HealthPlans
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Compliance Bulletin
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Federal Health Care Reform
Implementation of Regulations
Issue Number 2: Grandfathering Provisions

The Patient Protection and Affordable Care Act (otherwise known as federal health care reform or the Affordable Care Act) was signed into law effective March 23, 2010. Since then, the U.S. Departments of Health and Human Services, Labor and Treasury have been drafting regulations to address the various provisions of the Act.

This is the second in a series of *Federal Health Care Reform Compliance Bulletin*s that **Health Plans** will issue as the provisions of federal health care reform are implemented. Please also refer to the Compliance *Guide* issued June 2, 2010 for a more in-depth discussion of certain topics. This edition focuses on the grandfathering regulations issued on June 14, 2010. Inside you will find information about:

- Which plans are grandfathered and why it's important
- The changes that will (and will not) cause a plan to lose grandfathered status
- Transitional timing rules for changes made between March 23 and June 14, 2010
- How loss of grandfathered status impacts a plan
- Documentation and disclosure notice requirements
- Whether preserving grandfathered status always makes good business sense
- Grandfathering provisions reference chart

With this Bulletin, we are also including a Grandfathering Status Checklist and link to a Plan Grandfathering Calculator to help you determine whether a proposed change may impact your plan(s).

Which Plans are Grandfathered?

A grandfathered plan is a plan in effect on March 23, 2010 and which:

- Continues to cover at least one person since March 23, 2010
  Note: Membership may change over time as long as at least one individual (not necessarily the same individual) is always covered under the plan;
- Is not amended or modified in a way that would cause it to lose grandfathered status (see page 2); and
- Maintains documentation and discloses its status as a grandfathered plan (see page 5)

Important: If a plan has more than one coverage option, the grandfathering rules apply separately to each option offered.

A note about collectively bargained plans
The rules outlined above apply even to plans governed by collective bargaining agreements (CBAs). The regulations issued on June 14, 2010 clarified that self-insured plans subject to CBAs are ***not*** treated differently from other self-funded plans. Although the initial health care reform bill indicated that plans subject to CBAs would be exempt from the new rules until at least the expiration of the last CBA applicable to the plan, the regulations specify that any special provisions for plans subject to CBAs apply only to fully insured plans, not to self-funded plans such as those **Health Plans** administers for its clients. Thus, there is no special delayed effective date for self-funded grandfathered CBA plans.

A note about retiree-only and excepted benefits
The preamble to the grandfathering rules confirms that retiree-only and HIPAA excepted benefit plans (i.e. stand alone dental and visions plans, and flexible spending account plans) are exempt from the health plan reform mandates of federal health care reform. As such, it is not necessary to determine whether or not such plans are grandfathered.

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Why is it Important to be a Grandfathered Plan?

While grandfathered plans must still comply with the most significant insurance and group health plan reform mandates established by federal health care reform*, they do not need to comply with many other requirements (see *How Does Losing Grandfathered Status Impact a Plan?* on page 4. Also see the *Chart* on page 8 which summarizes the provisions applicable to grandfathered and non-grandfathered plans.)

*a) coverage of children to age 26, b) elimination of preexisting condition exclusions, c) restrictions and eliminations of annual dollar limits for essential health benefits, d) elimination of lifetime dollar limits on essential health benefits, and e) 90 days limitation on waiting periods

What Causes a Plan to Lose Grandfathered Status?

The grandfather rules focus on changes that increase the employee share of costs beyond certain levels and/or reduce coverage available under the plan. Specifically, a plan will lose grandfathered status if, at **any time after March 23, 2010**:

- All or substantially all benefits necessary to treat a particular condition are eliminated (e.g., if coverage for a prescription drug necessary to treat a particular condition is eliminated, the regulations consider that substantially all benefits to treat the condition are eliminated)
- Coverage of a necessary element to diagnose a particular condition is eliminated (e.g., if a test to diagnose a particular condition is no longer covered, a necessary element for diagnosis is eliminated)
- Coinsurance percentages in effect for members on March 23, 2010 are increased by any amount
- Deductibles or out-of-pocket maximums in effect on March 23, 2010 are increased by more than the *rate of medical inflation** plus 15 percentage points (Note: the permissible increase in deductibles or out-of-pocket maximums is calculated on a *cumulative* basis from March 23, 2010 to the date of the change)

  *The *rate of medical inflation* is measured as the difference between the medical care component of the Consumer Price Index-Urban (CPI-U) as of March 2010 (387.142) and the highest medical care component CPI-U amount for any of the 12 months before the plan change. If the plan change is made less than 12 months after March 2010, the formula uses the highest monthly CPI-U medical care component amount since March 2010. The CPI-U is updated on a monthly basis, generally mid-month, to add the prior month's index amounts.

- Copayments in effect on March 23, 2010, are increased by more than the greater of
  - ◊ $5.00 increased by the *rate of medical inflation*, or
  - ◊ The percentage *rate of medical inflation* plus 15 percentage points

  (Note: the permissible increase in copayments is calculated on a *cumulative* basis from March 23, 2010 to the date of the change)
- Overall annual limits in effect on March 23, 2010, are changed in any of the following ways:
  - ◊ An overall annual limit is added to a plan that had no overall annual or lifetime limits on March 23, 2010
  - ◊ An overall annual limit is added to a plan that is lower than the overall lifetime limit in effect on March 23, 2010
  - ◊ An overall annual limit that was in effect on March 23, 2010 is decreased by any amount
- The employer contribution rate in effect on March 23, 2010 is decreased by more than 5 percentage points (applicable to each tier and coverage classification; e.g., if the employer maintains the employee rate of contribution but increases the family rate by more than 5%, plan loses grandfathered status)
- The plan sponsor changes from one insurer to another
- The plan sponsor transfers employees previously covered under a grandfathered plan into another otherwise grandfathered plan when no bona fide employment based reason exists for doing so (the new plan will not be considered a grandfathered plan) (an increase in health plan costs is not a permissible reason)
- The employer undergoes a merger, acquisition, or similar business restructuring if the principal purpose of the activity is to cover new individuals under a grandfathered plan (the new plan will not be considered a grandfathered plan)

(See the Grandfathering Status Checklist attached with this *Bulletin* for a summary of the changes that may affect grandfathered status)

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What Will Not Cause a Plan to Lose Grandfathered Status?

- Changes to premiums
- Changes to comply with federal or state legal requirements
- Changes to comply with federal health care reform, including voluntary early implementation of any provisions
- Changing third party administrators
- Changes to increase benefits
- Adding new family members, new employees, or new enrollees
- Employees moving between benefit options at open enrollment

Note: A change in stop loss carrier is not specifically listed in the grandfathering rules as an event triggering loss of grandfather status; however it is not expected to be added in the future as long as the stop loss policy is in the name of the employer and not the plan since the Department of Labor's (DOL's) position has always been that a stop loss policy in the employer's name is not part of the plan.

Additional Future Guidance Affecting Grandfathered Status

The federal agencies are considering future guidance to be prospectively applied regarding additional plan changes which may cause a loss of grandfathered status, such as:

- Changing from an insured to self-funded arrangement or changing from a reimbursement arrangement to major medical
- Changing provider networks
- Changing prescription drug formulary
- Other substantial changes to benefit design

Transitional Rules on Timing

Any change to a plan which took effect **before March 23, 2010** (the date that health care reform legislation was passed) will not affect grandfathered status.

As described below, depending on the circumstances, changes which would otherwise cause a loss of grandfathered status may or may not cause an actual loss of grandfathered status if the changes were made between March 23 and June 14, 2010.

Treatment of changes made <u>on or before</u> March 23, 2010, but effective after March 23, 2010

A plan will not lose grandfathered status for any of the changes listed above if the change was made on or before March 23, 2010, *and*

- The change was the result of:
  - ◊ A legally binding contract entered into on or before March 23, 2010
  - ◊ A filing made with a state insurance department on or before March 23, 2010
  - ◊ An amendment adopted (i.e., signed) on or before March 23, 2010

Example 1

Facts: On March 10, 2010 a plan sponsor signed an amendment effective April 1, 2010, changing the employee share of coinsurance from 10% to 15%.

Outcome: Plan retains grandfathered status because even though the amendment is effective after March 23, 2010, it was adopted before March 23, 2010.

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Treatment of changes made after March 23, 2010, but before June 14, 2010

Changes or amendments *adopted after health care reform was passed*, but before the grandfathering regulations were issued will cause a plan to lose grandfathered status unless they are revoked or modified effective by the first day of the first plan year beginning on or after September 23, 2010.

A change is "adopted" between March 23 and June 14 if it:

- Became effective and, if applicable, was signed before June 14, 2010, or
- Became effective after June 14, 2010 and was made pursuant to:
  - ◊ A legally binding contract entered into before June 14, 2010,
  - ◊ A filing made with a state insurance department before June 14, 2010, or
  - ◊ An amendment signed before June 14, 2010.

Example 2a

Facts: On April 15, 2010, a plan sponsor signed an amendment effective June 1, 2010, increasing the emergency room copayment from $100 to $250.

Outcome: Plan loses grandfathered status unless the amendment is retroactively revoked.

Example 2b

Facts: On July 1, 2010, a plan sponsor signs an amendment effective June 1, 2010, increasing the emergency room copayment from $100 to $250.

Outcome: Plan loses grandfathered status because amendment was signed (adopted) after June 14, 2010, and the plan sponsor may not retroactively revoke the change.

Note about "good faith compliance": Changes made after March 23, 2010 but before June 14, 2010 will not affect grandfathered status if the change only "modestly" exceeds the parameters set forth in the rules. The rules do not define "modestly."

How Does Losing Grandfathered Status Impact a Plan?

The *Chart* on page 8 compares the provisions applicable to grandfathered and non-grandfathered plans, showing the effective dates of each provision.

Here is a summary of the provisions that apply to **non-grandfathered plans**. Additional regulations are expected to further clarify these rules.

- **Beginning plan years starting on and after September 23, 2010**
  - ◊ Provide coverage for children to age 26, without regard to whether the child is eligible to enroll in another employer-sponsored plan
  - ◊ Provide 100% coverage of specified preventive services, with no deductibles or copayments
  - ◊ Allow members to designate any participating primary care provider as their Primary Care Physician (PCP), including a pediatrician for a child and OB/GYN for a woman
  - ◊ Cover emergency care at in-network levels without any pre-authorization requirement
  - ◊ Provide an expanded appeals process that includes both internal and external review
- **Beginning March 2012**
  - ◊ Report to HHS and members on quality of care provided by the plan including incentives for case management, care coordination, chronic disease management, activities to prevent hospital readmission, and health and wellness promotion activities

- **Beginning January, 2014**
  - ◊ Report to HHS, the public and state agencies data for transparency purposes including: claim payment policies and practices, financial disclosures, enrollment data, number of denied claims, rating practices, cost-sharing and payments regarding out of network coverage, and information on participants' rights

- **Beginning plan years starting on/after January 1, 2014**
  - ◊ Plan deductibles and out-of-pocket maximums may not exceed specified limits that may be indexed in future years:
    - ♦ Maximum deductibles: $2,000 individual; $4,000 family (indexed)
    - ♦ Maximum out-of-pocket costs: $5,950 individual; $11,900 family (indexed)
  - ◊ Plans must cover routine costs of individuals participating in clinical trials
  - ◊ Plans may increase the incentive for participation in wellness programs from 20% of the total cost of coverage (employer and employee contributions combined) to 30%

Documentation Required for Grandfathered Status

Required notice for grandfathered plans

To maintain grandfathered status, a plan must announce its status on all plan materials. Starting with materials that describe coverage for plan years that begin on or after September 23, 2010, the plan must provide a statement that the plan believes it is a grandfathered plan. The statement must make reference to the Patient Protection and Affordable Care Act and must provide plan contact information for participant questions and complaints.

The Department of Labor provided the model language below to satisfy this disclosure requirement:

> *This group health plan believes this plan 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 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 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 employer's contact information].*
>
> *[For ERISA plans] 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 website has a table summarizing which protections do and do not apply to grandfathered health plans.*
>
> *[For nonfederal governmental plans] You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.*

Maintain Records

To maintain grandfathered status, a plan must also document the terms of the coverage in effect on March 23, 2010 and any other documents necessary to verify, explain or clarify its status as a grandfathered plan. The plan must make the records available for examination upon request by applicable governing federal agencies. Plan participants must also be allowed to inspect such documents to verify the status as a grandfathered plan. All records must be made available for examination for as long as the plan remains grandfathered.

Preservation of Grandfathered Status: How Long Does it Make Business Sense?

Initially, most employers were eager to preserve the grandfathered status of their plans to avoid reporting requirements and increased coverage mandates that would further strain their health benefits budgets. Now, with implementing regulations recently issued, employers are reconsidering how hard they should work to preserve grandfathered status. Why? It's possible that the tight constraints on plan design required to preserve grandfathered status could end up with a higher cost – in terms of both dollars and employee relations – than adding the mandated benefits applicable to non-grandfathered plans.

Moreover, with the regulatory constraints against plan changes, the loss of grandfathered status may be inevitable. If a relatively modest increase in copayments or any increase in the employee's share of coinsurance could cause a plan to lose grandfathered status, how long, as a practical matter, could a plan hold out?

With that in mind, employers will want to weigh the costs versus benefits of retaining grandfathered status. Some employers may determine that the additional requirements imposed on non-grandfathered plans are less onerous, given their plan's current benefit design, than the effort that would be needed to retain grandfathered status. Others may find the cost of complying with the new requirements for non-grandfathered plans to be quite significant.

Implementation

Health Plans' Actions

Analysis

Based on our understanding of the grandfathering regulations issued on June 14, 2010, we will review plan amendments made since March 23, 2010 to determine whether any plan design changes may have caused a loss of grandfathered status. In cases where changes appear to have changed the status of the plan to non-grandfathered, your **Health Plans** Account Manager will contact you. **Note: You will need to notify us if you have decreased your contribution rate for any plan option in effect on March 23, 2010 by more than 5 percentage points since this will trigger a loss of grandfathered status** (see list of changes causing loss of grandfathered status on page 2).

Plan Amendment

We will amend your plan(s) to include the grandfathered or non-grandfathered provisions as applicable. See the *Chart* on page 8 for the effective dates of the provisions.

Model Notice for Grandfathered Plans

Beginning with your first plan year that begins on or after September 23, 2010, we will include the Model Notice statement noted above under *Documentation* on Summaries of Benefits, Plan Documents and, if applicable, plan amendments as long as your plan retains its grandfathered status.

Employer's Actions

Analysis

For plan changes going forward, the Grandfathering Status Checklist attached with this *Bulletin* with its link to the Plan Grandfathering Calculator will help you evaluate whether plan changes under consideration may affect your plan's grandfather status. Your **Health Plans** Account Manager can assist with this analysis; however, you may also want to consult with your benefits counsel regarding the impact of any specific plan changes you are considering.

Model Notice for Grandfathered Plans

Beginning with the first plan year that begins on or after September 23, 2010, employers should include the Model Notice statement noted above under *Documentation* in the plan's Open Enrollment materials distributed to their eligible employees as long as the plan retains its grandfathered status.

Maintenance of Records

Employers should be careful to keep all documentation related to plan design and cost-sharing since March 23, 2010 to support any assertion that the plan is eligible for grandfathered status, in accordance with the requirements noted above under *Documentation.*

As additional health care reform regulations are issued and analyzed, future editions of our *Implementation of Regulations* series will provide in-depth reviews of provisions that will affect our clients' plans. In the meantime, if you have questions about your plans, please contact your **Health Plans** Account Manager.

This Bulletin *is intended to provide a summary of our understanding of significant developments which may affect our clients' plans. It should not be construed as specific legal advice or legal opinion. The contents are for general informational purposes only and are not a substitute for the advice of legal counsel.*

GRANDFATHERING PROVISIONS REFERENCE CHART

PROVISIONS IN BOLDFACE APPLY TO NON-GRANDFATHERED PLANS ONLY

No.	EFFECTIVE DATE	PROVISION	GF	NON-GF
1.	March 30, 2010	▶Change in definition of dependent for purposes of tax free health coverage*	✓	✓
2.	Effective date currently unknown; TBD in regulations	▶Automatic enrollment	✓	✓
3.	First plan year beginning on or after September 23, 2010	▶Elimination of preexisting conditions exclusions for enrollees under age 19*	✓	✓
		▶Restricted annual dollar limits on essential health benefits**	✓	✓
		▶No lifetime dollar limits on essential health benefits**	✓	✓
		▶Prohibition on rescissions (cancellations) of coverage*	✓	✓
		▶All plan materials distributed to participants must contain notice re: grandfathering*	✓	
		▶Extension of coverage for children to age 26, unless other employer coverage available*	✓	
		▶Extension of coverage for children to age 26 (no exception for other coverage)*		✓
		▶100% coverage with no cost-sharing on coverage for preventive care*		✓
		▶Expanded internal appeals process (more than current ERISA/DOL)**		✓
		▶Allow individuals to choose pediatrician or OB/GYN as PCP*		✓
		▶Allow ER services w/o pre-authorization and cover as in-network*		✓
4.	Starting with 2011 W-2	▶W-2 Reporting on value of health benefits	✓	✓
5.	March 2012	▶Standardized benefit summaries (by March 23, 2012)	✓	✓
		▶Advance notice of plan changes – 60 days in advance of effective date	✓	✓
		▶Administrative simplification provisions (varying effective dates beginning in 2012)	✓	✓
		▶Reporting requirements regarding quality of care^		✓
6.	Plan years ending after September 30, 2012	▶Comparative effectiveness fee based on average covered lives	✓	✓
7.	January 2014	**▶Reporting requirements regarding transparency data^**		✓
8.	First plan year on or after January 1, 2014	▶No annual dollar limits on essential health benefits**	✓	✓
		▶Elimination of preexisting conditions exclusions for all enrollees*	✓	✓
		▶Waiting periods limited to 90 days	✓	✓
		▶Extension of coverage for children to age 26 (no exception for other coverage)*	✓	✓
		▶Maximum limits on deductibles, coinsurance and copayments		✓
		▶Coverage required for routine costs of patients in clinical trials		✓
9.	January 1, 2018	▶Cadillac plan tax	✓	✓

* Implementing guidance/regulations have been issued

** Implementing guidance/regulations have been issued which do not address all aspects of the provision; more guidance should be forthcoming

^ Subject to implementing regulations on reporting requirements and/or establishment of Exchanges

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