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REFORM Update

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The much anticipated final regulations explaining how to determine whether a plan will be considered "grandfathered" under Health Care Reform were released on June 14, 2010. A plan that qualifies as grandfathered will be able to delay implementing several requirements of Health Care Reform.

These are the first Health Care Reform regulations issued as a single document by the combined efforts of several governmental entities including the Internal Revenue Service, Department of Treasury, Employee Benefits Security Administration, Department of Labor, the Office of Consumer Information and Insurance Oversight and the Department of Health and Human Services.

Under the original legislation, a section titled *Preservation of the Right to Maintain Existing Coverage* defined a grandfathered health plan to be "…coverage provided by a group health plan or a health insurance issuer in which an individual is enrolled on March 23, 2010..." The recently released regulations retain the idea that a grandfathered plan must have existed prior to March 23, 2010, but then adds a series of rules and tests that must be satisfied each year in order for a health plan to maintain grandfathered status.

The June 14, 2010 regulations discuss the benefits of being a grandfathered plan, steps health plans must take to preserve grandfathered status, and changes that a health plan could make that will affect grandfathered status. This *Update* will address the following:

- Plans that can qualify as grandfathered and plan changes that end grandfathered status
- Provisions delayed for grandfathered plans
- Action steps required to qualify for grandfathering
- Impact on collectively bargained (union) plans
- Employer considerations

Though reserving a grandfathered status provides the ability to delay specific aspects of health care reform, rising health care costs may drive many employers to make plan changes that will end grandfathered status. All employers will need to weigh the benefits of grandfathered status against their ability to make plan changes that allow them to manage cost.

Plan That Can Qualify As Grandfathered and Plan Changes That End Grandfathered Status

The regulations clearly indicate that a plan must have been in existence prior to March 23, 2010 in order to be considered grandfathered. For most group health plans, that will be relatively easy to demonstrate with existing ERISA documentation, health plan documents, or insurance policies. However, a number of actions will cause a plan to lose grandfathered status.

First, grandfathered status separately applies to each benefit package or option. For an employer that offers multiple benefit plan choices, one benefit option may be grandfathered while another might lose grandfathered status – each of the actions noted below must be evaluated for each benefit option.

One simple example of an action that causes loss of grandfathered status would be an employer entering into a new policy, certificate, or contract of insurance after March 23, 2010 - even if the new contract replaces one in effect prior to March 23, 2010. The example included in the regulations describes an employer offering three benefit options to employees through three different carriers. The employer replaces one carrier on January 1, 2011 – the benefit option with the new carrier will no longer be grandfathered, but the other two plans could (absent other changes) remain grandfathered.

The regulations include anti-abuse rules to make it clear that employers will not be allowed to take action designed solely to take advantage of the grandfathered rules:

- In a mergers and acquisition situation if the principal purpose of the restructuring is to cover individuals under a grandfathered plan - the health plan ceases to be a grandfathered plan
- Any eligibility change designed to transfer employees from one plan into a grandfathered plan with no bona fide employment-based reason for the transfer – the health plan ceases to be a grandfathered plan
- Some changes are permissible because there is a bona fide business reason for the change such as an employer offering two plans at open enrollment where an employee switches between plans or an employer closing down a facility and terminates the facility health plan. The employer is allowed to transfer the few remaining employees to another plan the employer maintains

The regulations make clear that certain changes to benefit provisions can cause a loss of grandfathered status. If a plan makes changes, it must pass a series of rules and tests in order to maintain grandfathered status. Not all changes will cause a loss of grandfathered status, however, the following changes will:

- Eliminate all or substantially all benefits to diagnose or treat a particular condition - 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 that particular condition
- Increase, in any way, a percentage cost-sharing requirement (coinsurance) above the level that was in effect on March 23, 2010
- Increase fixed cost sharing requirements other than copayments such as deductibles or out of pocket maximums **by a total percentage measured from March 23, 2010 that is more than the sum of medical inflation plus 15%**

- Increase copayments by an amount that **exceeds the greater** of:
    a) A total percentage measured from March 23, 2010 that is more than the sum of medical inflation plus 15%; or
    b) $5 increased by medical inflation measured from March 23, 2010
- For a group health plan, decreasing employer contribution rate by more than five percentage points below the rate on March 23, 2010 - decrease based on cost of coverage and applies separately to the cost at any coverage tier for any class of similarly situated individuals
- With respect to annual limits, group health plans that on March 23, 2010:
    a) Did not impose annual or overall lifetime limit on dollar value of all benefits adds annual limit on dollar value of benefits to the plan
    b) Did impose an overall lifetime limit on dollar value of all benefits but did not impose an overall annual dollar limit on benefits adopts an annual limit on dollar value of benefits lower than lifetime dollar limit plan had on March 23, 2010
    c) Did impose an overall annual limit on the dollar value of all benefits and decreased the dollar value of the annual limit

The regulations include a couple definitions of terms that will help in assessing the impact of changes:

- *Medical inflation* means increase since March 2010 in the overall medical care component for CPI-U unadjusted (Consumer Price Index for all Urban Consumers) published by the DOL using the 1982-1984 base of 100. Overall increase is calculated by subtracting 387.142 (March 2010 amount) from indexed amount for any month in 12 months before change takes effect and then dividing that result by 387.142
- *Contribution rate based on the cost of coverage* means the amount of contributions made by an employer compared with the total cost of coverage expressed as a percentage

The regulations also include a number of examples that explain practical situations to help employers understand these provisions:

- Plan with 20% coinsurance level on March 23, 2010 that increases the coinsurance level to 25% - as of the date coinsurance increases, plan no longer grandfathered
- Plan with $30 copay for a specialist visit on March 23, 2010 increases copay to $40
    1. 12 month period before change takes effect, overall medical component of CPI-U is 475
    2. Increase in copay expressed as percent (40-30=10; 10/30) = 33%
    3. Medical inflation expressed as percent (475 - 387.142 = 87.858 / 387.142) = 22.69%
    4. The maximum increase permitted (22.69% + 15%) = 37.69%
    5. Change value of 33.33% is below the 37.69% maximum – plan keeps grandfathered status

Please note, medical inflation has averaged under 4% a year for the past year, and so we are not certain why this example puts medical inflation at 22.69%. (If we use a 4% medical inflation rate, the change would cause a loss of grandfathered status.)

- Employer contributes 80% of total cost for single and 60% of total cost for family coverage on March 23, 2010, then employer decided to reduce contribution for family coverage to 50% with no change to single coverage - plan loses grandfathered status as 10% decrease to employer contribution for family coverage exceeds 5% limit (not changing single rate has no impact).

The rules do include transitional guidance for changes made prior to March 23, 2010. If a group health plan or health insurance carrier made any changes to the terms of the plan, these changes are considered part of the benefits in place on March 23, 2010 if any of the following circumstances apply:

- Changes made after March 23, 2010 pursuant to a legally binding contract entered into on or before March 23, 2010
- Changes made effective after March 23, 2010 pursuant to a filing on or before March 23, 2010 with a State insurance department
- Changes made effective after March 23, 2010 pursuant to a written amendment to the plan that was adopted on or before March 23, 2010

In some cases, employers made changes prior to the issuance of the grandfathering regulations. If employer made changes effective after March 23, 2010, but before these regulations were issued, the employer has two options:

- If changes sufficient to lose grandfather status, plan can maintain changes and simply be considered a non-grandfathered plan
- Employer can revoke or modify changes effective first day of the first plan year following September 23, 2010 and, assuming any other change does not cause the plan to lose grandfathered status, the plan can maintain the grandfathered status

Provisions Delayed For Grandfathered Plans

Health Care Reform includes a number of provisions that will affect employer-sponsored and individual insurance plans in the short and long term. Many of the provisions have different effective dates. In order to best understand the provisions affected, the following is a list of all the requirements addressed in the insurance reform section of the health reform acts, the effective date of each requirement, and if that effective date can be delayed for a grandfathered plan:

Reform Requirement	Effective Date	Delayed for Grandfathered Plan?
Prohibition on dollar lifetime limits	First day of first plan year following September 23, 2010	**NO**

Reform Requirement	Effective Date	Delayed for Grandfathered Plan?
Restriction on unreasonable annual dollar limits	First day of first plan year following September 23, 2010	**NO**
No pre-existing condition limitation on children under 19	First day of first plan year following September 23, 2010	**NO**
Prohibition on coverage recissions	First day of first plan year following September 23, 2010	**NO**
Specified preventive care services covered with no copayment	First day of first plan year following September 23, 2010	**YES**
Extension of Section 105(h) non-discrimination rules to insured plans	First day of first plan year following September 23, 2010	**YES**
Extension of coverage to adult children (age 26)	First day of first plan year following September 23, 2010	**NO**
New claim appeal procedures and rules	First day of first plan year following September 23, 2010	**YES**
Primary care physician rules	First day of first plan year following September 23, 2010	**YES**
Rules for emergency room coverage	First day of first plan year following September 23, 2010	**YES**
New quality reporting requirements	Not clear; Department of Health and Human Services has two years to develop reporting requirements	**YES**
Provision of the four-page summary of benefits requirement that is culturally and linguistically appropriate	Not clear; however, the government has until March 2011 to develop a model and employers have until March 2012 to deliver	**NO**
Limitation on new hire waiting periods	First day of first plan year on or after January 1, 2014	**NO**
Requirement to provide coverage for clinical trails	First day of first plan year on or after January 1, 2014	**YES**
Elimination of annual dollar limitations for essential benefits	First day of first plan year on or after January 1, 2014	**NO**
Prohibition of pre-existing condition limitation for all plan participants	First day of first plan year on or after January 1, 2014	**NO**
Changes to HIPAA non-discrimination rules when rewarding achievement of health factor	First day of first plan year on or after January 1, 2014	**YES** (please note – changes can be delayed by grandfathering, original HIPAA non-discrimination rules still apply)

Also, grandfathered plans have the ability to exclude adult children from their plan's eligibility if the child has coverage available through an employment-based health plan that is not related to either parent. This provision expires in 2014, even if your plan maintains grandfathered status beyond 2014.

When reviewing the cost/benefit of maintaining a grandfathered plan status, it is important to understand which aspects of health reform will have a delayed effective date. Interestingly, the regulations do not directly discuss the actual effective date of provisions that can be delayed. It is assumed that once a plan loses grandfathered status, the plan will have to comply with any provisions that were delayed by the grandfather protection.

Action Steps Required To Qualify For Grandfathering

In order to maintain the status of a grandfathered plan, the plan or health insurance carrier must include a statement in any plan materials provided to the participant or beneficiary describing the benefits provided by the plan that the plan believes it is a grandfathered health plan within the meaning of Section 1251 of the Patient Protection and Affordable Care Act. The plan must provide contact information for questions and complaints.

The regulations include model language that 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 limits on benefits.
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> 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.]

In addition to including the model disclosure language, an employer must document the plan and policy terms in effect on March 23, 2010. As long as the plan takes the position that it is a grandfathered plan, the plan must:

- Maintain records documenting the terms of the plan or coverage in effect on March 23, 2010

- Maintain any additional documentation needed to verify, explain or clarify the status as a grandfathered plan
- Make records available upon request

If an employer plan intends to maintain the status as a "grandfathered plan", the plan must meet the disclosure and documentation requirements.

Impact On Union Plans

Health Care Reform legislation included a provision stating certain requirements would not apply to health insurance coverage maintained pursuant to one or more collective bargaining agreements ratified before the March 23, 2010 **until** the longest running collective bargaining agreement associated with the plan terminates. The grandfathering regulations make some **very significant** clarifications to these general rules. In fact, union plans will not be allowed to delay effective dates in many cases, despite the original language in the statute.

The health reform acts only allow delays for "health insurance coverage" which would be considered fully insured plans. **Self-funded union plans will treated in the same manner as self-funded non-union medical plans.**

Insured union plans were initially permitted a delayed effective date on all the provisions included in the statute. These regulations clarify that if a fully insured plan is subject to a collective bargaining agreement that was ratified prior to March 23, 2010, that plan is granted automatic "grandfathered status" until the longest running collective bargaining agreement associated with the plan expires. This means fully insured union plans will need to comply with the provisions listed in the previous section of this *Update* that do not have a delayed effective date for grandfathered plans. In the case of a fully insured union plan, their grandfathered status is protected until the longest running union agreement expires. The regulation includes an example of a fully insured union plan with a CBA that expires on December 31, 2011. The plan changes insurance carriers on January 1, 2011. While this change would prompt other grandfathered plans to lose their grandfathered status, since the plan is a fully insured union plan, grandfathered status is protected until December 31, 2011 when the agreement expires.

If a plan chooses to adopt any element of health care reform early, that change will not be treated as a termination of the collective bargaining agreement.

Employer Considerations

Employers will need to review benefit changes carefully for the next three years and remember that changes will always be compared to the baseline benefits in place on March 23, 2010. While changes in 2011 may not cause a loss of grandfathered status, the employer must go though the same analysis when entertaining changes for 2012 and 2013 – with all changes compared to 2010.

Employers should project the cost assuming both grandfathered and non-grandfathered status, with non-grandfathered plans facing an additional 1% to 2% increase on top of health care cost trend. With health plan cost trends on the rise, some employers may be able to achieve budget goals with changes that allow maintenance of grandfathered status. Others may need to hit tighter budget numbers that will require changes that exceed those allowed by grandfathering rules. Given the wide range of benefit plans and employer financial conditions, every organization will need to complete a cost/benefit analysis to determine the approach that best meets their needs.