Benefit Comply, LLC

Health Reform Whitepaper

Grandfathered Plans

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Grandfathered Plans

One of the most common questions employers have asked since the passage of health reform legislation is what changes can be made to a plan and still retain its "grandfathered status". Much has already been written on what changes will cause a plan to lose its grandfathered status. This whitepaper also focuses on helping employers analyze if it matters to an employer to try to retain grandfathered status.

Employers will need to weigh the effect of the plan design restrictions that must be met to retain grandfathered status vs. the impact of health reform rules that must be implemented if a plan loses grandfathered status. We believe that many employers, particularly those small to mid-size fully insured plans, will find that the health reform related changes that would need to be adopted are relatively minor compared to the restrictions necessary to maintain grandfathered status. The primary reason an existing plan will find it attractive to retain grandfathered status is if the plan is fully insured and would not meet the Section 105 nondiscrimination rules which apply to fully-insured non-grandfathered plans.

Background

On Monday June 14th 2010, the IRS, DOL, and HHS jointly released interim final rules regarding health reform grandfathered plan status. The guidance is critical to employers since some of the rules contained in the Affordable Care Act (ACA) do not apply to grandfathered plans. Employers have been waiting to find out what changes can be made to a plan and retain its grandfathered status.

Changes that cause a loss of grandfathered status

Most of the changes that will cause a plan to lose its grandfathered status are related to reductions in benefits provided to employees. It seems that the grandfathered plan rules are designed to give employers a reason to keep benefits at or near current levels.

Plans will lose their grandfathered status if they make changes that exceed certain parameters when compared to the plan's polices in effect on March 23, 2010. The following changes would cause a plan to lose grandfathered status:

A significant cut or reduction in benefits for specific conditions. A plan would lose grandfathered status if it decided to eliminate "*all or substantially all benefits to diagnose or treat a particular condition"* for example, to no longer cover care for people with diabetes, cystic fibrosis or HIV/AIDS. The requirements specifically state the rule applies to cuts in coverage for specific "conditions", not individual treatments or procedures. Therefore, plans may be able to discontinue coverage for a particular procedure if other procedures are available to treat a medical condition . However, the regulations also state that "*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"* So any elimination of benefits must be carefully considered if a plan is trying to retain grandfathered status.

Raising co-insurance that is based on a percentage. Plans may not raise the % charged for co-insurance benefits where coverage is expressed as a percentage of costs (for example raising the hospital co-pay from 20% to 30%).

Reducing employer contributions. To retain grandfathered status an employer may not decrease the percent of premiums the employer pays by more than 5%. This does not mean the employer must pick up the entire premium increase, but it must maintain the % of contribution to a plan (within 5%).

For example: On March 23, 2010 an employer contributes a flat $300 toward a single plan with a total premium of $500. This equals an employer contribution of 60%. If the plan's rate increases to $600 the following plan year, the employer must contribute at least $330 (55% of $600) to retain grandfathered status. The contribution requirement applies to both single and family rates.

Reduction in annual limits. To retain their status as grandfathered plans, plans cannot reduce the annual dollar limit in place as of March 23, 2010. Plans that did not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit.

Change of Insurance Companies. Changing insurance companies no longer causes loss of grandfathered status. On 11/15/2010, the DOL, HHS and IRS (The Departments) jointly released an amendment to the interim regulations regarding grandfathered plan status which amended the rules regarding the effect changing insurance companies has on a plan's grandfathered status. According to the new rule, fully insured plans can now change insurance carriers without affecting their grandfathered status.

The rule applies only to changes made after the date of the publication of the amendment. If an employer with a fully-insured plan changed insurance carriers prior to 11/15/2010, the plan will lose grandfathered status. However, if an employer changes carriers after the notice was published, for example a change effective on 1/1/2011, the plan will not lose grandfathered status.

Significantly raising deductibles or fixed co-payment charges. Deductibles and fixed-dollar co-payments cannot be raised more than a specified amount. New deductibles and co-payments will be compared to those in effect on March 23, 2010. To retain grandfathered status plans can increase deductibles and co-pays by no more than a fixed percentage or $5 whichever is greater.

The allowed percentage increase is calculated by adding medical inflation since March 23, 2010 plus 15%. The medical inflation is defined as the unadjusted increase since March 2010 in the overall medical care component of the Consumer Price Index for all urban consumers (CPI–U).
To calculate the % increase allowed subtract 387.142 (the CPI-U medical value for March 2010) from the highest CPI-U medical component value in the 12 months prior to the change then divide that total by 387.142. Monthly CPI-U medical components values are published by the Department of Labor Bureau of Labor Statistics (BLS) and can be found at http://data.bls.gov/cgi-bin/surveymost?cu and then selecting "U.S. Medical Care, 1982-84=100 - CUUR0000SAM"

Example 1 - Plan considering a deductible increase effective January 1, 2012

- Plan deductible = $1000 on March 23rd, 2010
- Highest CPI-U medical component value in prior 12 months (as of Oct. 2011) = 403.43
- 403.43 – 387.142 = 16.288
- 16.288 ÷ 387.142 = 4.21%
- To retain grandfathered status the 1/1/2012 deductible can be raised to no more than $1194.20 (19.42% above the deductible in place on March 23, 2010).

Employers that offer multiple benefit options (i.e. giving employees a choice between a high deductible plan and a traditional PPO plan) will need to consider the grandfathered status of each option separately. Employer may find that changes will cause one option but not the other to lose grandfathered status.

Deciding if it matters that a plan loses grandfathered status

Possibly the most important question employers need to answer is does it even matter if their plan loses grandfathered status? While a number of health reform provisions do not apply to grandfathered plans, many may have a relatively small impact on plan design and administration depending on the current plan structure. The following health reform provisions do not apply to grandfathered plans. An attempt has been made to present them in order of likely impact on employer sponsored plans, however, we recognize that employer sponsored plans differ in many ways and employers may have different priorities so each employer must consider these in relation to their specific plans:

1. Section 105 non-discrimination rules - Non-grandfathered fully-insured plans will be subject to the Section 105 non-discrimination rules for the first time. These rules already apply to self-funded health plans so this change will not factor into an employer decision regarding grandfathered status for a self funded plan. The rule prohibits a plan from offering benefits in a manner that discriminates in favor of highly compensated employees. Penalties will be imposed on fully insured plans which violate these rules, so employers with benefit or eligibly rules that potentially favor highly compensated employees should have a qualified advisor review the rules prior to making any plan changes that would jeopardize grandfathered status.

2. Preventive care coverage requirements - Group health plans must cover certain preventive services, immunizations, and screenings, without any cost sharing. 100% coverage for preventive services is common in many employer sponsored group plans. Plans without current 100% preventive coverage benefits should consider the cost implication of adding this coverage.

3. Adult child coverage to age 26 – Grandfathered plans must offer coverage to adult children to the age of 26 if dependent coverage is offered. However, until 2014, grandfathered plans do not need to offer coverage if the adult child is eligible for other employer sponsored coverage. Beginning in 2014, grandfathered plans will need to offer coverage to adult children even if they have other employer sponsored coverage available.

4. Appeal Process - Group health plans must provide an internal appeals process of coverage determinations and claims and comply with any applicable State external review process. If the State has not established an external review process that meets minimum standards or the plan is self-insured, the plan or issuer shall implement an external review process that meets standards established by the health reform rules. For employers with fully-insured plans, it is anticipated that most fully-insured carriers will implement internal appeals procedures that will meet the requirements and that employers will not be required to set up their own separate procedures. Self-funded employers with plans that lose grandfathered status will need to work with their administrator to assure that qualified appeals procedures are in place.

5. Patient Protections - Group health plans must permit an individual to select a participating primary care provider, or pediatrician in the case of a child. Plans must also provide direct access to obstetrical or gynecological care without a referral. Plans may not require prior authorization or increased cost sharing for out-of-network emergency services.

6. Coverage for individuals participating in approved clinical trials - Prohibits health insurance issuers from dropping coverage because an individual (who requires treatment for cancer or another life-threatening condition) chooses to participate in a clinical trial. Issuers also may not deny coverage for routine care that they would otherwise provide because an individual is enrolled in a clinical trial.

7. Guaranteed renewability of coverage - Requires guaranteed renewability of coverage regardless of health status, utilization of health services, or any other related factor. Coverage can only

be cancelled under specific, enumerated circumstances. Most group plans offered by employers already operate in a way that would meet this requirement due to a variety of requirements including state insurance laws, HIPAA and the ADA.

Disclosure to Participants and Documentation

Disclosure to participants

Grandfathered plans must include a disclosure in plan materials stating that the plan believes it is a grandfathered plan and therefore is not subject to some of the provisions of the Affordable Care Act. The rules contain the following model language that can be used for this purpose.

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 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 website 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.healthreform.gov.]

Documentation

To maintain status as a grandfathered health plan, a group health plan must maintain records documenting the terms of the plan or health insurance coverage in connection with the coverage in effect on March 23, 2010.