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UNDERSTANDING GRANDFATHER STATUS AND OTHER HEALTH REFORM CLARIFICATIONS
HEALTHCARE REFORM IN AMERICA – Part IV

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*THIS EDITION OF OUR SERIES – **HEALTHCARE REFORM IN AMERICA** WILL FOCUS ON THE GRANDFATHER PROVISIONS UNDER THE AFFORDABLE CARE ACT (ACA), WHICH RELIEVES PLAN SPONSORS FROM COMPLYING WITH CERTAIN REQUIREMENTS OF THE LAW. WE WILL DEFINE GRANDFATHER STATUS, IDENTIFY HOW THE ACA PROVISIONS IMPACT GRANDFATHERED PLANS AND CLARIFY THE DESIGN CHANGES THAT WILL CAUSE A PLAN TO LOSE ITS ACA GRANDFATHER STATUS BASED ON NEWLY RELEASED REGULATIONS. IN ADDITION, THE PREAMBLE TO THE INTERIM RULES ISSUED ON JUNE 14, 2010 SHED LIGHT ON WHICH TYPES OF PLANS ARE NOT SUBJECT TO THE AFFORDABLE CARE ACT INSURANCE MARKET REFORM MANDATES.*

*SHORTLY AFTER THE GRANDFATHER PLAN REGULATIONS WERE RELEASED, GUIDANCE WAS ISSUED REGARDING PREEXISTING CONDITION LIMITATIONS, ANNUAL AND LIFETIME LIMIT RESTRICTIONS AND OTHER PATIENT PROTECTION MANDATES. THIS **INSIGHTS** WILL BRIEFLY SUMMARIZE THESE NEW RULES, AS WELL.*

PLANS NOT SUBJECT TO ACA

The preamble to the grandfather plan regulations clarify that retiree-only plans and HIPAA excepted benefits (dental, vision, Medigap, accidental death and dismemberment, disease-specific and flexible spending account plans), will not be subject to the ACA insurance market reforms such as the lifetime and annual limit restrictions, extending coverage to dependents to age 26, removing preexisting condition limitation requirements, and patient protections, just to name a few. More information about insurance market reforms is provided in the discussion of grandfather plans.

GRANDFATHERED PLANS

The law defines a grandfathered plan as a group health plan that was in existence on March 23, 2010, the date the law was enacted. A plan will not lose its grandfather status by enrolling and disenrolling employees and their dependents, as long as there has been at least one person covered under the plan since March 23, 2010. Each benefit option offered by an employer must independently meet the grandfather requirements, and a loss of grandfather status under one benefit option will not automatically compromise the status of another benefit option. The law applies to fully insured and self-funded plans, as well as nonfederal governmental and collectively bargained plans.

To prevent abuse, the rules state that a plan will lose its grandfather status if the principal purpose of a merger, acquisition or other business restructuring is to cover new individuals under a grandfathered plan. In addition, the rules require there be a bona-fide employment reason to transfer employees from one plan to another in order to retain grandfather status. Terminating a high cost plan option and transferring all employees into a remaining lower cost option plan is an example provided in the guidance that would cause a plan to lose grandfather status, because the "high cost" plan could have been amended, causing that plan option to lose its grandfather status.

Plans that retain grandfather status will be required to maintain records to support the grandfather status determination and be prepared to provide the records upon request. In addition, plan sponsors must communicate the plan's grandfather status to members, indicate that certain protections will not apply and provide contact information to seek additional guidance. The regulations include model language for this purpose.

GRANDFATHER PLANS EXEMPT FROM CERTAIN INSURANCE MARKET REFORMS

Plans that retain grandfather status will be exempt from the following mandates which basically become effective the first plan year after September 23, 2010:

- Cover required preventive health care with no member cost sharing,
- Perform nondiscrimination testing for fully insured plans (similar to the current testing requirements for self-funded plans),
- Provide certain patient protections such as selecting primary care physicians, having direct access to OB-GYN services, and accessing emergency services without prior authorization, and
- Expand claims appeal procedures to include both internal and external review processes.

Other 2014 mandates which will not apply include:

- Cover the costs for participation in approved clinical trials, and
- Provide government-defined comprehensive coverage (essential benefits) with limited member cost sharing. It should be noted that this mandate initially only applies to the small plan market (up to 100 employees) when coverage is purchased through the Exchange. This mandate will not apply to large employers (100+ employees) as well as self funded plans that provide coverage outside of the Exchange.

INSURANCE MARKET REFORMS THAT APPLY TO GRANDFATHER PLANS

Plans that retain grandfather status will be required to comply with the following insurance market reforms which basically become effective the first plan year beginning after September 23, 2010:

- Eliminate preexisting condition limitations for employees and dependents under age 19 (this will be extended to all members in 2014),
- Remove lifetime limits and restrict annual limits on the dollar value of benefits based on the guidelines released by the regulatory agencies, and
- Extend coverage to dependents up to age 26, however, prior to 2014 grandfather plans may exclude coverage to young adults who are eligible for other employer-sponsored coverage.

Other provisions with later implementation dates that will also apply include:

- Communicate benefits information using uniform explanation of coverage standards (2012), and
- Limit a plan's waiting period to 90 days (2014).

Other mandates, including the 2014 requirement for large employers, those with 50 or more full-time equivalent employees, to offer coverage or pay a penalty will apply regardless of grandfather status.

CHANGES THAT WILL CAUSE A PLAN TO LOSE GRANDFATHER STATUS

The regulations specifically note the following changes, measured from March 23, 2010, that will compromise a plan's grandfather status. Each modification will be discussed in further detail. Highlighted terms will be defined in Understanding New Terminology.

- Enter into a new insurance contract or policy,
- Eliminate all or substantially all benefits to diagnose or treat a particular illness or condition,
- Increase a percentage cost-sharing amount, such as coinsurance,
- Increase a fixed cost-sharing amount such as a deductible or out-of-pocket limit that is greater than the Maximum Percentage Increase,
- Increase a fixed amount copayment that is greater than either a) $5 adjusted by Medical Inflation, or b) the Maximum Percentage Increase,
- Decrease the employer's contribution rate for any benefit or tier level in excess of 5%, or
- Modify the plan's Annual Limits under certain circumstances.

The regulations specifically note that premium increases, modifying a plan to comply with federal and state required mandates, and changing third-party administrators for self-funded plans would not affect grandfather status. It is believed that changes, other than what has been specifically noted in the regulations, such as improving a benefit package, will be allowed and not compromise a plan's protected status. The regulators are also seeking public comment on various other types of changes.

UNDERSTANDING NEW TERMINOLOGY

The regulations define Medical Inflation as the increase since March 23, 2010 in the "medical care component" of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published each month by the Department of Labor. The Maximum Percentage Increase is defined as Medical Inflation (described above) plus 15%.

Therefore, if we assume that Medical Inflation (based on the regulations) at January 1, 2011 is 4%, then the Maximum Percentage Increase would be equal to 19%. Together, these two variables set the boundaries on

changes to copayments, deductibles, and out-of-pocket limits that a plan sponsor could make and still maintain grandfather status. We will refer to this inflation example throughout this *Insights*

ADDING OR CHANGING INSURANCE ARRANGEMENTS

Any new policy, certificate or contract of insurance issued after March 23, 2010 will cause a plan to lose grandfather status. Therefore, even if an employer changes insurance carriers, offers the same plan of benefits and secures a lower premium, the plan would no longer be grandfathered. Collectively bargained, fully insured arrangements, however, will maintain grandfather status under this scenario, until the expiration of the collectively bargained agreement.

ELIMINATING OR CHANGING BENEFITS

Any change that reduces or eliminates existing benefits or that reduces associated diagnostic and treatment protocol will cause a loss of grandfather status.

PERCENTAGE COST SHARING

Adding or increasing an existing coinsurance amount for plan members will cause the plan to be subject to all insurance market reforms. For example, changing the plan design for a service that on March 23, 2010 required a copayment to a deductible and coinsurance arrangement, or increasing a member's coinsurance for a particular service from 20% to 30% will compromise the plan's grandfather status.

FIXED-COST SHARING (OTHER THAN A COPAYMENT)

The following illustrates how the rules affecting changes to deductibles and out-of-pocket limits would work. Assume the plan on March 23, 2010 has a single deductible of $500 and a family deductible of $1,500. Remember, in our example, Medical Inflation at January 1, 2011 is 4%, and the Maximum Percentage Increase is 19%. Therefore, this plan sponsor could increase the single and family deductible to $595 [$500 x 1.19] and $1,785 [$1,500 x 1.19], respectively at January 1, 2011 to retain grandfather status.

COPAYMENTS

The following illustrates how the rules affecting copayment changes would work. Assume the plan on March 23, 2010 has a $30 office visit copayment. Medical Inflation at January 1, 2011 is 4%, and the Maximum Percentage Increase is 19%. Therefore, this plan sponsor could increase the copayment to the greater of: a) **$35.20** which is [$5 x 1.04 (Medical Inflation)] or **<u>$35.70</u>** which is [$30 x 1.19 (Maximum Percentage Increase)] to retain grandfather status.

EMPLOYER CONTRIBUTION RATES

Plan sponsors need to be aware of their Contribution Percentage Rate as of March 23, 2010 for each tier level and health benefit option offered, as a change in this contribution rate by more than 5% will cause the plan to lose grandfather status. Fully insured plans will determine the employer's contribution rate based on the percentage of the premium that the employer is paying. Self-funded plans will base this on the plan's "premium equivalent" rate. For example, assume a self-funded plan has a premium equivalent rate of $5,000 for single coverage and $12,000 for family coverage and the employer contributes $4,000 for single coverage and $8,000 for family coverage on March 23, 2010. The employer's contribution rate for each tier would be 80% [$4,000 ÷ $5,000] for single coverage and 66.67% [$8,000 ÷ $12,000] for family coverage. In the future, this employer could contribute 75% and 61.67% toward the cost of single and family coverage, respectively for this plan and retain grandfather status.

MODIFYING ANNUAL LIMITS

The regulations identify the following three circumstances in which changes in annual limits on the dollar value of benefits will cause a plan to lose grandfather status:

- Add an overall annual limit to a plan that previously contained no such limitation,
- Adopt an overall annual limit that is lower than the dollar value of a lifetime limit that was in the plan on March 23, 2010 ,and
- Decrease an existing overall annual limit that was contained in the plan on March 23, 2010.

Note: Subsequent to the issuance of the grandfather rules, the regulatory agencies issued guidance about the application of annual limits. Annual limit restrictions do not apply to Flexible Spending Accounts, Health Savings Accounts and Health Reimbursement Arrangements that are integrated with other group health plan coverage (that satisfies the requirements).

These rules state that annual limits on the dollar value of "essential benefits" cannot be less than the following amounts based on plan years that begin as follows:

- 9/23/10 – 9/22/11 $750,000

- 9/23/11 – 9/22/12 $1,250,000
- 9/23/12 – 1/1/14 $2,000,000
- 1/1/14 and after no annual limits

Essential benefits include the following general categories of items and services:

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance abuse services,
- Prescription drugs,
- Rehabilitative services and devices,
- Laboratory services,
- Preventive , wellness and chronic disease management services, and
- Pediatric services including oral and vision care.

The rules also allow the Secretary of Health and Human Services to issue waivers if the implementation of these annual limit restrictions will cause a significant increase in cost or loss of coverage. This exception may come as welcome relief to plan sponsors of "mini-med" plans that offer a basic package of benefits with lower levels of reimbursement than currently proposed in the regulations.

TRANSITION RULES AND GRACE PERIOD

Due to the delay in clarifying the grandfather plan requirements, the following will not cause a plan to lose grandfather status:

- Plan changes made in accordance with a legally binding contract that were entered into prior to March 23,2010,
- Changes to the terms of a fully insured plan pursuant to a rate filing with a State Insurance Department that took place prior to March 23, 2010, or
- Plan changes that were made in accordance with written plan amendments that were adopted prior to March 23, 2010.

In addition, for purposes of enforcement, the regulators have stated that plan changes made prior to June 14, 2014 in a good faith effort to comply with a reasonable interpretation of the Affordable Care Act may be disregarded (for purposes of loss of grandfather status) if the changes that were made only modestly exceed the standards put forth in the June 14, 2010 regulations.

Plan sponsors who implemented more substantial plan changes after March 23, 2010 will have an opportunity to "re-instate" grandfather status if the plan changes are revoked effective on the first day of the plan year on or after September 23, 2010.

AND STILL MORE REGULATIONS

The regulators were busy in June as guidance was issued on a variety of miscellaneous provisions including preexisting condition limitations, lifetime and annual limits and other patient protections.

PREEXISTING CONDITION LIMITATIONS

Group health plans, including grandfather plans, will no longer be allowed to impose preexisting condition limitations beginning January 1, 2014. However, preexisting condition limitations for all members (employees and dependents) under the age of 19 will no longer be allowed for plan years that begin on and after September 23, 2010. It should be noted that the plan is still required to provide Certificates of Creditable Coverage for these individuals, even though no preexisting condition limits will apply.

LIFETIME (AND ANNUAL) LIMITS

Group health plans, including grandfather plans, will no longer be allowed to impose lifetime limits on the dollar value of essential benefits beginning with the first plan year on and after September 23, 2010. Individuals who reached a lifetime limit and are otherwise eligible under the plan must be provided a notice that lifetime limits no longer apply. If an individual is no longer enrolled under the plan they must be given a special enrollment opportunity (and have the ability to elect any benefit plan offered and to enroll dependents) beginning with the first plan year on and after September 23, 2010.

While the issuance of guidance has been helpful, there are still a number of questions that remain unanswered which hopefully will be addressed in the final regulations. Some questions include:

- Can there be a lifetime limit on out-of-network benefits?
- Do the overall allowable annual limits apply to both in and out of network benefits? If so, would they be applied separately or can the limits cross-apply to services?
- Can plan sponsors limit essential benefits in other ways such as placing a limit on the number of visits for these services?

OTHER PATIENT PROTECTIONS

Group health plans that require the designation of a primary care physician (PCP) must allow enrollees the ability to select any PCP who will accept the participant and a child's PCP can be a pediatrician who specializes in allopathic or osteopathic medicine. Female members must be afforded direct access to OB-GYN services without a referral. The plan must provide a notice about these rights when a summary of benefit information is provided. Model language is available in the regulations.

Group health plans that cover emergency services must do so without requiring prior authorization (even for out-of-network services) and without regard to whether the provider participates in the network. In general, out-of-network emergency services cannot be more restrictive than in-network emergency services and out-of-network copayments and coinsurance amounts cannot exceed in-network requirements.

A plan is allowed to balance bill a member for out-of-network emergency services, but the regulations stipulate using the greatest of three acceptable methods for determining the "plan cost" which would therefore, be the basis for the balance billing amount.

These patient protections, which do not apply to grandfather plans, will be required to be implemented the first plan year on and after September 23, 2010.

AND FINALLY – ACTION STEPS

With so much going on and so many rules and regulations it is important to **start planning for your upcoming open enrollment season as early as possible**. For those employers whose next plan year is prior to October 1, 2010 (when ACA mandates will first apply), it is still important to understand the rules and prepare for the changes. Some practical guidance:

- Gather all plan documents, certificates of coverage, employee communications and plan-related information such as employer-employee contribution requirements for the group health plans that were in place on March 23, 2010. In particular, plans that retain grandfather status must be able to defend this and produce documents when requested.
- Assess the advantages and disadvantages of retaining grandfather status. Understand how each of the mandates as well as plan design changes you may be considering would impact your plan and organization both financially as well as administratively.
- Identify all notice and model language requirements for your employee communications.
- Maintain good records and documentation going forward.
- Begin to review payroll and census-capturing abilities to prepare for the new W-2 reporting requirements as well as nondiscrimination testing. Note: We will provide a separate *Insights* on the nondiscrimination requirements that will provide the specific requirements. Stay Tuned!

ADDITIONAL INFORMATION

For specific questions concerning information contained in this ***Insights***, please contact your Chernoff Diamond consultant.

Information contained in this ***Insights*** is not intended to render tax or legal advice. Employers should consult with qualified legal and/or tax counsel for guidance in respect of matters of law, tax and related regulation.

Chernoff Diamond provides comprehensive consulting and administrative services with respect to all forms of employee benefits, risk management and qualified and non-qualified retirement plans.

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