after March 23, 2010, and the change was effective prior to Nov. 15, 2010, the plan will have relinquished grandfather status. The plan is not a grandfathered plan.** **TIP** 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. See 29 CFR 2590.715-1251(f) for collectively bargained plans.			
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 Nov. 15, 2010, the plan will continue to be a grandfathered plan provided no other changes are made that would relinquish grandfather status. *29 CFR 2590.715-1251(a)(1)(ii), as amended.* 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 Nov. 15, 2010, the plan will have relinquished grandfather status. The plan is not a grandfathered plan.**			

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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. *29 CFR 2590.715-1251(a)(3)(ii), as amended.* **For all plans that, based on questions 1 through 11, have not relinquished grandfather status, complete questions 12-13.**			
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. *29 CFR 2590.715-1251(a)(2).*			
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. *29 CFR 2590.715-1251(a)(3)(i)(A) & (i)(B), as amended.*			

MORE INFORMATION

Please contact National Insurance Services, Inc. for any of the following additional checklists on ACA compliance:

- Health Care Reform: Compliance Checklist for Dependent Coverage to Age 26;
- Health Care Reform: Compliance Checklist for Rescission of Coverage;

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- Health Care Reform: Compliance Checklist for Lifetime Limits and Annual Limits;
- HCR: Compliance Checklist for Preexisting Exclusions for Individuals Under 19;
- Health Care Reform: Compliance Checklist for SBC and Uniform Glossary;
- Health Care Reform: Compliance Checklist for Patient Protections;
- Health Care Reform: Compliance Checklist for Preventive Services; and
- HCR: Compliance Checklist for Internal Claims and Appeals and External Review.

Source: Department of Labor