To Grandfather or Not: Affordable Care Act Requirements

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William M. Freedman

Introduction. On June 17, 2010, the U.S. Departments of Treasury, Health & Human Services, and Labor issued an interim final regulation detailing changes that will -- or will not -- cause an employer's group health benefit plan to lose its "grandfathered plan" status.

The three Departments then issued three sets of interim final regulations that address changes made by the Affordable Care Act that apply to plan years beginning on or after September 23, 2010:

- On June 28, 2010, the Departments of Health and Human Services, Labor and Treasury issued interim final regulations implementing the Act's requirements that prohibit preexisting condition exclusions, lifetime and annual limits, and recisssions, and the Act's requirements designed to ensure choice of primary care physician and greater access to benefits for emergency services.
- On July 19, 2010, these Departments issued interim final regulations implementing the Act's requirements for coverage of preventive services.
- On July 28, 2010, the Departments issued interim final regulations implementing the Act's requirements that codify existing regulations on internal appeals of denied claims and mandate external independent review of certain claims appeals.

One of these new issued regulations implement provisions of the Act applies to all group health plans (choice of primary care physician and benefits for emergency services); the rest will only apply to nongrandfathered plans.

Employers must now weigh the potential benefits of preserving their existing group health benefit plans' grandfathered status against the costs they may incur to achieve that objective.

Background. At the end of March, Congress passed and the President signed the Patient Protection and Affordable Care Act. Days later, Congress amended that legislation when the President signed the Health Care and Education Reconciliation Act (we will refer to the two pieces of legislation collectively as the "Affordable Care Act"). The Affordable Care Act (i) authorizes the creation of state insurance exchanges, effective for 2014, through which insurers will offer "qualified health plans" -- plans that offer a panoply of benefits mandated by the Affordable Care Act, satisfy Act-mandated limits on employee deductible and out of pocket obligations, and satisfy Act-mandated underwriting standards that must be used to determine premiums; (2) beginning in 2014, obligates individuals to enroll in a health plan that offers "minimum essential benefits" or pay a penalty; (3) beginning in 2014, obligates "large employers" (50 or more full-time equivalent employees) to either offer employees the opportunity to enroll in an affordable employer-sponsored group health plan or pay a penalty; and (4) obligates employer-sponsored group health plans to incorporate a variety of new coverage, benefit, and nondiscrimination requirements. Some of those requirements are effective within the next few months; some take effect in 2014.

Wherever there is a general rule, there is an exception. The Affordable Care Act (1) permits "grandfathered health plans" to serve as a plan in which individuals may enroll in order to avoid the individual-level "pay or play" penalty and to satisfy the employer-level "pay or play" penalty; and (2) exempts "grandfathered health plans" from having to comply with a number of those new coverage, benefit, and nondiscrimination requirements.

The Problem. The Affordable Care Act tells us what constitutes a "grandfathered health plan": a group health benefit plan that covered participants on March 23, 2010 (the date of enactment of the Patient Protection and Affordable Care Act). The Affordable Care Act says that enrolling new participants will not cause a plan to lose its grandfathered status -- and provides virtually no other guidance.

The Concern. Employers that sponsor group health plans that were in effect on March 23, 2010 need to know what changes they can make without losing grandfathered status so that they can evaluate (1) whether grandfathered status is important to them, and, if so, (2) if preserving grandfathered status may prove to be the less costly route, what they must do to preserve that status.

All group health plans -- grandfathered or not -- will be required to comply with these new requirements (some take effect for plan years that begin on or after September 23, 2010 and some will take effect later):

- No lifetime limits on coverage for all plans;
- No rescissions of coverage when people get sick and have previously made an unintentional mistake on their application;
- Extension of parents' group health plan coverage to children under 26 years old.
- No coverage exclusions for children with pre-existing conditions; and
- No "restricted" annual limits (e.g., annual dollar-amount limits on coverage below standards to be set in future regulations).

Plans that successfully preserve their grandfathered status will escape these requirements:

- Health insurance companies underwriting fully insured plans that are not grandfathered must determine premiums for using adjusted community rating rules. (NB: *Self-insured group health plans -- whether or not grandfathered -- are not subject to this requirement*.)
- Health insurance companies underwriting fully insured plans that are not grandfathered must offer coverage on a guaranteed issue and guaranteed renewal basis. (NB: *Self-insured group health plans -- whether or not grandfathered -- are **not** subject to this requirement*.)
- All nongrandfathered group health plans -- fully insured and self-insured -- will be prohibited from discriminating in their choice of health care providers that may serve as participating health care providers. (2014)
- Health insurance companies underwriting fully insured group health plans *in the small group market (employers with 100 or fewer employees)* that are not grandfathered will be required include the "essential health benefits package" necessary for a plan to constitute a "qualified health plan" and participate in the health exchanges. (2014)
- All nongrandfathered group health plans -- fully insured and self-insured -- must satisfy the limits on annual cost-sharing that accompany the "essential benefits package -- the HSA annual cost-sharing limit of $2,000/$4,000 (single/other). (2014)
- All nongrandfathered group health plans -- fully insured and self-insured -- must not deny participation in, and must cover routine patient costs of, individuals with respect to participation in approved clinical trials involving cancer or other life-threatening conditions. (Plan years beginning after September 23, 2010.)
- All nongrandfathered group health plans -- fully insured and self-insured -- must cover certain preventive services, immunizations, and screenings, without any cost sharing. (Plan years beginning after September 23, 2010.)

- Comply with the nondiscrimination rules in Internal Revenue Code §105(h)(2) -- which, prior to the passage of the Affordable Care Act, only applied to self-insured plans. These rules prohibit discrimination in favor of highly compensated individuals as to eligibility to participate or as to benefits. (Plan years beginning after September 23, 2010.)
- Not only provide for an internal appeals process for coverage determinations (the Affordable Care Act codifies the existing Department of Labor claims review regulations, shortening the time within which urgent health claims must be adjudicated) but also comply with any applicable State external review process requiring independent review of claims denied for medical reasons. If the State has not established an external review process that meets minimum standards or the plan is self-insured, the plan or issuer must implement an external review process that meets standards to be established by the Federal government. (Plan years beginning after September 23, 2010.)
- Plans/insurers may not limit types of providers that may serve as primary care providers; plans/insurers that cover emergency services may not require prior authorization and must afford in- and out-of-network providers with the same coverage limits and cost-sharing; prohibits requiring referrals for OB/Gyn services. (Plan years beginning after September 23, 2010.)

Of these requirements, which are the ones that are likely to result in material additional costs to a group health plan that loses its grandfathered status? Focus on these:

- *Switch to modified community rating.* This requirement affects fully insured group health plans. The Affordable Care Act shrinks the age spread premium multiplier insurers may use in underwriting plans. This change will shift overall plan costs from older workers to younger workers.
    - *Result:* Employers with a relatively old work force may see their premiums decline. Employers with a relatively young work force may see their premiums increase.
- *Limits on annual cost sharing.* If an employer's current plan design uses cost sharing limits that exceed $2,000/$4,000, loss of grandfathered status means health plan costs will shift from employees to the employer.
    - Employers that are self-insured are most likely to be affected by this. (More on why this is so appears below).
- *Coverage of preventive services.* On July 19, 2010, the Departments of Health and Human Services, Labor and Treasury issued interim final regulations implementing the Act's requirements for coverage of preventive services. In the preamble to those regulations, the Departments made this estimate of the cost nongrandfathered plans will incur as a result of the preventive services requirements: The Departments calculated an estimate of the average impact using the information from the analyses described [on preceding pages of the preamble discussion], using estimates of the number of individuals in non-grandfathered health plans in the group and individual markets in 2011. The Departments estimate that premiums will increase by approximately 1.5 percent on average for enrollees in non-grandfathered plans.
    - *Result:* When weighing whether to incur additional costs to remain grandfathered, the average group health plan should budget for a 1.5% premium increase if the plan chooses to forego (or loses) grandfathered status just for this requirement.
- *Compliance with the nondiscrimination rules.* This factor only affects employers that sponsor fully insured group health plans, since the rules already apply to self-insured plans. The plan must not cover a disproportionate number of "highly compensated individuals" (one of the five highest paid officers, a shareholder who owns more than ten percent in value of the stock of the employer, or anyone else who is among the highest paid 25% of all employees).
    - *The problem.* If a fully insured plan does not currently satisfy this requirement, loss of grandfathered status could be very expensive: it will require expanding coverage to nonhighly compensated employees. That could be expensive, depending upon the total premium cost and the number of nonhighly compensated employees who must be added to the plan.

What Changes Will Cause a Grandfathered Plan to Lose That Status and Become a Nongrandfathered Plan?

The June 17, 2010 interim final regulations list these events as ones that will cause a grandfathered plan to lose its grandfathered status:

- *Significantly Cut or Reduce Benefits.* If a plan eliminates all or substantially all beneits to diagnose or treat a particular conditions. Example: a plan decides to no longer cover care for people with diabetes, cystic fibrosis or HIV/AIDS.
- *Raise Co-Insurance Charges.*
  - Co-insurance: the enrollee pays a fixed percentage of a charge (20% of a hospital bill).
  - If a grandfathered plan increases a co-insurance percentage, the plan loses its grandfathered status.
- *Significantly Raise Fixed Dollar Copayment Charges.*
  - Fixed dollar copayment: a fixed-dollar amount for doctor's office visits or other services.
  - If at any time the total increase in any fixed dollar copayment, measured from March 23, 2010 to the date of a change, exceeds the greater of (i) $5, adjusted annually for medical inflation since March 23, 2010, or) or (ii) a percentage equal to medical inflation since March 23, 2010 plus 15 percentage points, then the plan loses its grandfathered status.
    - Medical inflation: the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by the Department of Labor using the 1982 – 1984 base of 100.
    - The index number for medical inflation for March, 2010 is 387.142. In the future, determine the index, and subtract 387.142; divide the result by 387.142. The result is the medical inflation expressed in the correct percentage form.
  - Example:
    - On March 23, 2010, a grandfathered health plan has a copayment requirement of $30 per office visit for specialists. The plan is subsequently amended to increase the copayment requirement to $40. The value of the overall medical care component of the CPI-U (unadjusted) has risen to 475.
    - The increase in the copayment 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 copayment requirement at that time does not cause the plan to lose its grandfathered status.
- *Significantly Raise Fixed Amount Deductibles.*
  - Example of a fixed amount deductible: the plan requires an enrollee to pay the first $500, $1,000, or $1,5000 of medical expenses incurred each year
  - The rule: If at any time the total increase in any fixed dollar amount deductible (or any other fixed amount cost sharing requirement other than a copayment), measured from March 23, 2010 to the date of a change, exceeds a percentage equal to medical inflation since March 23, 2010 plus 15 percentage points, then the plan loses its grandfathered status.
- *Significantly Lower Employer Contributions.* If a plan decreases the percent of premiums the employer pays by more than five percentage points below the percentage in effect on March 23, 2010, then the plan loses its grandfathered status.
  - Example.

        - As of March 23, 2010, Employer's share of the health plan premium is 85%. On January 1, 2011, Employer lowers its percentage to 80% and increases the employees' share from 15% to 20%.
            - The cumulative decrease since March 23, 2010 is five percentage points. Since that doesn't exceed the maximum allowable cumulative percentage point decrease of more than five percentage points, the plan does **not** lose its grandfathered status.
        - On January 1, 2012, Employer again lowers its percentage, this time from 80% to 75%.
            - The cumulative decrease since March 23, 2010 is ten percentage points. That exceeds the maximum allowable cumulative percentage point decrease of more than five percentage points. The plan **loses** its grandfathered status as of January 1, 2012.
- *Add an Annual Limit, or Decrease an Existing Annual Limit.* If a Plan has an annual dollar limit as of March 23, 2010 and decreases that annual limit, or adds an annual dollar limit (unless it replaces a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit), the plan loses its grandfathered status.
- *Fully Insured Plan Changes Insurance Company.* If an employer that sponsors a fully insured group health plan elects to change insurance carriers, the plan **loses** its grandfathered status -- even if the plan design does not change.
    - May a self-insured plan change third party administrators without imperiling its grandfathered status? Yes, assuming the new TPA doesn't require one of the plan design changes that triggers a loss of grandfathered status.
    - Special rule for collectively bargained plans: health insurance coverage maintained under a collective bargaining agreement ratified before March 23, 2010 remains a grandfathered plan at least until the last of the collective bargaining agreements relating to coverage in effect on March 23, 2010 terminates.
- *Transfer Employees to a Different Health Plan or Different Benefit Package Under a Health Plan For Which There Was No Bona Fide Employment-Based Reason for the Transfer and Which Would Otherwise Trigger Loss of Grandfathered Status if the Transferor Plan Had Been Amended to Mimic the Transferee Plan*
    - Step One: Assume the transferor plan had been amended so that it adopts the features of the transferee plan. Did any of the changes trigger one of the rules outlined above that would cause the transferor plan to lose its grandfathered status?
        - If the answer is, no, then the transfer does **not** cause the transferee plan to lose its grandfathered status.
        - If the answer is, yes, then proceed to Step Two.
    - Step Two: Was there a bona fide employment-based reason for the transfer?
        - Examples of a bona fide employment-based reason:
            - The transferor plan covered employees at Plant A. Plant A is sold, and some of the employees formerly employed at Plant A are offered coverage under a different plan sponsored by the employer.
            - Employer offers two benefit packages and permits employees to switch between the packages at each open enrollment on the same basis as new employees.
        - Example of a reason that is **not** a bona fide employment-based reason: a plan or benefit package is discontinued due to its cost.

How Should Employers Determine the Potential Costs They May Be Forced to Incur in Order to Maintain Grandfathered Status and Compare Those Costs to the Savings They Hope to Reap From Preserving Grandfathered Status?

To accomplish this feat, first determine whether the employer sponsoring the plan really has a choice. If the employer does have a choice, then determine whether the employer *must* preserve grandfathered status in order to keep the plan. Finally, assuming the employer still has a choice, determine whether preserving grandfathered status will generate cost savings and whether those savings offset the loss of freedom in changing plan design elements necessary to preserve grandfathered status.

Does the employer really have any choice? If the employer sponsors a fully insured plan, the employer may not have a long term choice. Several of the largest health insurance companies have already informally said that they will ***not*** sponsor two sets of health insurance products (grandfathered and nongrandfathered). Those companies have already announced that they will only sponsor nongrandfathered plans.

Therefore, most employers that sponsor fully insured plans need not flagellate themselves through worry over preserving grandfathered status: these employers are unlikely to be able to preserve that status in any event. Instead, they should continue to evaluate their health plans and the plans' costs as they have done in the past, even if that means changing insurers or instituting features that cause the loss of grandfathered status.

The only employers with fully insured plans who possess a meaningful shot at preserving their grandfathered status are employer sufficiently large that health insurance companies will be prepared to underwrite and obtain state insurance commission approval for the plan design that employer desires.

Does the employer sponsor a fully insured plan that does not satisfy the nondiscrimination requirements that will apply to nongrandfathered plans? If the employer sponsors a fully insured group health plan that currently does not satisfy the nondiscrimination reaquirements that will apply to nongrandfathered plans, the employer must assess the cost of adding a sufficient number of nonhighly compensated employees to the plan so as to enable the plan to meet the requirements. How much is that likely to cost? Compare that recurring annual cost to the additional expense the employer may incur in order to avoid losing grandfathered status. Those additional expenses fall into these sorts of categories:

- Staying with the current insurer -- even though other insurers offer lower premiums
- Avoiding shifting additional cost responsibilities to participating employees
- Preserving health plans that the employer might otherwise abandon because of their cost

For sponsors of self insured plans: Determine the additional expenses the employer may incur in order to preserve grandfathered status (see the categories of expense, above) and compare that cost to the additional compliance costs the employer will incur if the plan loses its grandfathered status and must now provide the additional features that apply only to nongrandfathered plans. Self-insured plans are not at the mercy of health insurers -- at least, not directly. Employers that sponsor self-insured plans should determine what, if any additional costs, they will incur if their plan(s) lose grandfathered status. For many self-insured plans, the additional costs may not be substantial. Those plans may already offer fully subsidized preventive care services, a broad range of in-network providers, and may already use independent reviewers of appeals of claims that have been denied for medical reasons. The one requirement that may affect some self-insured plans is the limit on cost sharing that will apply to nongrandfathered plans.

If the savings associated with preserving grandfathered status is small, and the costs of preserving grandfathered status is material -- giving up the ability to increase the proportion of plan costs that employees must absorb --, then self-interest impels these employers to continue to pursue plan design issues and changes as they traditionally have performed that task, even if the results mean, loss of grandfathered status.

In the preamble to their interim final regulation on grandfathered status, the Departments confirm that most employers will make group health benefit plan design decisions without regard to the effect those decisions

may have on their grandfathered status. As a result, the Departments also believe there will be few grandfathered plans left standing by 2014:

- "Combining the estimates of the percentage of employers that would relinquish grandfather status because they chose to make cost-sharing, benefit or employer contribution changes beyond the permitted parameters with the estimates of the percentage that would relinquish grandfather status because they change issuers, ***the Departments estimate that approximately 31 percent of small employers and 18 percent of large employers would make changes that would require them to relinquish grandfather status in 2011.*** The Departments use these estimates as our mid-range scenario." Federal Register, June 17, 2010, page 34552.
- *"[T]he Departments' mid-range estimate is that 66 percent of small employer plans and 45 percent of large employer plans will relinquish their grandfather status by the end of 2013.* The low-end estimates are for 49 percent and 34 percent of small and large employer plans, respectively, to have relinquished grandfather status, and *the high-end estimates are 80 percent and 64 percent, respectively.* Federal Register, June 17, 2010, page 34552.

Click on the links below for more information on the provisions of the Affordable Car Act that do and do not apply to grandfathered plans, including the Public Health Service Act section, description, and it's effective date.

Provisions in subtitles A and C of title I of The Affordable Care Act that **do apply** to grandfathered plans.

Provisions in subtitles A and C of title I of The Affordable Care Act that **do not apply** to grandfathered plans for so long as they retain grandfathered status.