

## HEALTH REFORM UPDATE GRANDFATHERED GROUP HEALTH PLANS August 3, 2010

In July 2010, the Departments of Treasury, Labor, and Health and Human Services jointly released the Interim Final Rules for Group Health Plans and Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act. These rules, while titled “interim”, are to be considered final until modified or changed.

*Please note that all information contained in this Update pertains only to self-funded plans. The provisions of Health Reform that are specific to fully insured plans are not discussed here.*

The Health Reform law, commonly being called the Affordable Care Act (“ACA”) as amended by the Health Care and Education Reconciliation Act, permitted certain plans that covered at least one (1) participant on March 23, 2010, and that were in existence on the date the ACA law was enacted, March 23, 2010, to be “grandfathered” under the law and therefore only subject to a subset of the reform provisions in the law as long as the Plan maintained grandfathered status. Specifically exempted from compliance with the Affordable Care Act reform provisions are retiree only plans, and stand alone plans that provide HIPAA excerpted benefits.

According to the Interim rule, a group health plan is a grandfathered health plan with respect to individuals actively enrolled for coverage on March 23, 2010. As long as the plan continuously covers at least one (1) person since March 23, 2010 (not necessarily the same person, but at all times at least one person) they can be considered for continued grandfather status. Addition of new employees and their dependents or dependents of plan participants who were covered on March 23, 2010, will not cause a plan to lose grandfather status. Insured plans maintained pursuant to a collectively bargained agreement that was ratified before March 23, 2010, qualify as grandfathered, at least until the date on which the last agreement relating to the coverage in effect on March 23, 2010 terminates. In order to maintain Grandfather status, the Plan must:

- Include a statement in the plan materials provided to plan participants describing the benefits provided under the plan, that the plan believes that “it is a grandfathered plan within the meaning of Section 1251 of the Affordable Care Act”, and include a contact information for plan participants who may have questions or complaints. Model language is available.

- Maintain and make available for inspection records that document the terms of the plan that were in effect on March 23, 2010, including any documents needed to verify, explain, or clarify its status as a grandfathered plan. Examples are copies of plan documents, summary plan descriptions, certificates or contracts of insurance, documentation of premiums or the cost of coverage, and documentation of required employee contribution rates.
- Avoid any of the prohibited changes described in Chart 1 attached to this document.

New plans instituted after March 23, 2010 will not be considered for grandfather status. Entering into a new policy, certificate or contract of insurance after March 23, 2010 (as compared to renewing a policy) creates a new plan. It is currently unclear if changing from fully-insured to self-funded will be considered as creating a new plan. Clarification is expected.

Grandfathered plans must continue to comply with the HIPAA portability and non-discrimination requirements, the Genetic Information Non-Discrimination act, mental health parity, the Newborns and Mothers' Health Protection Act provisions, the Women's Health and Cancer Rights act, and Michelle's Law. See Chart 1 for descriptions of the changes that will cause a plan to lose Grandfathered status.

Please note, however, that Grandfathered plans may add new employees and dependents to coverage, change premium rates (within limits), implement plan changes to comply with Federal or State legal requirements, voluntarily comply with the Affordable Care Act, and/or change Third Party Administrators without losing Grandfather status as long as the changes do not exceed the limits established in the law and summarized in Chart 1.

If a Plan made changes prior to March 23, 2010, that were to be effective after March 23, 2010, the Plan may still be able to retain Grandfather status, if one of the following situations applies:

- If the changes to the Plan are pursuant to a written plan amendment that was adopted on or before March 23, 2010, or
- If the changes were made pursuant to a legally binding contract entered into on or before March 23, 2010.

If neither of these situations apply, the Plan may still qualify for Grandfather status. A grace period has been provided to allow plans to revoke changes made to their Plans after March 23, 2010 which were adopted prior to June 14, 2010, that would result in loss of

Grandfather status. As long as the Plan is modified and brought within the limits for retaining Grandfather status effective as of the first day of the plan year or policy year beginning on or after September 23, 2010, it will be considered Grandfathered as of March 23, 2010.

If HMA prepares your Summary Plan Description(s), we are currently in the process of developing appropriate plan language for inclusion in your SPDs.

It is expected that over time, more and more plans currently considered Grandfathered will voluntarily relinquish that status in order to make necessary changes to their plan of benefits. One estimate stated in the regulations is that by 2013 over 50% of employers who were considered Grandfathered on March 23, 2010 will have surrendered that status. Plan Sponsors of Grandfathered plans need to weigh the cost of preserving Grandfather status against the ability to make changes to their plan that may address their current economic and benefit needs and the cost of complying with the ACA benefit mandates.

As more information becomes available on this or other provisions of the Affordable Care Act, HMA will provide you additional updates. If you have any questions, please don't hesitate to contact any member of your HMA Account Team.

*Disclaimer: The information contained herein is not intended to be legal advice, and while every effort has been made to ensure that the content of this legislative update is accurate, HMA makes no representations or warranties in relation to the information provided, and assumes no liability or responsibility for any acts or omissions based on this information. As always, we encourage you to consult with your own legal counsel prior to making any decisions regarding plan design or administration.*

**CHART 1: PLAN CHANGES THAT WILL RESULT IN THE LOSS OF GRANDFATHERED PLAN STATUS**

Elimination of all or substantially all benefits to diagnose or treat a particular condition, or the elimination of benefits for any necessary element to diagnose or treat a particular condition.
Increases in employee’s fixed amount cost-sharing requirements of the plan in excess of those permissible (i.e. deductible, co-payments, out of pocket maximum amounts). With the exception of co-payments, increases in fixed amount cost sharing <u>greater</u> than the <b>Maximum Percentage Increase</b> (defined as the overall medical care component of the CPI for all Urban consumers from March 23, 2010 plus 15%) will result in the loss of Grandfather status.
Increases in employee’s co-payment amount that exceeds A) Maximum Percentage Increase (see above for definition), or B) five dollars increased by medical inflation as measured on March 23, 2010 will result in the loss of Grandfather status.
Any increase in the employee’s percentage cost-sharing requirement (such as the co-insurance level) above the level that existed on March 23, 2010 will result in the loss of Grandfather status.
Decreases in the employer’s contribution towards the cost of any tier of coverage for any class of similarly situated individuals by more than 5% below the employer’s contribution rate on March 23, 2010 (using the plans COBRA rates as the base) will result in the loss of Grandfather status. The employers cost under a self-insured plan is equal to the total of the cost of coverage minus the employees contributions to the total cost of coverage.
A plan that did not have an overall annual or lifetime limit on the dollar value of benefits on March 23, 2010, that imposes an overall annual limit on the dollar value of benefits after that date will lose Grandfather status.
A plan that had an overall lifetime limit on the dollar value of benefits on March 23, 2010, but had no overall annual limit, ceases to be a grandfathered plan if the Plan adopts an overall annual limit on the dollar value of benefits that is lower than the dollar value of the lifetime limit on March 23, 2010.
A plan that had an overall annual limit on the dollar value of benefits on March 23, 2010, ceases to be a grandfathered plan if the dollar value of the overall annual limit is decreased.

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**CHART 2: HEALTH REFORM PROVISIONS APPLICABLE TO GRANDFATHERED PLANS**

Preexisting condition exclusions for children under age 19 and under and discrimination based on health status prohibited (PHSA 2704)	Plan years beginning after September 23, 2010 (effective 2014, all preexisting condition exclusions for all plan participants are prohibited)
Coverage waiting periods in excess of 90 days from date of hire prohibited (PHSA 2708)	Plan years beginning 1/1/2014
No lifetime limits permitted for essential health benefits. Annual limits on essential health benefits are permitted until 2014 but are “Restricted”. (PHSA 2711)	Plan years beginning after September 23, 2010 (effective 2014, no lifetime or annual limits will be permitted)
Rescission of coverage prohibited unless due to fraud or intentional misrepresentation of material fact (PHSA 2712)	Plan years beginning after September 23, 2010
Extension of coverage to adult children to age 26 required ( <i>Grandfathered plans may deny coverage to adult dependents if the adult child is eligible for coverage under their employer’s group health plan until 2014</i> ) (PHSA 2714)	Plan years beginning after September 23, 2010
Development and utilization of uniform explanations of coverage documents and standardized definitions required. (PHSA 2715)	First plan year beginning after September 23, 2010, however, first disclosures not required by statute until March 23, 2012– guidance pending.
Non-prescription over the counter drugs not eligible for reimbursement under a health FSA, HSA or HRA	Taxable years beginning after 12/31/2010
Annual limitation on pre-tax contributions to a health FSA capped at \$2,500 (indexed) per year	1/1/2013
Inclusion in W-2 of the value of group health coverage	First reportable in January 2012 for 2011 tax year.

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**CHART 3: HEALTH REFORMS APPLICABLE TO NON-GRANDFATHERED PLANS OR THOSE WHO LOSE GRANDFATHER STATUS**

Preventive services coverage with no cost-sharing.	Specific preventive services must be covered with no deductible, co-pay or co-insurance.	Plan years beginning after September 23, 2010
Standardized Appeals process for claims denials or adverse benefit determinations	Specified internal and external appeal process must be implemented. There are expected to be few material changes for self-funded plans governed by ERISA under this new law. Regulations and additional information pending.	Plan years beginning after September 23, 2010
Emergency services	No pre-authorization may be required for Emergency Services, and Reimbursement and cost sharing for both In network or out of network emergency services must be the same in the plan.	Plan years beginning after September 23, 2010
Out of Pocket maximums	Limited to HDHP levels. Regulations pending.	2014
Clinical trial coverage	Routine costs for clinical trials for life threatening conditions must be considered an eligible expense.	2014
Reporting on Quality of Care provided by the plan	Reports on whether the benefits of the Plan improve health outcomes,	2012
Reporting on Claims and plan statistics	Financial disclosures, information regarding claims policies and practices, and other plan information required.	Plan years beginning after September 23, 2010
Designation of a Primary Care Provider	If designation of a primary care provider is required by the plan, each participant must be permitted to designate any participating network primary care provider who is available to accept them, including a pediatrician for a child. And, a female participant must be allowed to obtain care from an in-network OB/GYN without prior authorization or referral. Plans must provide a notice of these requirements whenever a SPD is provided.	Plan years beginning after September 23, 2010

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