

emergency service received by the individual, the reasonable amount calculated using this method is \$116. The amount that would be paid under Medicare for the emergency service, excluding any copayment or coinsurance for the service, is \$80.

(ii) *Conclusion.* In this *Example 5*, the plan is responsible for paying \$92.80, 80% of \$116. The median amount among those agreed to for the emergency service is \$115 and the amount the plan would pay is \$92 (80% of \$115); the amount calculated using the same method the plan uses to determine payments for out-of-network services—\$116—excluding the in-network 20% coinsurance, is \$92.80; and the Medicare payment is \$80. Thus, the greatest amount is \$92.80. The individual is responsible for the remaining \$32.20 charged by the out-of-network provider.

Example 6. (i) *Facts.* Same facts as *Example 5*. The group health plan generally imposes a \$250 deductible for in-network health care. With respect to all health care provided by out-of-network providers, the plan imposes a \$500 deductible. (Covered in-network claims are credited against the deductible.) The individual has incurred and submitted \$260 of covered claims prior to receiving the emergency service out of network.

(ii) *Conclusion.* In this *Example 6*, the plan is not responsible for paying anything with respect to the emergency service furnished by the out-of-network provider because the covered individual has not satisfied the higher deductible that applies generally to all health care provided out of network. However, the amount the individual is required to pay is credited against the deductible.

(4) *Definitions.* The definitions in this paragraph (b)(4) govern in applying the provisions of this paragraph (b).

(i) *Emergency medical condition.* The term *emergency medical condition* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). (In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.)

(ii) *Emergency services.* The term *emergency services* means, with respect to an emergency medical condition—

(A) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

(iii) *Stabilize.* The term *to stabilize*, with respect to an emergency medical condition (as defined in paragraph (b)(4)(i) of this section) has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(c) *Applicability date.* The provisions of this section are applicable to group health plans and health insurance issuers for plan years (in the individual market, policy years) beginning on or after January 1, 2017. Until the applicability date for this regulation, plans and issuers are required to continue to comply with the corresponding sections of 45 CFR parts 144, 146 and 147, contained in the 45 CFR, parts 1 to 199, edition revised as of October 1, 2015.

[80 FR 72286, Nov. 18, 2015]

§ 147.140 Preservation of right to maintain existing coverage.

(a) *Definition of grandfathered health plan coverage—(1) In general—(i) Grandfathered health plan coverage* means coverage provided by a group health plan, or a group or individual health insurance issuer, in which an individual was enrolled on March 23, 2010 (for as long as it maintains that status under the rules of this section). A group health plan or group health insurance coverage does not cease to be grandfathered health plan coverage merely because one or more (or even all) individuals enrolled on March 23, 2010 cease to be covered, provided that the plan or group health insurance coverage has continuously covered someone since

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March 23, 2010 (not necessarily the same person, but at all times at least one person). In addition, subject to the limitation set forth in paragraph (a)(1)(ii) of this section, a group health plan (and any health insurance coverage offered in connection with the group health plan) does not cease to be a grandfathered health plan merely because the plan (or its sponsor) enters into a new policy, certificate, or contract of insurance after March 23, 2010 (for example, a plan enters into a contract with a new issuer or a new policy is issued with an existing issuer). For purposes of this section, a plan or health insurance coverage that provides grandfathered health plan coverage is referred to as a grandfathered health plan. The rules of this section apply separately to each benefit package made available under a group health plan or health insurance coverage. Accordingly, if any benefit package relinquishes grandfather status, it will not affect the grandfather status of the other benefit packages.

(ii) *Changes in group health insurance coverage.* Subject to paragraphs (f) and (g)(2) of this section, if a group health plan (including a group health plan that was self-insured on March 23, 2010) or its sponsor enters into a new policy, certificate, or contract of insurance after March 23, 2010 that is effective before November 15, 2010, then the plan ceases to be a grandfathered health plan.

(2) *Disclosure of grandfather status.* (i) To maintain status as a grandfathered health plan, a plan or health insurance coverage must include a statement that the plan or coverage believes it is a grandfathered health plan within the meaning of section 1251 of the Patient Protection and Affordable Care Act, and must provide contact information for questions and complaints, in any summary of benefits provided under the plan.

(ii) The following model language can be used to satisfy this disclosure requirement:

This [group health plan or health insurance issuer] believes this [plan or coverage] is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered

health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.]

(3)(i) *Documentation of plan or policy terms on March 23, 2010.* To maintain status as a grandfathered health plan, a group health plan, or group or individual health insurance coverage, must, for as long as the plan or health insurance coverage takes the position that it is a grandfathered health plan—

(A) Maintain records documenting the terms of the plan or health insurance coverage in connection with the coverage in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan; and

(B) Make such records available for examination upon request.

(ii) *Change in group health insurance coverage.* To maintain status as a grandfathered health plan, a group health plan that enters into a new policy, certificate, or contract of insurance must provide to the new health insurance issuer (and the new health insurance issuer must require) documentation of plan terms (including benefits, cost sharing, employer contributions, and annual dollar limits) under the prior health coverage sufficient to determine whether a change causing a cessation of grandfathered

health plan status under paragraph (g)(1) of this section has occurred.

(4) *Family members enrolling after March 23, 2010.* With respect to an individual who is enrolled in a group health plan or health insurance coverage on March 23, 2010, grandfathered health plan coverage includes coverage of family members of the individual who enroll after March 23, 2010 in the grandfathered health plan coverage of the individual.

(b) *Allowance for new employees to join current plan—(1) In general.* Subject to paragraph (b)(2) of this section, a group health plan (including health insurance coverage provided in connection with the group health plan) that provided coverage on March 23, 2010 and has retained its status as a grandfathered health plan (consistent with the rules of this section, including paragraph (g) of this section) is grandfathered health plan coverage for new employees (whether newly hired or newly enrolled) and their families enrolling in the plan after March 23, 2010. Further, the addition of a new contributing employer or new group of employees of an existing contributing employer to a grandfathered multiemployer health plan will not affect the plan's grandfather status.

(2) *Anti-abuse rules—(i) Mergers and acquisitions.* If the principal purpose of a merger, acquisition, or similar business restructuring is to cover new individuals under a grandfathered health plan, the plan ceases to be a grandfathered health plan.

(ii) *Change in plan eligibility.* A group health plan or health insurance coverage (including a benefit package under a group health plan) ceases to be a grandfathered health plan if—

(A) Employees are transferred into the plan or health insurance coverage (the transferee plan) from a plan or health insurance coverage under which the employees were covered on March 23, 2010 (the transferor plan);

(B) Comparing the terms of the transferee plan with those of the transferor plan (as in effect on March 23, 2010) and treating the transferee plan as if it were an amendment of the transferor plan would cause a loss of grandfather status under the provi-

sions of paragraph (g)(1) of this section; and

(C) There was no bona fide employment-based reason to transfer the employees into the transferee plan. For this purpose, changing the terms or cost of coverage is not a bona fide employment-based reason.

(iii) *Illustrative list of bona fide employment-based reasons.* For purposes of this paragraph (b)(2)(i)(C), bona fide employment-based reasons include—

(A) When a benefit package is being eliminated because the issuer is exiting the market;

(B) When a benefit package is being eliminated because the issuer no longer offers the product to the employer;

(C) When 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;

(D) When a benefit package is eliminated from a multiemployer plan as agreed upon as part of the collective bargaining process; or

(E) When 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.

(3) *Examples.* The rules of this paragraph (b) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan offers two benefit packages on March 23, 2010, Options *F* and *G*. During a subsequent open enrollment period, some of the employees enrolled in Option *F* on March 23, 2010 switch to Option *G*.

(ii) *Conclusion.* In this *Example 1*, the group health coverage provided under Option *G* remains a grandfathered health plan under the rules of paragraph (b)(1) of this section because employees previously enrolled in Option *F* are allowed to enroll in Option *G* as new employees.

Example 2. (i) *Facts.* A group health plan offers two benefit packages on March 23, 2010, Options *H* and *I*. On March 23, 2010, Option *H* provides coverage only for employees in one manufacturing plant. Subsequently, the plant is closed, and some employees in the closed plant are moved to another plant. The employer eliminates Option *H* and the employees that are moved are transferred to Option *I*. If instead of transferring employees from Option *H* to Option *I*, Option *H* was amended to match the terms of Option *I*,

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then Option *H* would cease to be a grandfathered health plan.

(ii) *Conclusion.* In this *Example 2*, the plan has a bona fide employment-based reason to transfer employees from Option *H* to Option *I*. Therefore, Option *I* does not cease to be a grandfathered health plan.

(c) *General grandfathering rule.* (1) Except as provided in paragraphs (d) and (e) of this section, subtitles A and C of title I of the Patient Protection and Affordable Care Act (and the amendments made by those subtitles, and the incorporation of those amendments into ERISA section 715 and Internal Revenue Code section 9815) do not apply to grandfathered health plan coverage. Accordingly, the provisions of PHS Act sections 2701, 2702, 2703, 2705, 2706, 2707, 2709 (relating to coverage for individuals participating in approved clinical trials, as added by section 10103 of the Patient Protection and Affordable Care Act), 2713, 2715A, 2716, 2717, 2719, and 2719A, as added or amended by the Patient Protection and Affordable Care Act, do not apply to grandfathered health plans. In addition, the provisions of PHS Act section 2704, and PHS Act section 2711 insofar as it relates to annual dollar limits, do not apply to grandfathered health plans that are individual health insurance coverage.

(2) To the extent not inconsistent with the rules applicable to a grandfathered health plan, a grandfathered health plan must comply with the requirements of the PHS Act, ERISA, and the Internal Revenue Code applicable prior to the changes enacted by the Patient Protection and Affordable Care Act.

(d) *Provisions applicable to all grandfathered health plans.* The provisions of PHS Act section 2711 insofar as it relates to lifetime dollar limits, and the provisions of PHS Act sections 2712, 2714, 2715, and 2718, apply to grandfathered health plans for plan years (in the individual market, policy years) beginning on or after September 23, 2010. The provisions of PHS Act section 2708 apply to grandfathered health plans for plan years (in the individual market, policy years) beginning on or after January 1, 2014.

(e) *Applicability of PHS Act sections 2704, 2711, and 2714 to grandfathered group health plans and group health in-*

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surance coverage. (1) The provisions of PHS Act section 2704 as it applies with respect to enrollees who are under 19 years of age, and the provisions of PHS Act section 2711 insofar as it relates to annual dollar limits, apply to grandfathered health plans that are group health plans (including group health insurance coverage) for plan years beginning on or after September 23, 2010. The provisions of PHS Act section 2704 apply generally to grandfathered health plans that are group health plans (including group health insurance coverage) for plan years beginning on or after January 1, 2014.

(2) For plan years beginning before January 1, 2014, the provisions of PHS Act section 2714 apply in the case of an adult child with respect to a grandfathered health plan that is a group health plan only if the adult child is not eligible to enroll in an eligible employer-sponsored health plan (as defined in section 5000A(f)(2) of the Internal Revenue Code) other than a grandfathered health plan of a parent. For plan years beginning on or after January 1, 2014, the provisions of PHS Act section 2714 apply with respect to a grandfathered health plan that is a group health plan without regard to whether an adult child is eligible to enroll in any other coverage.

(f) *Effect on collectively bargained plans—In general.* 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 March 23, 2010, the coverage is grandfathered health plan coverage at least until the date on which the last of the collective bargaining agreements relating to the coverage that was in effect on March 23, 2010 terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage that amends the coverage solely to conform to any requirement added by subtitles A and C of title I of the Patient Protection and Affordable Care Act (and the amendments made by those subtitles, and the incorporation of those amendments into ERISA section 715 and Internal Revenue Code section 9815) is not treated as a termination of the collective bargaining

agreement. After the date on which the last of the collective bargaining agreements relating to the coverage that was in effect on March 23, 2010 terminates, the determination of whether health insurance coverage maintained pursuant to a collective bargaining agreement is grandfathered health plan coverage is made under the rules of this section other than this paragraph (f) (comparing the terms of the health insurance coverage after the date the last collective bargaining agreement terminates with the terms of the health insurance coverage that were in effect on March 23, 2010).

(g) *Maintenance of grandfather status*—(1) *Changes causing cessation of grandfather status.* Subject to paragraph (g)(2) of this section, the rules of this paragraph (g)(1) describe situations in which a group health plan or health insurance coverage ceases to be a grandfathered health plan. A plan or coverage will cease to be a grandfathered health plan when an amendment to plan terms that results in a change described in this paragraph (g)(1) becomes effective, regardless of when the amendment was adopted. Once grandfather status is lost, it cannot be regained.

(i) *Elimination of benefits.* The elimination of all or substantially all benefits to diagnose or treat a particular condition causes a group health plan or health insurance coverage to cease to be a grandfathered health plan. For this purpose, 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. Whether or not a plan or coverage has eliminated substantially all benefits to diagnose or treat a particular condition must be determined based on all the facts and circumstances, taking into account the items and services provided for a particular condition under the plan on March 23, 2010, as compared to the benefits offered at the time the plan or coverage makes the benefit change effective.

(ii) *Increase in percentage cost-sharing requirement.* Any increase, measured from March 23, 2010, in a percentage cost-sharing requirement (such as an

individual's coinsurance requirement) causes a group health plan or health insurance coverage to cease to be a grandfathered health plan.

(iii) *Increase in a fixed-amount cost-sharing requirement other than a copayment.* Any increase in a fixed-amount cost-sharing requirement other than a copayment (for example, deductible or out-of-pocket limit), determined as of the effective date of the increase, causes a group health plan or health insurance coverage to cease to be a grandfathered health plan, if the total percentage increase in the cost-sharing requirement measured from March 23, 2010 exceeds the maximum percentage increase (as defined in paragraph (g)(3)(ii) of this section).

(iv) *Increase in a fixed-amount copayment.* Any increase in a fixed-amount copayment, determined as of the effective date of the increase, and determined for each copayment level if a plan has different copayment levels for different categories of services, causes a group health plan or health insurance coverage to cease to be a grandfathered health plan, if the total increase in the copayment measured from March 23, 2010 exceeds the greater of:

(A) An amount equal to \$5 increased by medical inflation, as defined in paragraph (g)(3)(i) of this section (that is, \$5 times medical inflation, plus \$5), or

(B) The maximum percentage increase (as defined in paragraph (g)(3)(ii) of this section), determined by expressing the total increase in the copayment as a percentage.

(v) *Decrease in contribution rate by employers and employee organizations*—(A) *Contribution rate based on cost of coverage.* A group health plan or group health insurance coverage ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate based on cost of coverage (as defined in paragraph (g)(3)(iii)(A) of this section) towards the cost of any tier of coverage for any class of similarly situated individuals (as described in §146.121(d) of this subchapter) by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010.

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(B) *Contribution rate based on a formula.* A group health plan or group health insurance coverage ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate based on a formula (as defined in paragraph (g)(3)(iii)(B) of this section) towards the cost of any tier of coverage for any class of similarly situated individuals (as described in § 146.121(d) of this subchapter) by more than 5 percent below the contribution rate for the coverage period that includes March 23, 2010.

(C) *Special rules regarding decreases in contribution rates.* An insured group health plan (or a multiemployer plan) that is a grandfathered health plan will not cease to be a grandfathered health plan based on a change in the employer contribution rate unless the issuer (or multiemployer plan) knows, or should know, of the change, provided:

(1) Upon renewal (or, in the case of a multiemployer plan, before the start of a new plan year), the issuer (or multiemployer plan) requires relevant employers, employee organizations, or plan sponsors, as applicable, 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, or multiemployer plan, does not already have it); and

(2) The relevant policies, certificates, contracts of insurance, or plan documents disclose in a prominent and effective manner that employers, employee organizations, or plan sponsors, as applicable, are required to notify the issuer (or multiemployer plan) if the contribution rate changes at any point during the plan year.

(D) *Application to plans with multi-tiered coverage structures.* The standards for employer contributions in this paragraph (g)(1)(v) apply on a tier-by-tier basis. Therefore, 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. For example, if the employer con-

tribution rate for family coverage was 50 percent on March 23, 2010, the employer contribution rate for any new tier of coverage other than self-only (i.e., self-plus-one, self-plus-two, self-plus-three or more) must be within 5 percentage points of 50 percent (i.e., at least 45 percent). If, however, 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 for changes in employer contributions. For example, if a plan with self-only as the sole coverage tier added a family coverage tier, the level of employer contributions toward the family coverage would not cause the plan to lose grandfather status.

(E) *Group health plans with fixed-dollar employee contributions or no employee contributions.* A group health plan that requires either fixed-dollar employee contributions or no employee contributions will not cease to be a grandfathered health plan solely because the employer contribution rate changes so long as there continues to be no employee contributions or no increase in the fixed-dollar employee contributions towards the cost of coverage.

(vi) *Changes in annual limits—(A) Addition of an annual limit.* A group health plan, or group or individual health insurance coverage that, on March 23, 2010, did not impose an overall annual or lifetime limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage imposes an overall annual limit on the dollar value of benefits. (But see § 147.126, which generally prohibits all annual dollar limits on essential health benefits for plan years (in the individual market, policy years) beginning on or after January 1, 2014).

(B) *Decrease in limit for a plan or coverage with only a lifetime limit.* Grandfathered individual health insurance coverage, that, on March 23, 2010, imposed an overall lifetime limit on the dollar value of all benefits but no overall annual limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or

health insurance coverage adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010. (*But see* §147.126, which generally prohibits all annual dollar limits on essential health benefits for plan years (in the individual market, policy years) beginning on or after January 1, 2014).

(C) *Decrease in limit for a plan or coverage with an annual limit.* A group health plan, or group or individual health insurance coverage, that, on March 23, 2010, imposed an overall annual limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage decreases the dollar value of the annual limit (regardless of whether the plan or health insurance coverage also imposed an overall lifetime limit on March 23, 2010 on the dollar value of all benefits). (*But see* §147.126, which generally prohibits all annual dollar limits on essential health benefits for plan years (in the individual market, policy years) beginning on or after January 1, 2014).

(2) *Transitional rules*—(i) *Changes made prior to March 23, 2010.* If a group health plan or health insurance issuer makes the following changes to the terms of the plan or health insurance coverage, the changes are considered part of the terms of the plan or health insurance coverage on March 23, 2010 even though they were not effective at that time and such changes do not cause a plan or health insurance coverage to cease to be a grandfathered health plan:

(A) Changes effective after March 23, 2010 pursuant to a legally binding contract entered into on or before March 23, 2010;

(B) Changes effective after March 23, 2010 pursuant to a filing on or before March 23, 2010 with a State insurance department; or

(C) Changes effective after March 23, 2010 pursuant to written amendments to a plan that were adopted on or before March 23, 2010.

(ii) *Changes made after March 23, 2010 and adopted prior to issuance of regulations.* If, after March 23, 2010, a group health plan or health insurance issuer makes changes to the terms of the plan or health insurance coverage and the

changes are adopted prior to June 14, 2010, the changes will not cause the plan or health insurance coverage to cease to be a grandfathered health plan if the changes are revoked or modified effective as of the first day of the first plan year (in the individual market, policy 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 cease to be a grandfathered health plan under the rules of this section, including paragraph (g)(1) of this section. For this purpose, changes will be considered to have been adopted prior to June 14, 2010 if:

(A) The changes are effective before that date;

(B) The changes are effective on or after that date pursuant to a legally binding contract entered into before that date;

(C) The changes are effective on or after that date pursuant to a filing before that date with a State insurance department; or

(D) The changes are effective on or after that date pursuant to written amendments to a plan that were adopted before that date.

(3) *Definitions*—(i) *Medical inflation defined.* For purposes of this paragraph (g), the term *medical inflation* means 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. For this purpose, the increase in the overall medical care component is computed by subtracting 387.142 (the overall medical care component of the CPI-U (unadjusted) published by the Department of Labor for March 2010, using the 1982–1984 base of 100) from the index amount for any month in the 12 months before the new change is to take effect and then dividing that amount by 387.142.

(ii) *Maximum percentage increase defined.* For purposes of this paragraph (g), the term *maximum percentage increase* means medical inflation (as defined in paragraph (g)(3)(i) of this section), expressed as a percentage, plus 15 percentage points.

(iii) *Contribution rate defined.* For purposes of paragraph (g)(1)(v) of this section:

(A) *Contribution rate based on cost of coverage.* The term *contribution rate based on cost of coverage* means the amount of contributions made by an employer or employee organization compared to the total cost of coverage, expressed as a percentage. The total cost of coverage is determined in the same manner as the applicable premium is calculated under the COBRA continuation provisions of section 604 of ERISA, section 4980B(f)(4) of the Internal Revenue Code, and section 2204 of the PHS Act. In the case of a self-insured plan, contributions by an employer or employee organization are equal to the total cost of coverage minus the employee contributions towards the total cost of coverage.

(B) *Contribution rate based on a formula.* The term *contribution rate based on a formula* means, for plans that, on March 23, 2010, made contributions based on a formula (such as hours worked or tons of coal mined), the formula.

(4) *Examples.* The rules of this paragraph (g) are illustrated by the following examples:

Example 1. (i) *Facts.* On March 23, 2010, a grandfathered health plan has a coinsurance requirement of 20% for inpatient surgery. The plan is subsequently amended to increase the coinsurance requirement to 25%.

(ii) *Conclusion.* In this *Example 1*, the increase in the coinsurance requirement from 20% to 25% causes the plan to cease to be a grandfathered health plan.

Example 2. (i) *Facts.* Before March 23, 2010, the terms of a group health plan provide benefits for a particular mental health condition, the treatment for which is a combination of counseling and prescription drugs. Subsequently, the plan eliminates benefits for counseling.

(ii) *Conclusion.* In this *Example 2*, the plan ceases to be a grandfathered health plan because counseling is an element that is necessary to treat the condition. Thus the plan is considered to have eliminated substantially all benefits for the treatment of the condition.

Example 3. (i) *Facts.* On March 23, 2010, a grandfathered health plan has a copayment requirement of \$30 per office visit for specialists. The plan is subsequently amended to increase the copayment requirement to \$40. Within the 12-month period before the \$40 copayment takes effect, the greatest value of

the overall medical care component of the CPI-U (unadjusted) is 475.

(ii) *Conclusion.* In this *Example 3*, the increase in the copayment from \$30 to \$40, expressed as a percentage, is 33.33% ($40 - 30 = 10$; $10 \div 30 = 0.3333$; $0.3333 = 33.33\%$). Medical inflation (as defined in paragraph (g)(3)(i) of this section) from March 2010 is 0.2269 ($475 - 387.142 = 87.858$; $87.858 \div 387.142 = 0.2269$). The maximum percentage increase permitted is 37.69% ($0.2269 = 22.69\%$; $22.69\% + 15\% = 37.69\%$). Because 33.33% does not exceed 37.69%, the change in the copayment requirement at that time does not cause the plan to cease to be a grandfathered health plan.

Example 4. (i) *Facts.* Same facts as *Example 3*, except the grandfathered health plan subsequently increases the \$40 copayment requirement to \$45 for a later plan year. Within the 12-month period before the \$45 copayment takes effect, the greatest value of the overall medical care component of the CPI-U (unadjusted) is 485.

(ii) *Conclusion.* In this *Example 4*, the increase in the copayment from \$30 (the copayment that was in effect on March 23, 2010) to \$45, expressed as a percentage, is 50% ($45 - 30 = 15$; $15 \div 30 = 0.5$; $0.5 = 50\%$). Medical inflation (as defined in paragraph (g)(3)(i) of this section) from March 2010 is 0.2527 ($485 - 387.142 = 97.858$; $97.858 \div 387.142 = 0.2527$). The increase that would cause a plan to cease to be a grandfathered health plan under paragraph (g)(1)(iv) of this section is the greater of the maximum percentage increase of 40.27% ($0.2527 = 25.27\%$; $25.27\% + 15\% = 40.27\%$), or \$6.26 ($\$5 \times 0.2527 = \1.26 ; $\$1.26 + \$5 = \$6.26$). Because 50% exceeds 40.27% and \$15 exceeds \$6.26, the change in the copayment requirement at that time causes the plan to cease to be a grandfathered health plan.

Example 5. (i) *Facts.* On March 23, 2010, a grandfathered health plan has a copayment of \$10 per office visit for primary care providers. The plan is subsequently amended to increase the copayment requirement to \$15. Within the 12-month period before the \$15 copayment takes effect, the greatest value of the overall medical care component of the CPI-U (unadjusted) is 415.

(ii) *Conclusion.* In this *Example 5*, the increase in the copayment, expressed as a percentage, is 50% ($15 - 10 = 5$; $5 \div 10 = 0.5$; $0.5 = 50\%$). Medical inflation (as defined in paragraph (g)(3) of this section) from March 2010 is 0.0720 ($415.0 - 387.142 = 27.858$; $27.858 \div 387.142 = 0.0720$). The increase that would cause a plan to cease to be a grandfathered health plan under paragraph (g)(1)(iv) of this section is the greater of the maximum percentage increase of 22.20% ($0.0720 = 7.20\%$; $7.20\% + 15\% = 22.20\%$), or \$5.36 ($\$5 \times 0.0720 = \0.36 ; $\$0.36 + \$5 = \$5.36$). The \$5 increase in copayment in this *Example 5* would not cause the plan to cease to be a grandfathered health plan pursuant to paragraph (g)(1)(iv) this section,

which would permit an increase in the copayment of up to \$5.36.

Example 6. (i) *Facts.* The same facts as *Example 5*, except on March 23, 2010, the grandfathered health plan has no copayment (\$0) for office visits for primary care providers. The plan is subsequently amended to increase the copayment requirement to \$5.

(ii) *Conclusion.* In this *Example 6*, medical inflation (as defined in paragraph (g)(3)(i) of this section) from March 2010 is 0.0720 ($415.0 - 387.142 = 27.858$; $27.858 \div 387.142 = 0.0720$). The increase that would cause a plan to cease to be a grandfathered health plan under paragraph (g)(1)(iv)(A) of this section is \$5.36 ($\$5 \times 0.0720 = \0.36 ; $\$0.36 + \$5 = \$5.36$). The \$5 increase in copayment in this *Example 6* is less than the amount calculated pursuant to paragraph (g)(1)(iv)(A) of this section of \$5.36. Thus, the \$5 increase in copayment does not cause the plan to cease to be a grandfathered health plan.

Example 7. (i) *Facts.* On March 23, 2010, a self-insured group health plan provides two tiers of coverage—self-only and family. The employer contributes 80% of the total cost of coverage for self-only and 60% of the total cost of coverage for family. Subsequently, the employer reduces the contribution to 50% for family coverage, but keeps the same contribution rate for self-only coverage.

(ii) *Conclusion.* In this *Example 7*, the decrease of 10 percentage points for family coverage in the contribution rate based on cost of coverage causes the plan to cease to be a grandfathered health plan. The fact that the contribution rate for self-only coverage remains the same does not change the result.

Example 8. (i) *Facts.* On March 23, 2010, a self-insured grandfathered health plan has a COBRA premium for the 2010 plan year of \$5000 for self-only coverage and \$12,000 for family coverage. The required employee contribution for the coverage is \$1000 for self-only coverage and \$4000 for family coverage. Thus, the contribution rate based on cost of coverage for 2010 is 80% ($(5000 - 1000)/5000$) for self-only coverage and 67% ($(12,000 - 4000)/12,000$) for family coverage. For a subsequent plan year, the COBRA premium is \$6000 for self-only coverage and \$15,000 for family coverage. The employee contributions for that plan year are \$1200 for self-only coverage and \$5000 for family coverage. Thus, the contribution rate based on cost of coverage is 80% ($(6000 - 1200)/6000$) for self-only coverage and 67% ($(15,000 - 5000)/15,000$) for family coverage.

(ii) *Conclusion.* In this *Example 8*, because there is no change in the contribution rate based on cost of coverage, the plan retains its status as a grandfathered health plan. The result would be the same if all or part of the employee contribution was made pre-tax through a cafeteria plan under section 125 of the Internal Revenue Code.

Example 9. (i) *Facts.* A group health plan not maintained pursuant to a collective bargaining agreement offers 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 coinsurance under Option *H* from 10% to 15%.

(ii) *Conclusion.* In this *Example 9*, the coverage under Option *H* is not grandfathered health plan coverage as of July 1, 2013, consistent with the rule in paragraph (g)(1)(ii) of this section. Whether the coverage under Options *F* and *G* is grandfathered health plan coverage is determined separately under the rules of this paragraph (g).

[80 FR 72289, Nov. 18, 2015]

§ 147.145 Student health insurance coverage.

(a) *Definition.* Student health insurance coverage is a type of individual health insurance coverage (as defined in § 144.103 of this subchapter) that is provided pursuant to a written agreement between an institution of higher education (as defined in the Higher Education Act of 1965) and a health insurance issuer, and provided to students enrolled in that institution of higher education and their dependents, that meets the following conditions:

(1) Does not make health insurance coverage available other than in connection with enrollment as a student (or as a dependent of a student) in the institution of higher education.

(2) Does not condition eligibility for the health insurance coverage on any health status-related factor (as defined in § 146.121(a) of this subchapter) relating to a student (or a dependent of a student).

(3) Meets any additional requirement that may be imposed under State law.

(b) *Exemptions from the Public Health Service Act and the Affordable Care Act—* (1) *Guaranteed availability and guaranteed renewability.* (i) For purposes of sections 2741(e)(1) and 2742(b)(5) of the Public Health Service Act, student health insurance coverage is deemed to be available only through a bona fide association.

(ii) For purposes of section 2702 of the Public Health Service Act, a health insurance issuer that offers student health insurance coverage is not required to accept individuals who are not students or dependents of students in such coverage, and, notwithstanding