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Healthcare Reform: Long-Awaited "Grandfathered" Regulations Released – What Do Employers Need to Know?

By Ilyse Schuman and Melissa Kurtzman

On June 17, 2010, the Departments of Labor, Health and Human Services and Treasury published in the *Federal Register* Interim Final Rules (pdf) relating to "grandfathered" health care plans under the Patient Protection and Affordable Care Act (PPACA).[1] Under PPACA, as amended by the Health Care and Education Reconciliation Act of 2010[2] (Reconciliation Act), health plans that were implemented before PPACA was signed into law on March 23, 2010, are exempt from many, but not all, of the law's consumer protections. Employers have anxiously awaited release of the Interim Final Rules to clarify how health plans may qualify for or lose such grandfathered status.

The grandfathering provisions contained in section 1251 of PPACA have served as the basis for contending that the new health care reform law will allow individuals to keep their current health care coverage. For the 133 million people with employer-sponsored health coverage, the application of the grandfathering rules may significantly impact whether or not this claim proves to be valid over time. For employers, the Interim Final Rules present difficult choices about making changes to their plans that may result in a loss of grandfathered status. As employers evaluate the value of providing grandfathered health coverage in comparison to their need for flexibility, a number of them may well conclude that the benefits of flexibility outweigh those of grandfathering.

Advantages of Grandfathered Status

Grandfathered health plans do not need to comply with many of the new insurance market reform rules under the PPACA. Retiree only health plans, dental and vision only plans and health Flexible Spending Accounts (FSAs) are also generally exempt from the PPACA's plan operations and design changes. Those employer-sponsored plans that lose their grandfathered status will be considered new plans subject to the full application of PPACA's consumer protection provisions.

The insurance market reform requirements that new, non-grandfathered plans, are required to meet include:

- Requiring coverage of preventative care (effective for plan years beginning on or after September 23, 2010).
- A new appeals process that includes both internal and external reviews for appeals of coverage determinations and claims (effective for plan years beginning on or after September 23, 2010).
- Prohibiting discrimination in favor of highly compensated employees by fully-insured plans. The nondiscrimination requirements of section 105(h) of the Internal Revenue Code are extended to fully-insured plans (effective for plan years beginning on or after September 23, 2010).
- Requiring coverage of emergency services without prior authorization and in-network requirements (effective for plan years beginning on or after September 23, 2010).
- Allowing the designation of a participating primary care provider and pediatricians (effective for plan years beginning on or after September 23, 2010).
- Prohibiting required authorization or referral for an OB-GYN (effective for plan years beginning on or after September 23, 2010).
- Quality of care reporting regarding plan benefits and reimbursement structures (the secretary shall establish reporting requirements no later than March 23, 2012).
- Requiring "essential health benefits" for insurers in the individual and small group markets (effective for plan years beginning on or after January 1, 2014).
- Prohibiting annual cost-sharing limits that exceed the thresholds applicable to health saving accounts (HSAs) (effective for plan years beginning on or after January 1, 2014).
- Prohibiting small group health plans from imposing a deductible greater than $2,000 for self-only coverage, or $4,000 for any other coverage (effective for plan years beginning on or after January 1, 2014).
- Prohibiting basing eligibility on health-status related factors (effective for plan years beginning on or after January 1, 2014).
- Coverage for participation in clinical trials for life-threatening diseases (effective for plan years beginning on or after January 1, 2014).

Accordingly, the exemptions applicable to grandfathered plans are not insignificant. The exemption from the 105(h) nondiscrimination requirements for grandfathered fully-insured plans may be of particular importance to some employers. However, grandfathered status will not exempt employers from new penalties and taxes included elsewhere in the PPACA. For example, the employer penalties, excise tax on high-cost or "Cadillac" plans, and new restrictions on flexible spending accounts apply regardless of a plan's grandfathered status. Moreover, the amendments contained in the Reconciliation Act diminished considerably the advantages to grandfathered plans by applying certain consumer protections to both new and existing plans.

The insurance market reform requirements that both grandfathered and new plans, are required to meet include:

- Extending dependent coverage up to age 26. Prior to 2014, grandfathered group health plans must only extend dependent coverage to age 26 if the dependent is not eligible for other employer-sponsored coverage (effective for plan years beginning on or after September 23, 2010).
- Prohibiting rescissions except in the case of fraud or intentional misrepresentation of material fact (effective for plan years beginning on or after September 23, 2010).
- Prohibiting pre-existing condition exclusions. Plans are prohibited from imposing preexisting condition exclusions for children

under the age of 19 effective for plan years beginning on or after September 23, 2010. Beginning in 2014, plans are prohibited from including a preexisting condition exclusion for any participant.

- Prohibiting lifetime dollar limit on essential health benefits (effective for plan years beginning on or after September 23 , 2010).
- Restricting annual benefit limits. Effective for plan years beginning on or after September 23, 2010 and prior to January 1, 2014, grandfathered plans may impose annual limits on the dollar value of essential health benefits only as determined by the Secretary of Health and Human Services. Beginning in 2014, annual dollar limits are prohibited for all essential health benefits.
- Uniform explanation of coverage documents (effective no later than March 23, 2012).
- Prohibiting waiting periods greater than 90 days (effective for plan years beginning on or after January 1, 2014).

Definition of Grandfathered Health Plan Coverage

Any group health plans in which an individual was enrolled on March 23, 2010, is a grandfathered health plan, even if all of the individuals enrolled in the plan on March 23, 2010, cease to be covered in the future as long as someone is enrolled. Family members enrolling after March 23, 2010 do not impact grandfathered status. Each benefit package under a group health plan is treated as a separate grandfathered plan.

New employees may join an existing plan without causing it to lose grandfathered status. However, the regulations contain an anti-abuse feature to stop employers from using mergers, acquisitions or similar business reorganizations to avoid losing grandfathered status. The regulations also include another anti-abuse provision intended to prevent transferring employees between grandfathered plans for the purpose of retaining grandfathered status. For example, a group health plan offers two benefit packages on March 23, 2010, Options F and G. The plan sponsor then eliminates Option F because of its high costs 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 plan. In this case, there was no bona fide business reason for the transfer, and Option G would cease to be a grandfathered plan.

Collectively Bargained Plans

PPACA contains a special rule for collectively bargained plans. However, the interpretation of this provision in the Interim Final Rule significantly diminishes its apparent intent, scope and utility, and is expected to generate controversy. With respect to health insurance coverage maintained pursuant to one or more collective bargaining agreements ratified before March 23, 2010, the coverage is grandfathered at least until the date on which the last of the agreements relating to the coverage terminates, even if there is a change in issuers. However, this provision applies only to fully-insured health plans maintained pursuant to a collective bargaining agreement. At the termination of the last agreement, the terms of the coverage will be compared to the terms in effect on March 23, 2010, to determine if the coverage remains grandfathered.

Moreover, there is no deferred effective date for collectively bargained plans from the provisions that apply to grandfathered plans, such as the extension of dependent coverage or prohibition on lifetime limits. In essence, these changes may need to be made to the health care coverage *before* the contract expires just as they must be made to other grandfathered plans. The preamble notes that similar language in previous bills that were not enacted would have provided a delayed effective date for collectively bargained plans. The preamble acknowledges that "questions have arisen as to whether section 1251(d) as enacted in the [PPACA] similarly operated to delay the application of the [PPACA's] requirements to collectively bargained plans." However, the regulators conclude that collectively bargained plans that are grandfathered health plans are subject to the same requirements as other

grandfathered health plans, and are not provided with a delayed effective date for insurance market reforms with which other grandfathered plans must apply. Such an interpretation is likely to face challenge as contrary to statutory language and intent by effectively eviscerating the special rule with respect to collectively bargained plans and giving rise to mid-contract changes that a special rule has historically sought to avoid.

New Policies, Certificates or Contracts

With respect to plans other than collectively bargained plans, if an employer enters into a new policy after March 23, 2010, the employer's plan will no longer be a grandfathered plan. However, for self-funded plans, changing third party administrators will not result in a loss of grandfathered status.

Disclosure and Recordkeeping Requirements

Grandfathered plans must provide a written notice to all participants and beneficiaries about the grandfathered status of the plan. A model notice is contained in the regulations. The notice specifically provides "[b]eing a grandfathered health plan means your plan does not include certain consumer protections of the PPACA, that apply to other plans. For example, the requirement for the provision of preventive health services without any cost-sharing." This language may be problematic in maintaining good employee relations. A grandfathered health plan must retain records regarding the coverage and costs in effect on March 23, 2010. This should not be problematic since record retention is currently required under ERISA.

Changes Causing Cessation of Grandfathered Status

In drafting the Interim Final Rules, the Departments stated that they "sought to provide adequate flexibility to plan sponsors and issuers to ease transition and mitigate potential premium increases while avoiding excessive flexibility that would conflict with the goal of permitting individuals who like their healthcare to keep it and might lead to longer term market segmentation as the least costly plans remained grandfathered the longest." In order to temper the building criticism over a draft of the regulations, Labor Secretary Hilda Solis and Department of Health and Human Services Secretary Kathleen Sebelius held a press conference to outline the new regulations and answer questions. As explained during the press conference and reiterated in a fact sheet, the regulations stipulate that health plans will lose their grandfathered status if they chose to make "significant changes that reduce benefits or increase costs to consumers." However, the Interim Final Rules do constrain an employer's flexibility in making plan changes that, over time, would diminish the value of retaining grandfathered status.

The Interim Final Rules outline those changes that would trigger a loss of grandfathering.

- **Elimination of Benefits**. The elimination of all or substantially all benefits to diagnose or treat a particular condition will cause a plan to lose grandfathered status. For example, eliminating the treatment for cystic fibrosis will cause a plan to lose grandfathered status. The elimination of benefits for any necessary element to diagnose or treat a condition is also an automatic loss of grandfathered relief. For example, if a certain mental illness requires counseling and prescription drugs, the elimination of counseling will cause the plan to lose grandfathered status. Plans may make voluntary increases in benefits without losing grandfathered status.
- **Increase in Percentage of Cost Sharing**. Any increase, measured from March 23, 2010, in a percentage cost-sharing requirement (co-insurance) causes a group health plan to lose grandfathering. For example, an increase from 20% for in-patient surgery to 30% will cause the plan to lose grandfathered status.
- **Increase in Fixed-Amount Cost-Sharing (excluding co-pays)**. Any change to the fixed amount cost-sharing (i.e., $500 deductible or $2,500 out of pocket) must be less than the maximum amount determined by a formula. If the total percentage increase in the cost-sharing measured from March 23, 2010, exceeds the maximum percentage increase then a plan loses its

grandfathered status. The maximum percentage increase is medical inflation plus 15 percentage points. The employer must always look back to the data in place on March 23, 2010, to determine if the increase is, in fact, acceptable.

- **Increase in a Fixed-Amount Co-Pay**. Any increase in a fixed-amount co-pay, determined as of the date of the increase, will cause a plan to lose grandfathered status if the total increase in the co-pay measured from March 23, 2010, exceeds the GREATER of: (1) $5 increased by medical inflation ($5 times medical inflation, plus $5) or (2) the maximum percentage increase determined by expressing the total increase in the co-pay as a percentage. To illustrate: on March 23, 2010, grandfathered plan A has a $30 specialist office visit co-pay and the plan is amended to increase the specialist co-pay to $40. On that date the medical care component of the CPI-U is 475. The $10 increase in co-pay is expressed as a percentage (33.33%) (40-30=10;10 divided by 30=.3333; 3333=33.33%). Medical inflation from March 23, 2010, is .2269. The maximum percentage increase permitted is 37.69% (22.69% +15% = 37.69%). The change is allowed because 33.33% is less than 37.69%). The employer must look back to the data in place on March 23, 2010, when an increase is made to determine if it is, in fact, acceptable.
- **Decrease in Contribution Rate by Employers**. A grandfathered plan will lose its grandfathered status if the employer decreases its contribution rate towards the cost of ANY tier of coverage for any class of similarly situated individuals by more than five percentage points below the contribution rate for the coverage period that includes March 23, 2010. Although a plan may increase premiums, it may not reduce the percent of the premium the employer pays by more than five percent below the contribution rate in effect on March 23, 2010. Again, employers must always look back to the data in place on March 23, 2010.
- **Increase in Annual Dollar Limits**. Plans that do not have annual or lifetime dollar limits cannot add an annual limit if it wishes to maintain grandfathered status. A plan that had a lifetime limit, but no annual limit, cannot add an annual limit that is lower than the dollar value of the lifetime limit in effect on March 23, 2010. A plan that had an annual limit in effect on March 23, 2010, cannot decrease the dollar value of the annual limit.

It remains uncertain what other plan changes may result in a loss of grandfathering. For example, the regulators are inviting comments on whether the following changes would result in a cessation of grandfathered health plan status: (1) changes to a plan structure (such as switching from a health reimbursement account to major medical coverage or from an insured product to a self-insured product); (2) changes in the plan's provider network; (3) changes to a prescription drug formulary; or (4) "any other substantial change to overall plan design."

Transition Rules

Any changes made after March 23, 2010, and before the Interim Final Rules are first officially released to the public can be rescinded retroactively to maintain grandfathered status.

Implications for Employers

Employers should consider the following as they prepare for implementation of PPACA:

- Has the necessary disclosure statement been made to participants and beneficiaries about the grandfathered status of the plan?
- Have insurers changed since March 23, 2010?
- Have any changes been made after March 23, 2010, and before the publication of the Interim Final Rules that would trigger a loss of grandfathering? Consideration should perhaps be given to rescinding or modifying such a change.
- Are any plan changes being considered that would result in a loss of grandfathering?

- Are any alternative plan changes being considered that may achieve the same cost-saving objectives without exceeding the permissible thresholds set in the Interim Final Rules?
- Has there been an evaluation of the benefit of maintaining grandfathered status in relation to the value of making plan changes that would lead to a loss of grandfathering?

According to the HHS fact sheet, it is estimated that between 71 and 87 percent of large employer plans will remain grandfathered in 2011, but only 36 to 66 percent will retain this status by the year 2013. As for small employer plans, it is projected that between 58 and 80 percent will remain grandfathered in 2011, while in 2013 this range will drop to between 20 and 51 percent. Employers need to carefully weigh the advantages of grandfathered health plans status relative to the advantages of making plan changes that would result in a cessation of such status. As the value of the grandfathering provision diminishes over time, the choice between maintaining this status or implementing plan changes that prompt a loss of grandfathering will likely become more pronounced.

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[1] Pub. L. No. 111-148.

[2] Pub. L. No. 111-152.