PPACA – Interim Final Regulations – Grandfather Status

Status

- This interim final regulation (IFR) was issued by the Internal Revenue Service, Department of Labor and Department of Health and Human Services ("Departments"), on June 10, 2010 and constitutes the initial guidance under in the Patient Protection and Affordable Care Act ("PPACA") regarding "grandfathered" status. The IFR was published on June 17, 2010.

  As this is an interim regulation the Departments provided a comment period. The comments were due 60 days after publication. *See page 5 for some key open items pursuant to the agencies request for feedback.*

- The IFR has been amended to allow grandfathered group health plans to enter into a new policy, contract or certificate of insurance (e.g., change insurance carriers), on or after November 15, 2010, without losing grandfather status as long as no other changes are made to the plan that would cause loss of such status. An additional comment period is provided, which ends on December 17, 2010.

Cautionary Statement: The Departments may issue additional guidance other than in the form of regulations to clarify or further interpret the IFR prior to issuing final regulations. In addition, some State laws go beyond the Federal requirements and the PPACA generally allows States to impose requirements on issuers (fully insured plans) in the group market that are more protective than the Federal provisions.

Summary of the Guidance

- Grandfather status applies to individual and group coverage in effect on the date of enactment of the PPACA (March 23, 2010). Grandfathered plans are exempt from some of the insurance reform provisions in the PPACA, not all. For example, grandfathered group plans must comply with the following insurance reform provisions on their effective dates:

  - the prohibition of lifetime and certain annual benefit limits on Essential Health Benefits;
  - the prohibition on rescissions;
  - the prohibition on preexisting condition exclusions for children under 19 (extended to all enrollees in 2014);
  - the requirement to extend coverage to adult child to the age of 26 (unless, prior to 1/1/2014, the adult child has other employer sponsored group coverage).

- See Attachment A for a more detailed listing of the provisions, and whether grandfathered status shall be initially allowed.

- Grandfathered plans are also not exempt from any provision of the PPACA that is outside specified sections relating to insurance reform, such as revenue raisers (e.g., tax on medical device manufacturers).

- The rules of the IFR apply separately to each benefit plan offered by a plan sponsor. In other words, each plan maintained by a plan sponsor needs to be reviewed to determine its grandfathered status.

- Plans may voluntarily enhance benefits, including adopting some of the consumer protections set forth in the PPACA early, without losing grandfathered status.

Permissible Changes

- The IFR provides that a group health plan or group health insurance coverage does not cease to be grandfathered plan coverage merely because one or more (or all) individuals enrolled on March 23, 2010 cease to be covered, provided that the plan or group health insurance coverage has continuously covered an individual since March 23, 2010.

- Under the PPACA and the IFR, new employees (whether newly hired or newly enrolled) and their family members may enroll in a grandfathered plan after March 23, 2010, without the plan losing grandfathered status.

- Pursuant to prior guidance, grandfathered plans that choose to extend dependent coverage to adult children up to age 26 earlier than required by PPACA will not lose grandfathered status.

- Under the IFR, provided these changes are made without exceeding other standards set forth in the rules, certain changes will be deemed permissible. These include:

    - changes to premiums;
    - changes to comply with Federal or State legal requirements, such as Mental Health Parity;
    - changes to voluntarily comply with provisions of the PPACA; and
    - changes to a self insured plans third party administrator (as opposed to insurance carrier on a fully insured basis).

- The IFR states that the guidance is "designed to strike a balance among preserving the ability to maintain existing coverage, containing costs, and having as many individuals as possible benefit from the health care reforms."

- The Departments acknowledge that group health plans and issuers make changes on an annual basis and provided several examples that are noteworthy: "premiums fluctuate, provider networks and drug formularies change, employer and employee contributions change, and covered items and services may vary."

Losing Grandfathered Status :

The IFR sets forth initial rules for determining when changes to the terms of a group health plan or health insurance coverage causes the plan to cease to be a grandfathered plan, and these include the following:

- Eliminates all or substantially all benefits to diagnose or treat a particular condition. The 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 a particular condition;

- Plans changing insurance carriers or entering into new policies, contracts or certificates of insurance (on fully insured offerings), with coverage effective dates between March 23 and November 15, 2010 (Note this rule was changed to provide prospective relief to groups changing carriers or entering into new policies or certificates with the same carrier, with coverage effective dates on or after November 15, 2010, provided the plan change parameters of the grandfather rules are complied with);

- Increases a percentage cost-sharing requirement (such as coinsurance) above the level at which it was on March 23, 2010;

- Increases fixed-amount cost-sharing requirements 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 and 15 percentage points;

- Increases copayments by an amount that exceeds the greater of: a total percentage measured from March 23, 2010 that is more than the sum of medical inflation plus 15 percentage points, or $5 increased by medical inflation measured from March 23, 2010;

- For a group health plan or group health insurance coverage, an employer or employee organization decreases its contribution rate by more than five percentage points below the contribution rate on March 23, 2010; or

- With respect to annual limits (1) a group health plan, or group or individual health insurance coverage, that, on March 23, 2010, did not impose an overall annual or lifetime limit on the dollar value of all benefits imposes an overall annual limit on the dollar value of benefits; (2) a group health plan, or group or individual health insurance coverage, that, on March 23, 2010, imposed an overall lifetime limit on the dollar value of all benefits but no overall annual limit on the dollar value of all benefits adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010; or (3) a group health plan, or group or individual health insurance coverage, that, on March 23, 2010, imposed an overall annual limit on the dollar value of all benefits decreases the dollar value of the annual limit (regardless of whether the plan or health insurance coverage also imposes an overall lifetime limit on the dollar value of all benefits).

Further examples and guidance is provided in the IFR, and a sampling of the guidance follows below.

First Example – Reduction in Benefits

- If a plan "eliminates all benefits for cystic fibrosis, the plan will cease to be a grandfathered health plan."

- The IFR also illustrates that if a plan "provides benefits for a particular mental health condition, the treatment for which is a combination of counseling and prescription drugs, and subsequently eliminates benefits for counseling, the plan is treated as having eliminated all or substantially all benefits for that mental health condition."

Second Example – Increasing Fixed-Amount and % of Cost-Sharing

- The IFR provides that any increase in a ***percentage cost-sharing*** requirement (such as increasing an individual's 20 percent coinsurance requirement to 30 percent) will cause a plan or health insurance coverage to cease to be a grandfathered health plan.

- With respect to ***fixed-amount cost-sharing*** requirements ***other than copayments***, a plan will lose grandfathered status if there is an increase, since March 23, 2010, in a fixed-amount cost-sharing requirement that is greater than the "maximum percentage increase" allowed. The "maximum percentage increase" allowed is defined as "medical inflation (from March 23, 2010) plus 15 percentage points". Medical inflation is defined in the IFR as the overall medical care component of the Consumer Price Index for All Urban Consumers, unadjusted (CPI), published by the Department of Labor.

  For ***copayments***, a plan or health insurance coverage will lose grandfathered status if there is an increase, since March 23, 2010, in the copayment that exceeds the greater of "the maximum percentage increase" defined above, or five dollars increased by medical inflation.

Third Example – Decrease of Contribution Rates

- Under this rule, a group health plan or group health insurance coverage ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate towards the cost of any tier of coverage for "any class of similarly situated individuals"[1] by more than five percentage points below the contribution rate as of March 23, 2010. The total cost of coverage shall be determined in the same manner as the applicable premium is calculated under the COBRA continuation provisions. In the case of a self-insured plan, contributions are calculated by subtracting the employee contributions towards the total cost of coverage from the total cost of coverage.

NOTE:

- The IFR provides "transitional relief" – meaning that a policy or plan will not lose its grandfathered status – for changes that might otherwise cause a loss of grandfather status under the IFR which were approved ***before*** March 23, 2010, but which went into effect after such date.
- For changes approved ***after*** March 23, 2010 but before the IFR was issued, the agencies "will take into account" good-faith efforts to comply with PPACA, if the changes only "modestly exceed" changes that would otherwise cause a loss of grandfather status.
- The IFR also provides a "grace period" during which insurers or plan sponsors may revoke changes which were adopted after March 23, 2010 and prior to the date the IFR was issued, if the changes would cause a loss of grandfathered status.

Changing Fully Insured Carriers

The original IFR provides that, other than the special rules for plans maintained under a collectively bargained plan, if an employer or employee organization enters into a "new policy, certificate, or contract of insurance" after March 23, 2010, then that policy, certificate, or contract of insurance is not a grandfathered health plan.

The IFR was amended on November 15, 2010 to limit the automatic loss of grandfather status to new group policies, contracts or certificates of insurance entered into between March 23 and November 15, 2010. The amendment now provides prospective relief to group health plans making such changes on and after November 15, 2010:

- A grandfathered group health plan may enter into a new policy, contract or certificate of insurance (e.g., change its insurance carrier, or change its certificate with the same carrier), with a coverage effective date on or after November 15, 2010, and still maintain its grandfathered status, if the new coverage makes no changes that would cause loss of grandfather status under the rule. To avail itself of this right, the plan sponsor must provide the new health insurer with documentation of the plan terms (including benefits, cost sharing, annual limits and employer contributions) under the prior plan.
- A new policy, contract or certificate of insurance entered into, with an effective date after March 23, 2010 and before November 15, 2010, is not grandfathered retrospectively under the amended rule.

Plans Maintained Pursuant to a Collective Bargaining Agreement

- The IFR provides special rules for health insurance coverage maintained pursuant to one or more collective bargaining agreements ratified before March 23, 2010. In this instance the coverage will remain grandfathered at least until the date on which the last agreement relating to the coverage that was in effect on March 23, 2010 terminates. Thus, before the

[1] Similarly situated individuals are described in the HIPAA nondiscrimination regulations at 26 CFR 54.9802-1(d), 29 CFR 2590.702(d), and 45 CFR 146.121(d).

last of the applicable collective bargaining agreement terminates, any health insurance coverage provided pursuant to the collective bargaining agreements is a grandfathered plan, even if there is a change in a fully insured carrier during the period of the agreement. The statutory language of the provision refers solely to "health insurance coverage" and does not refer plans administered on a self-funded basis.

- When the last of the collective bargaining agreements terminates, the comparison of the current plan will be matched up to the terms of the coverage that were in effect on March 23, 2010, to determine if the plan is still grandfathered.

- Collectively bargained plans that are grandfathered plans (either fully insured or ASO) are subject to the same requirements as other grandfathered health plans, and are not provided with a delayed effective date for the market reform provisions with which other grandfathered health plans must comply (e.g., adult dependent coverage to age 26, restricted annual limits on Essential Health Benefits). Thus, these provisions apply to collectively bargained plans before and after termination of the last of the applicable collective bargaining agreement.

Abuse rules and M&A

- The IFR provides that if the "principal purpose" of a merger, acquisition, or similar business restructuring is to cover new individuals under a grandfathered health plan, the plan ceases to be a grandfathered health plan.

- The IFR also contains a second "anti-abuse rule" designed to prevent a plan or issuer from circumventing the rules and limits. Under this rule, to retain grandfathered status where employees are transferred into another plan, there must be a bona fide employment-based reason for the transfer. (Changing the terms or cost of coverage is not a bona fide employment-based reason).

Providing a Notice

To maintain grandfathered status a plan or issuer must include in its plan materials that describe benefits, a statement declaring the plan is a grandfathered plan, and contact information for questions and complaints. Model language is provided in the IFR and can be used to satisfy this disclosure requirement.

Maintaining Records

To maintain grandfathered status a plan or issuer must also maintain records documenting the terms of the plan or health insurance coverage that were in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered plan. In addition, the plan or issuer must make such records available for examination. Plan participants, beneficiaries, individual subscribers, or State or Federal agency officials are entitled to inspect such documents to verify the status of the plan or health insurance coverage as a grandfathered health plan.

Invitation to Provide Comments – Also Sheds Some Light

The Departments invite comments to assist the agencies in determining whether certain changes should result in the loss of grandfathered status. The items open to interpretation and future guidance include, whether:

(1) changes to plan structure (such as switching from an HRA to major medical coverage or from an insured product to a self-insured product);
(2) changes in a plan's provider network, and if so, what magnitude of changes would

have to be made;
(3) changes to a prescription drug formulary, and if so, what magnitude of changes would have to be made; or
(4) any other substantial change to the overall benefit design….

The Departments did state that any new standards published in the final regulations that are more restrictive than those set forth in the IFR would only apply prospectively (meaning after the publication of the final rules).

Attachment A

Benefits of Grandfathered Status
Applies to Both New and Grandfathered Plans
• **Pre-Existing Conditions** – Plans cannot exclude coverage for pre-existing conditions of children under 19 years old. • **Annual/Lifetime Limits** – Lifetime limits are prohibited on "essential health benefits," a term which has yet to be defined by regulations. In addition, both grandfathered plans and new plans must comply with as yet unissued regulations regarding restricted annual limits on "essential health benefits." • **Plan Rescission** – Plans cannot rescind coverage when an individual files a claim unless there is fraud or intentional misrepresentation of material facts. • **Dependent Coverage for Young Adults** – Employers must provide dependent coverage to young adults until age 26. Grandfathered plans that are group health plans are only required to extend such coverage if the adult child is not eligible to enroll in a qualified employer-sponsored plan. Several states also have enacted laws requiring that insured plans extend coverage for children up to or beyond age 26, and the requirements of these state laws may not be identical to the federal law (e.g., Ohio requires coverage until age 28 effective for plan years beginning on or after July 1, 2010). • **Notice of Material Changes** – Plans must provide employees with 60 days' prior notice of material changes to their plan. The effective date for this provision is unclear. Pre-released *draft* grandfathered clause interim final regulation guidance indicates a March, 2012 effective date. • **Auto Enrollment** - Employers that employ more than 200 full-time employees will be required to automatically enroll new full-time employees in the plan, pursuant to forthcoming regulations. The effective date is unclear but is likely to be effective upon the issuance of guidance by the DOL.
Applies to New Plans Only and Plans Losing Grandfathered Status
• **Non-Discrimination** – Fully insured group health plans cannot discriminate in favor of highly compensated individuals with respect to eligibility or benefits. (Self-insured plans are currently subject to this requirement, so the change is applicable to fully insured plans.) • **Dependent Coverage for Young Adults** – Must extend coverage to all young adults until the age of 26 even if the young adult is eligible to enroll in other employer sponsored coverage. • **Primary Care Provider** – Plans must permit participants to designate a child's pediatrician as the primary care provider. • **Pre-Authorization** -- Plans cannot require prior authorization for OB/GYN care or emergency care provided by out-of-network providers. • **Emergency Coverage** – Emergency care, if otherwise covered, must be covered both in and out-of-network. • **Preventive Health Services** – Plans must offer preventive health services without the application of certain cost-sharing requirements. • **Appeals** – There must be an external claim appeal process in place, and employees must receive continued coverage pending the outcome of the appeals process.

Attachment B – FAQs

Question #1: What constitutes a grandfathered plan?

Answer #1: A grandfathered plan is a group health plan or health insurance coverage (group or individual) in which an individual was enrolled on March 23, 2010. Grandfathered plans include self-funded employer-sponsored plans, and insured group and individual health plans in effect on this date.

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Question #2: Why would grandfathered status be important to group health plans and health insurers on the group side?

Answer #2: A grandfathered plan is exempt from some, but not all, of the key requirements of Subtitles A and C of Title I of the new law. Exemptions include, but are not limited to:

- Appeal requirements: Non-grandfathered plans must have an internal review process, and external review process that meets NAIC Uniform External Review Model Act or standards set by HHS.
- Choice of Provider requirements: must allow the plan member to designate a child's pediatrician as the primary care provider; may not require authorization or referral for a participating OB-GYN.
- Non-discrimination requirements: Section 105(h) (non-discrimination rules prohibiting highly-compensated employees from receiving more favorable eligibility terms or benefits) is extended to insured group health plans.
- Preventive Services requirements: Certain preventive services must be covered without cost sharing.
- 2014 requirements: fair insurance premiums (community rating), comprehensive benefit packages, cost share limits on out-of-pocket maximums and deductible caps.

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Question #3: May individuals be added to a grandfathered plan without impacting its grandfathered status?

Answer #3: Yes. Individuals (whether new hires or new enrollees) and their dependents may be enrolled in the grandfathered plan after March 23, 2010 without jeopardizing the plan's grandfathered status.

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Question #4: Can an employer plan sponsor simply change insurers or third party administrators, and not their underlying plan design, without jeopardizing their plan's grandfathered status?

Answer #4: Under an amendment to the grandfather rule, plan sponsors who elect to enter into a new insurance policy or contract or certificate of insurance after March 23, 2010 and before November 15, 2010 will lose their grandfathered status unless the plan is maintained pursuant to a collective bargaining agreement. The amended rule allows a grandfathered group health plan to enter into a new policy, contract or certificate of insurance (e.g., change insurance carriers), effective on or after November 15, 2010, and still maintain its grandfather status if the plan makes no other changes that would cause loss of such status under the rule.

Plan sponsors who elect to change third party administrators (administering a self funded product) will not lose their grandfathered status provided the benefit changes do not exceed the standards set forth in the IFR.

Question #5: What are some of the key provisions of the PPACA not subject to the grandfathering provision?

Answer #5: The following provisions go into effect for grandfathered plans on the first plan year that begins on or after September 23, 2010:

- Prohibition of rescissions, except in cases of fraud or misrepresentation.
- Required coverage of dependents up to the age of 26, except that grandfathered plans may exclude from coverage adult children who are eligible for other employer sponsored group health coverage for plan years beginning before 2014.
- Prohibition of preexisting condition exclusions for enrollees who are under 19.
- Prohibition of lifetime limits on "Essential Health Benefits".
- Restriction on annual limits on "Essential Health Benefits" until 2014

Note: The term "Essential Health Benefits" is very broadly defined to include wide-open categories (i.e., hospitalization, laboratory services, mental health and substance use disorder services), therefore we will need regulatory guidance to understand which types of benefits are subject to lifetime and annual limits.

The following provisions go into effect for grandfathered plans on the first plan year that begins on or after January 1, 2014:

- Required coverage of dependents up to the age of 26, regardless of their eligibility for other employer sponsored coverage.
- Prohibition of preexisting condition exclusions for all enrollees.
- Prohibition of waiting periods of more than 90 days.
- Prohibition of all annual limits on "Essential Health Benefits".

Question #6: Do the special exemptions for plans maintained pursuant to a collective bargaining agreement apply to plans administered on a self funded basis?

Answer #6: No, the language in PPACA refers solely to "health insurance coverage" and does not refer to plans administered on a self funded basis. The IFR clarifies that the collectively bargained exception to grandfather status applies only to *insured* collectively bargained plans—not self-funded collectively bargained plans.