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TO: **Clients and Colleagues**
FROM: **Christine P. Roberts**
RE: **Health Care Reform Update**
DATE: **October 25, 2010**

Postponing the Impact of Health Care Reform: The Grandfathering Rules

Introduction – What is "Grandfathering"?

In March of this year Congress passed major health care reform legislation, specifically, the Patient Protection and Affordable Care Act ("Affordable Care Act"), enacted on March 23, 2010, and the Health Care and Education Affordability Reconciliation Act of 2010 (the "Reconciliation Act"), enacted on March 30, 2010. As used in this memo, the term "health care reform" refers to both of these measures.

Health care reform has limited effect on health plans and policies that were in place when reform was enacted; in other words, these plans and policies are "grandfathered" from reform. Specifically, group health plans and policies existing as of March 23, 2010 (the date the Affordable Care Act was enacted) are exempt from certain provisions of the Affordable Care Act, such as first-dollar coverage of certain preventative services, and continuation of coverage during the pendency of a benefit claim appeal. (Certain other health reform measures, such as coverage of adult dependent children to age 26, or the prohibition on lifetime caps or "restrictive" annual caps on coverage, apply regardless of grandfathered status.)

This memo does not go into great detail on the "pros" and "cons" of retaining grandfathered status, as this is a very fact-based analysis that will be different for each employer and each plan. To some extent, employers are assuming that grandfathered status is desirable just because health care reform is new, and scary, and likely to be somewhat more expensive than their current arrangements. Some reasons for retaining grandfathered status are more concrete. For instance, one very significant benefit of grandfathered status for insured group health plans is the ability to retain a "discriminatory" benefit plan – i.e., one that provides greater benefits for highly-paid employees and owners, than for rank and file. This type of discrimination has always been prohibited for self-funded (self-insured) group health plans, which are fairly rare, but has been permitted under *insured* group health plans (at least for employers of more than 50 employees, in California). Health care reform takes this option away in the insured plan arena. The ability to give executives added health plan benefits has been an important recruiting and retention tool that will be lost under the new regime, if grandfathered status is forfeited.

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The New Grandfathering Regulations and Subsequent "Soft Guidance"

This "grandfathering rule" is set forth in Section 1251 of the Affordable Care Act and in interim final regulations (the "grandfathering regulations") jointly published on June 17, 2010 by the Treasury Department, the Department of Labor and the Department of Health and Human Services (collectively, the "Agencies"). Since the regulations issued, the Agencies have followed up with "soft guidance" on the grandfathering rules, in the form of Frequently Asked Questions ("FAQs") issued on September 20, 2010 and October 8, 2010.

The grandfathering regulations describe:

(a) Two things a plan existing on March 23, 2010 **must do** to retain grandfathered status,
(b) Six things a plan **must avoid** in order to retain grandfathered status, and
(c) Eight things a plan **may do** without losing grandfathered status.

Each of these is described in Appendix A to this memo. Among the permitted changes are premium increases (which presumably are imposed by an insurer or, in the case of a self-funded plan, are backed by claims data and actuarial assumptions). However, significantly increasing employees' share of premium costs (or reducing the employer's share) will cause loss of grandfathered status.

The September 22, 2010 FAQ helpfully explains that the six prohibited actions are the "**only** changes that would cause a cessation of grandfathered status under the interim final regulations." (Emphasis in original.) This is in very marked contrast with the grandfathering regulations, which provided that changes that were not listed on either the "prohibited" or "may do" lists, but that were "significant" or "substantial," would result in a loss of grandfathered status.

The regulations and FAQs also provide that grandfathered status may be retained (or lost) on a "benefit-package-by-benefit-package" basis, such that, for instance, significant changes to a PPO option would result in loss of that option's grandfathered status but not that of the HMO option under the same plan. By contrast, reduction in an employer's share of dependent coverage by more than 5% across all benefit packages or options would result in loss of grandfathered status for the entire plan.

What about "structural" changes or changes in "overall plan design," such as conversion from a fully insured to a self-insured plan, changes to a provider network or to prescription drug formularies, addition of a new benefit tier or option, or addition of a class of eligible employees? Any new package, tier or option added to a plan would itself not be grandfathered and would have to comply with health care reform. But how would such additions or changes impact the grandfathered status of the plan as a whole?

In the October 8, 2010 FAQs, the Agencies clarified that this would not cause loss of overall grandfathered status if the plan:

- Added one or more new coverage tiers without eliminating or modifying any previous tiers; and
- The new coverage tiers covered individuals not previously covered under the plan (e.g., adding dependent coverage to a self-only plan).

The grandfathering regulations include transition relief, including a grace period until the beginning of the 2011 plan year (January 1, 2011 for calendar year plans) to revoke any changes to a plan that were adopted before June 14, 2010 and that would cause a plan to lose grandfathered status. Plan changes made after March 23, 2010 but before grandfathering regulations issued (June 17, 2010) will not affect grandfathered status if the changes only modestly exceed the parameters set forth in the regulations and if the changes were made in a good faith effort to comply with a reasonable interpretation of health care reform measures. Application of this particular type of transition relief will obviously be a fact-based, case by case process. Finally, plan changes (e.g., formal amendments) that an employer adopted prior to March 23, 2010 but which did not go into effect until after that date will not affect grandfathered status.

Special grandfathering rules that apply to collectively-bargained plans (i.e. union) are beyond the scope of this memo.

Although the six "prohibited" actions are the only plan design/coverage changes to cause loss of grandfathered status, there are two additional actions that can jeopardize grandfathered status. The first is to enter into a business transaction that violates "anti-abuse" rules set forth in the regulations, i.e., to:

- Engage in a merger, acquisition, or similar business restructuring if the "principal purpose" of the transaction is to cover new individuals under a grandfathered plan; or
- Transfer employees between grandfathered plans for the purpose of retaining grandfathered status i.e. where amending the transferor plan to match the terms of the transferee plan would cause the transferor plan to lose grandfathered status.

Additionally, insured plans will lose grandfathered status if they enter into a new policy, certificate, or contract of insurance. The regulations also prohibit change of carriers, but the September 20, 2010 FAQs state that the Agencies will soon address circumstances under which plans may change carriers without loss of grandfathered status. Potentially then, change of carriers while maintaining the same coverage substantively will not cause loss of grandfathered status, while changing coverage with the same carrier will do so.

Now What? Short and Long Term Strategies May Differ

Retaining grandfathered status may be a desirable short-term goal for many employers, but it may not be a realistic goal for the long term. Real world pressures, including demographics and costs, inevitably will force departure from the stringent maintenance rules. It may be that, by the time the second major round of health care reform measures go into effect in 2014 (the first round takes effect in 2011), grandfathered health plans may largely have been voluntarily abandoned by competitive employers. Additionally, some carriers are prohibiting maintenance of grandfathered plans due in part to the complexity of separating administration of grandfathered and non-grandfathered policies. The preamble to the grandfathering regulations contain federal mid-ranges estimates that 66% of small employers those with (fewer than 100 employees) and 45% of large employers will relinquish grandfathered status for their group health plans by the end of 2013. Each employer will have to weigh the unique costs and benefits of retaining grandfathered status for their plan, as healthcare reform measures are implemented over time.

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Appendix A

Summary of Grandfathering Regulations

A. Two steps a plan **must take** to remain grandfathered:

1. Beginning with the 2011 plan year, include a written statement of the employer's belief that their group health plan(s) is/are a grandfathered plan(s), in any plan materials provided to participants or beneficiaries. The regulations include a model disclosure that employer may adapt.
2. Maintain records documenting the terms of the plan and coverage in existence as of March 23, 2010. This would mean insurance policies, HMO contracts, self-funded plan documents and SPDs, explanations of benefits, premium rate grids, and all other written explanations of plan terms. Employers must retain this material as long as grandfathered status is to be maintained.

B. Six steps a plan **must avoid** to remain grandfathered:

1. Eliminate all or substantially all benefits to diagnose or treat a particular condition, or eliminate an essential component for treating a particular condition (e.g., therapy, in the case of psychiatric ailments).
2. Increase a percentage cost sharing requirement, including co-insurance, above the level at which it was on March 23, 2010 (e.g, increasing an employee's share of in-patient surgery costs from 20% to 30%).
3. Increase a fixed-amount cost-sharing requirement other than copayments, such as a $500 deductible or a $2,500 out-of-pocket limit, by a total percentage measured from March 23, 2010 that is more than the sum of medical inflation (equal to the medical services component of the Consumer Price Index for Urban consumers (CPI-U), which has averaged 4% - 5% in recent years) and 15 percentage points.
4. Increase fixed-amount copayments by an amount that exceeds the greater of:

    i. A total percentage measured from March 23, 2010 that is more than the sum of medical inflation plus 15 percentage points, or
    ii. $5 increased by medical inflation (i.e., $5 times medical inflation, plus $5).

Example from Regulations: On March 23, 2010, grandfathered Plan A has a $30 specialist office visit co-pay. Plan A is amended to increase the specialist co-pay to $40.

- The proposed cost increase is converted to a percentage: (40 - 30 = 10; 10 ÷ 30 = 0.3333; 0.3333 = 33.33%).
- The percentage increase in medical care costs since March 23, 2010 is determined.
  - Start with the overall medical care component of the CPI-U for March 2010 (unadjusted), which is 387.142. That amount must be subtracted from an amount that is equal to the greatest value of the overall medical care component of the CPI-U (unadjusted) at any point within the 12-month period before the $40 copayment is to take effect. The Example in the regulations provides that that number is 475. (475 - 387.142 = 87.858)
  - Then, that number must be converted to a percentage of the March 2010 rate. (87.858 ÷ 387.142 = 0.2269)
  - Therefore medical inflation from March 2010 is 0.2269, or 22.69% (475 - 387.142 = 87.858; 87.858 ÷ 387.142 = 0.2269)
- Then, determine the maximum percentage increase by adding 15% to that calculated rate of inflation. In this case, the maximum percentage increase permitted is 37.69% (22.69% + 15% = 37.69%).
- Because the planned percentage increase (33.33%) does not exceed the maximum 37.69%, the increased copayment does not cause Plan A to cease to be a grandfathered health plan.

5. Decrease the employer contribution rate toward the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below the March 23, 2010 rate. 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.

   i. The employer contribution rate is defined as the amount of contributions made by an employer compared to the total cost of coverage, expressed as a percentage. In the case of a self-insured plan, contributions by an employer are calculated by subtracting the employee contributions toward the total cost of coverage. The total cost of coverage is calculated in the same manner as the applicable premium under COBRA continuation coverage, minus the 2% administration fee.

   ii. "Similarly situated individuals" are, as defined in HIPAA regulations, groups of employees sharing bona-fide employment based classifications consistent with the employer's usual business

practice such as full-time versus part-time, one geographic location versus another, different dates of hire or lengths of service.

iii. The October 8, 2010 FAQs clarified that, when an employer is restructuring its coverage tiers, it must test the 5% decrease by comparison to the employer contribution rate for the corresponding tier on March 23, 2010. For example, if the employer contribution rate for family coverage was 50% on March 23, 2010, the employer contribution rate for any new tier of coverage other than self-only (i.e., self-plus-one, self-plus-two, self-plus-three or more) must be within 5% of 50% (i.e., at least 45%).

6. Change annual limits.

i. Add an overall annual or lifetime limit on benefits that did not exist on March 23, 2010

ii. If no prior annual limit: Grandfathered status will be lost if the employer adds an overall annual limit that is lower than the value of the overall lifetime limit in place on March 23, 2010.

iv. If reduction in prior annual limit: Grandfathered status will be lost if the employer decreases the dollar value of the annual limit.

C. Eight steps a plan ***may* take** without jeopardizing its grandfathered status:

1. Increase benefits available under the plan.
2. Change premium amounts.
3. Change or amend the plan as mandated by federal or state law, including health care reform, genetic privacy laws, mental health parity, and the like. Voluntary amendments to comply with health care reform are also permitted.
4. Adopt consumer protection measures.
5. Change third party administrators.
6. Implement plan amendments that were adopted prior to March 23, 2010 but did not become effective after that date.
7. Enroll family members of individuals already enrolled.
8. Enroll new employees (whether newly hired or newly enrolled).