June 17, 2010

Grandfathered Plan Regulations Released

The Departments of Labor, Health and Human Services and the Treasury (collectively, the Departments) issued interim final rules addressing grandfathered status under the recently enacted *Patient Protection and Affordable Care Act* (PPACA).[1] The regulations are effective for the first plan year that begins on or after September 23, 2010.

This guidance provides some much needed clarification, particularly as it relates to what a plan can and cannot do in order to retain grandfathered status. The following summarizes the rule in a question and answer format.

WHAT IS A GRANDFATHERED PLAN?

Grandfathered health plan coverage means coverage provided by a group health plan in which an individual was enrolled on March 23, 2010 (for as long as the plan maintains this status under the prescribed rules). A group health plan that provided coverage on March 23, 2010 is also a grandfathered plan with respect to new employees (whether newly hired or newly enrolled) and their families who enroll after March 23, 2010.

WHAT WILL CAUSE A GROUP HEALTH PLAN TO LOSE GRANDFATHERED STATUS?

The regulations identify the following ways a group health plan may lose grandfathered status:

- Entering into a new policy, certificate or contract of insurance after March 23, 2010 (because, for example, any previous policy, certificate or contract of insurance was not renewed);
- Eliminating all or substantially all benefits to diagnose or treat a particular condition (e.g. eliminating benefits for cystic fibrosis or AIDS);
- Any increase in a percentage cost-sharing requirement, such as coinsurance, measured from March 23, 2010 (e.g. moving from 20% cost-sharing to 30% cost-sharing);
- Any increase in a fixed-amount cost-sharing requirement other than a copay (e.g. increases to deductibles or out-of-pocket limits), if the total percentage increase in the cost-sharing requirement measured from March 23, 2010 exceeds medical inflation[2] plus 15 percentage points;
- Any increase in a fixed-amount copay, determined as of the effective date of the increase, if the total increase in the copay measured from March 23, 2010 exceeds the greater of:
  - An amount equal to $5 increased by medical inflation (that is, $5 times medical inflation, plus $5), or
  - The *maximum percentage increase* (defined as medical inflation expressed as a percentage plus 15 percentage points), determined by expressing the total increase in the copay as a percentage;
- A decrease in the employer's contribution rate[3] toward the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below the contribution rate in effect on March 23, 2010 (e.g. reducing the employer contribution from 80% to 70%); and

[1] As amended by the *Health Care and Education Affordability Reconciliation Act of 2010*, enacted March 30, 2010.
[2] The regulations define the term *medical inflation* to mean the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Customers (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 (overall medical care component of the CPI-U for March 2010) 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.

- With respect to annual limits[4]:
    - By implementing an annual or lifetime limit when the plan or coverage did not impose such limitations as of March 23, 2010;
    - When a plan that, as of March 23, 2010, did not have an overall annual limitation on the dollar value of benefits but imposed an overall lifetime limitation, adopts an annual limit at a dollar value lower than the lifetime limit in effect as of March 23, 2010; and
    - When a plan that imposed an overall annual limit on the dollar value of benefits, as of March 23, 2010, decreases the dollar value of the limit (e.g. from a $10,000 annual limit to a $5,000 annual limit).

At this point, it is unclear whether any of the following would revoke grandfathered status:

- Changes to the plan's structure (such as switching from an insured plan to a self-insured plan);
- Changes in a network plan's provider network, and if so, what magnitude of changes would have to be made;
- Changes in the prescription drug formulary; or
- Any other substantial change to the overall benefits design.

The Departments are seeking comments from the public on whether the list of changes is appropriate and whether additional changes (like the ones described above) should be incorporated.

WHAT CHANGES CAN WE MAKE THAT WILL NOT IMPACT OUR GRANDFATHERED STATUS?

The following will not cause a group health plan to lose grandfathered status, provided the plan otherwise remains grandfathered (i.e. the plan does not make other changes, for example, a carrier change, that would revoke grandfathered status):

- The group health plan no longer covers some (or even all) of the individuals who were enrolled on March 23, 2010, provided that the group health plan has continuously covered someone since March 23, 2010 (not necessarily the same person, but at all times at least one person);
- Mere enrollment changes (adding family members, new hires or new enrollees);
- Changes to the copay, deductible or out-of-pocket limits that do not exceed the thresholds described above;
- Changes in the employer contribution rate, provided the change is an increase in the employer contribution or, if a decrease, the decrease is not more than 5 percentage points below the contribution rate in effect on March 23, 2010;
- A change in the premiums (however, an employer contribution change as a result of the premium adjustment could result in a loss of grandfathered status);
- Changes to comply with Federal or State law;

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[3] *Contribution Rate* means either *a contribution rate based on the cost of coverage* or *a contribution rate based on a formula.*

- *A contribution rate based on the cost of coverage* means the amount of contributions made by an employer 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 COBRA premium In the case of a self insured plan, contributions by an employer are equal to the total cost of coverage minus the employee contributions toward the total cost of coverage.
- *A contribution rate based on a formula* means, for plans that, on March 23, 2010, made contributions based on a formula (for example hours worked), the formula.

[4] Independent of these "grandfathered status" rules dealing with newly adopted or reduced annual limits, additional restrictions on annual limitations are to be imposed on all group health plans effective with the first plan year that begins on or after September 23, 2010. Annual limitations on benefits will only be permitted as defined in regulations, which are expected to be issued in the near future.

- Changes to voluntarily comply with the PPACA; and
- Making a change in third-party administrators (TPA).

ARE THERE EXAMPLES ILLUSTRATING HOW A PLAN MAY (OR MAY NOT) LOSE GRANDFATHERED STATUS?

Coinsurance Change

Example: On March 23, 2010, a grandfathered health plan has an employee coinsurance requirement of 20% for inpatient surgery (i.e. the employee pays 20% toward inpatient surgery expenses). The plan is subsequently amended to increase the coinsurance requirement to 25%. The plan loses grandfathered status as a result of the increase in the coinsurance requirement from 20% to 25%.

Elimination of Benefits

Example: 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. 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.

Copay Change (2-part example)

Example 1(a): On March 23, 2010, a grandfathered health plan has a copay of $30 per office visit for specialists. The plan is subsequently amended to increase the copay to $40. Within the 12-month period before the $40 copay takes effect, the greatest value of the overall medical care component of the CPI-U (unadjusted) is 475.

The increase in the copay from $30 to $40, expressed as a percentage, is 33.33% (40 - 30 = 10; 10 ÷ 30 = 0.3333; 0.3333 = 33.33%).

Medical inflation from March 2010 is 0.2269 (475 – 387.142 = 87.858; 87.858 ÷ 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 copay at that time does not cause the plan to lose grandfathered status.

Example 1(b): Now assume for a later plan year, that the grandfathered health plan increases the $40 copay to $45. Within the 12-month period before the $45 copay takes effect, the greatest value of the overall medical care component of the CPI-U (unadjusted) is 485.

In this example, the increase in the copay from $30 (the copay that was in effect on March 23, 2010) to $45, expressed as a percentage, is 50% (45 - 30 = 15; 15 ÷ 30 = 0.5; 0.5 = 50%).

Medical inflation from March 2010 is 0.2527 (485 – 387.142 = 97.858; 97.858 ÷ 387.142 = 0.2527).

The increase that would cause a plan to cease to be a grandfathered health plan is the greater of the maximum percentage increase of 40.27% (0.2527 = 25.27%; 25.27% + 15% = 40.27%), or $6.26 ($5 x 0.2527 = $1.26; $1.26 + $5 = $6.26).

Because 50% exceeds 40.27% and $15 exceeds $6.26, the change in the copay at that time causes the plan to lose grandfathered status.

Decrease in Employer Contributions

Example 1: 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. The decrease of 10 percentage points for family coverage in the contribution rate based on cost of coverage causes the plan to lose grandfathered status. The fact that the contribution rate for self-only coverage remains the same does not change the result.

Example 2: On March 23, 2010, a self-insured grandfathered health plan has a COBRA premium for the 2010 plan year of $5,000 for self-only coverage and $12,000 for family coverage. The required employee contribution for the coverage is $1,000 for self-only coverage and $4,000 for family coverage. Thus, the contribution rate based on cost of coverage for 2010 is 80% ((5,000 – 1,000)/5,000) for self-only coverage and 67% ((12,000 – 4,000)/12,000) for family coverage. For a subsequent plan year, the COBRA premium is $6,000 for self-only coverage and $15,000 for family coverage. The employee contributions for that plan year are $1,200 for self-only coverage and $5,000 for family coverage. Thus, the contribution rate based on cost of coverage is 80% ((6,000 – 1,200)/6,000) for self-only coverage and 67% ((15,000 – 5,000)/15,000) for family coverage.

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.

WE OFFER A CHOICE OF HEALTH PLAN OPTIONS UNDER OUR GROUP HEALTH PLAN. IF WE CHANGE ONE BENEFIT PACKAGE UNDER THE PLAN (E.G. CHANGE THE CARRIER), DO WE LOSE GRANDFATHERED STATUS WITH RESPECT TO ALL OPTIONS OFFERED UNDER THE PLAN?

Whether or not a group health plan is grandfathered will apply separately to each benefit package made available under the group health plan or health insurance coverage. In other words, making a change to one benefit package under the group health plan may not necessarily change the grandfathered status of the other available benefit options.

Example: A group health plan (which is not maintained pursuant to a collective bargaining agreement) offers three benefit packages on March 23, 2010. Option C is a self-insured option. Options D and E are insured options. Beginning July 1, 2013, the plan replaces the insurance carrier for Option E with a new carrier. The coverage under Option E is not grandfathered health plan coverage as of July 1, 2013. This change to the grandfathered status of Option E does not affect the grandfathered status of Options C and D, provided C and D have not made changes that alter this status. If the plan enters into a new policy, certificate, or contract of insurance for Option D, then Option D's status as a grandfathered health plan would also cease.

ARE THERE OTHER WAYS OUR GROUP HEALTH PLAN COULD LOSE GRANDFATHERED STATUS?

Yes. The regulations contain specific anti-abuse provisions that apply in the following scenarios:

- 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; and
- 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 –
    - 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);
    - 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; and
    - There was no bona fide employment-based reason to transfer the employees into the transferee plan. For this purpose, changing the terms and the cost of coverage are not bona fide employment-based reasons.

Example: A group health plan offers two benefit packages on March 23, 2010, Options F and G. The plan sponsor eliminates Option F because of its high cost and transfers employees covered under Option F to Option G. If instead of transferring employees from Option F to Option G, Option F was amended to match the terms of Option G, then Option F would cease to be a grandfathered health plan. In this scenario, the plan did not have a bona fide employment-based reason to transfer employees from Option F to Option G. Therefore, Option G ceases to be a grandfathered health plan with respect to all employees.

WE RENEWED AND MADE PLAN DESIGN CHANGES PRIOR TO THE ISSUANCE OF THESE REGULATIONS – IS THERE ANY TRANSITION RELIEF?

Yes. The general rule is that grandfathered status is determined based on the coverage that was in place on March 23, 2010. However, the regulations provide some limited relief for plans that made changes prior to March 23, 2010, when the change is not effective until after that date, as well as plans that made changes after March 23, 2010, but before issuance of these regulations.

Changes made prior to March 23, 2010

A group health plan will not lose grandfathered status under the following circumstances if changes are made to the terms of the plan or health insurance coverage, even though such changes were effective after March 23, 2010:

- Changes made pursuant to a legally binding contract entered into on or before March 23, 2010;
- Changes made pursuant to a filing on or before March 23, 2010 with a State insurance department; or
- Changes made pursuant to written amendments to a plan that were adopted on or before March 23, 2010.

Changes made after March 23, 2010 and adopted prior to the 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 lose grandfathered status if the changes are revoked or modified effective as of the first day of the first plan year that begins on or after September 23, 2010 and the terms of the plan as modified would not cause the plan to cease to be a grandfathered plan.

Changes are considered to have been adopted prior to June 14, 2010 if the changes are effective:

- Before June 14, 2010;
- On or after June 14, 2010, pursuant to a legally binding contract entered into before that date;
- On or after June 14, 2010, pursuant to a filing before that date with the State insurance department; and
- On or after June 14, 2010, pursuant to written amendments to a plan that were adopted before that date.

Good-Faith Compliance

For purposes of enforcement, the Departments will take into account any good-faith efforts to comply with a reasonable interpretation of the statutory requirements and may disregard changes to plan terms that only modestly exceed the requirements described in the regulations, provided these changes were adopted before June 14, 2010.

WHAT REFORM REQUIREMENTS APPLY TO A GRANDFATHERED PLAN?

All group health plans (grandfathered and non-grandfathered) must comply with many of the various health care reform requirements. From a plan design perspective, these requirements include:

Effective with the first plan year that begins on or after September 23, 2010:

- No lifetime or annual limits on essential benefits (annual limits may be permitted as prescribed in future guidance);

- No rescissions of coverage;
- Extend coverage to dependent children up to age 26, unless the child is eligible for other employer-sponsored group health plan coverage (other than employer-provided coverage through the child's parent);
- No pre-existing condition exclusions imposed on children under age 19; and
- Insured plans must comply with medical loss ratio requirements.

Effective on or after March 23, 2012:

- Development and utilization of uniform explanation of coverage documents and standardized definitions.

Effective with the first plan year that begins on or after January 1, 2014:

- No pre-existing condition exclusions or other discrimination based on health status;
- No waiting periods in excess of 90 days;
- Coverage to children up to age 26, regardless of other employer coverage; and
- All annual limits prohibited.

All plans, regardless of grandfathered status, will also be subject to, among other things, W-2 reporting (2011), health FSA limits (2013), automatic enrollment requirements (2014), potential employer penalties (2014) and the excise tax associated with high-cost plans (2018).

IF WE LOSE GRANDFATHERED STATUS, WHAT ADDITIONAL REQUIREMENTS WILL APPLY TO OUR PLAN?

Plans that lose grandfathered status will need to comply with additional reform requirements.

For the first plan year that begins on or after September 23, 2010, the following applies:

- Preventive services must be covered without cost-sharing;
- Fully insured plans are prohibited from discriminating in favor of highly compensated individuals with respect to eligibility and benefits (as defined under Code Section 105(h));
- Group health plans must permit an individual to select a participating primary care provider, or pediatrician in the case of a child and provide direct access to obstetrical or gynecological care without a referral;
- Group health plans are prohibited from imposing prior authorization requirements or increased cost sharing for out-of-network emergency services; and
- A new appeals process.

In 2014, additional reform requirements will apply including specific plan design requirements such as providing "comprehensive health insurance coverage" [5], and imposing maximum deductible limits ($2,000 single; $4,000 family) in the small group market.

[5] The term "comprehensive health insurance coverage" needs further clarification, but is expected to include:

- Providing "essential benefits" (a term to be defined in future regulations);
- Covering at least 60% of the actuarial value of covered benefits; and
- Having annual cost-sharing limits capped at current limits for qualified high-deductible health plans tied to a Health Savings Account (HSA) - $5,950/single and $11,900/family.

ARE THERE ANY NOTIFICATION OR DOCUMENTATION REQUIREMENTS ASSOCIATED WITH A GRANDFATHERED PLAN?

Yes – there are disclosure and documentation requirements.

Disclosure

To maintain grandfathered status, a group health plan must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan, that the plan believes it is a grandfathered health plan within the requirements of the PPACA and must provide contact information for questions and complaints.

It appears this notification may be provided in plan documents, health insurance policies (or certificates or contracts of insurance), a summary plan description, documentation of premiums or the cost of coverage, and documentation of the required employee contribution rates.

The regulations provide model language can be used to satisfy this disclosure requirement. For a link to the model language, visit http://www.dol.gov/ebsa/ (click on *Model Notice* under *Grandfathered Health Plans*).

Documentation

To maintain status as a grandfathered plan, a group health plan or group health insurance coverage must, for as long as the plan or health insurance coverage takes the position that it is a grandfathered health plan:

- 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
- Make such records available for examination upon request.

WE ARE A COLLECTIVELY BARGAINED PLAN, ARE THERE SPECIAL GRANDFATHERED RULES THAT PERTAIN TO US?

In general, a grandfathered collectively bargained plan (insured and self-insured) will need to comply with the same reform rules that apply to any other grandfathered group health plan.

When dealing with insured coverage provided pursuant to a collective bargaining agreements that was ratified before March 23, 2010, the coverage is considered grandfathered 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 to modify the coverage solely to conform to any requirement added by the PPACA 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 is made by 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. A limited exception to this rule applies if, before the expiration of the collective bargaining agreement, the group health plan made a carrier change, then the carrier change alone will not cause a loss of grandfathered status, assuming that the change occurred before the expiration of the last collective bargaining agreement.

Health Reform Update

An Ongoing Analysis Concerning the Direction of Healthcare Policy

WHAT SHOULD PLAN SPONSORS DO?

- Review proposed changes to your group health plan to determine whether or not your plan will be considered a grandfathered plan. You will likely want to weigh any benefit of being a grandfathered plan against any plan design or cost changes you may be considering that would remove this status.
- If your group health plan made changes prior to June 14, 2010 (e.g. an April or May renewal), determine whether such changes removed your plan from grandfathered status and decide whether to revoke or modify the changes with the next renewal to reinstate your grandfathered coverage.
- If you are a grandfathered plan, ensure you provide proper disclosure to participants and beneficiaries and maintain records to comply with the documentation requirement.

WHERE CAN I GET MORE INFORMATION?

For a copy of the regulations (including how to submit comments), visit http://www.dol.gov/federalregister/PdfDisplay.aspx?DocId=23967

For a Fact Sheet, visit http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html.

For the FAQ, visit http://healthreform.gov/about/grandfathering.html.

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