

# AFSCME Facts

## Patient Protection and Affordable Care Act Grandfathered Status – What is it and how does a plan lose it?

The Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010 and amended by the Health Care and Education Reconciliation Act (HCERA), signed on March 30, 2010) contains provisions "grandfathering" certain health plans from some of the reform's terms. A grandfathered health plan is any individual or group health plan coverage that was in effect on March 23, 2010. A plan maintaining grandfathered status will be exempt from certain insurance reform provisions of the Act. In addition, there are temporary exemptions from the Act's mandates for collectively bargained plans.

The Departments of Treasury, Labor, and Health and Human Services published interim final rules relating to "grandfathered" status on June 17, 2010 in the *Federal Register*. Public comments are being accepted until August 16, 2010. Links to the regulations and fact sheets can be found here: <http://www.hhs.gov/ocio/regulations/grandfather/index.html>.

### Reform Provisions Applicable to Grandfathered Plans

Although grandfathered status allows a plan to avoid the application of some of the new law's requirements, some key reform provisions apply to both grandfathered and non-grandfathered plans:

- Coverage for dependent children up to age 26 – for grandfathered plans, this is only required if the child is not eligible to enroll in other employer-sponsored health plan coverage. On January 1, 2014, this limitation is lifted;
- Elimination of pre-existing condition exclusions or other discrimination based on health status from group health plans for children under the age of 19 (Pre-existing condition exclusions are eliminated for all ages on January 1, 2014). Grandfathered plans in the individual market may maintain such exclusions;
- Prohibition on rescission – the practice of dropping people from coverage when they get sick is prohibited;
- Elimination of lifetime benefit limits on coverage of "essential benefits" (to be defined);
- Annual essential benefit limits are restricted – in 2014 all annual limits are prohibited.

The annual dollar-amount limits would be no less than:

- \$750,000 for plan years that begin on or after Sept. 23, 2010, but before Sept. 23, 2011;
  - \$1.25 million for plan years that begin on or after Sept. 23, 2011, but before Sept. 23, 2012; and
  - \$2 million for plan years that begin on or after Sept. 23, 2012, but before Jan. 1, 2014.
- Waiting periods for plan eligibility are limited to 90 days (January 2014);
  - Uniform explanation of coverage and standardized definitions will be applicable to coverage documents in March 2012.

## Reform Provisions Not Applicable to Group Grandfathered Health Plans

A number of the consumer protections and benefit mandates of PPACA are not applicable to a plan with grandfathered status. The reforms that may not be applicable to grandfathered plans include:

- Prohibition on discrimination against health care providers acting within the scope of their licenses;
- Prohibition on dropping coverage because an individual (who requires treatment for cancer or another life-threatening condition) chooses to participate in a clinical trial. Coverage may not be denied for routine care that the plan would otherwise provide because an individual is enrolled in a clinical trial;
- Plans must cover certain preventive services, immunizations, and screenings, without any cost sharing (coverage to be determined at a later date).
- Various financial and quality of care reporting requirements;
- Minimum requirements for claims appeal processes;
- Patient protections that allow plan participants to select their own primary care provider and pediatrician. OB/GYN services may not be subject to pre-authorization. Prior authorization and higher cost sharing for out of network emergency services are prohibited.

A complete summary of health reform provisions applicable and inapplicable to grandfathered plans is at this link: <http://www.dol.gov/ebsa/pdf/grandfatherregtable.pdf>

## What Causes an Existing Group Health Plan to Lose Grandfathered Status?

The following changes will cause a plan to lose its status as a grandfathered plan:

- **Elimination of all or substantially all benefits to diagnose or treat a particular condition.** For example, if the plan currently provides counseling and prescription drug benefits to treat mental illness and subsequently eliminates counseling benefits, the plan loses grandfathered status. If a plan ceases coverage for an illness in total, it would lose grandfathered status;
- **Any increase in a percentage cost-sharing requirement (coinsurance).** For example, if a plan currently pays 80% of the cost of a covered service and it reduces the coverage to 75%, it would lose grandfathered status;
- **Any increase in fixed-dollar cost-sharing (e.g. deductibles, out-of-pocket expenses – not copayments) in excess of the rate of medical inflation since March 23, 2010, plus 15 percentage points.** For example, if a plan has an annual deductible of \$500, and at the time it increases the deductible to \$1,000 the medical component of CPI had increased by 40 percent since March 2010, the plan would lose grandfathering status because it had increased the deductible by 100 percent while the “allowable” increase was 55 percent (40 percent plus 15 percent). To maintain grandfathered status, the plan could not increase the deductible above \$775 in this hypothetical example (\$500 plus 55 percent equals \$775);
- **Any increase in copayments in excess of the greater of a) the rate of medical inflation, plus 15 percentage points, or b) \$5.00, increased by medical inflation.** For example, plans with zero co-payments could implement co-payments of \$5. This \$5 threshold is indexed by the change in the medical component of the CPI;

- **Any decrease in the employer contribution towards the cost of any tier of coverage by more than 5 percent of the contribution rate in effect on March 23, 2010.** For example, if the employer currently contributes 90% towards the cost of premiums and decreases the share of contribution to below 85% of the cost, the plan would no longer be a grandfathered plan. The loss of grandfathered status would occur even if just one of the employer's tiers of coverage (single or dependent) is affected by the change in premium contribution. For plans where premiums are not based on a percentage of the plan costs, but on a fixed dollar or other amount, the employer contribution as of March 23, 2010 is converted to a percentage (using COBRA rates, if necessary). The regulations are not clear how this provision will be applied in cases where employee premium payments are a percentage of salary;
- **Changes in annual benefit limits as follows:**
  - If the plan did not have an annual limit on March 23, 2010 but then imposes an overall annual limit;
  - If the plan had an overall lifetime limit but no annual limit but then imposes an overall annual limit that is lower than the lifetime limit on March 23, 2010;
  - If the plan had an annual limit on March 23, 2010 but then decreases the dollar value of the annual limit.

These rules apply separately to each benefit package offered by an employer. For example, an employer may offer three coverage options: an HMO, PPO A, and PPO B. Only PPO B undergoes a change referenced above. The HMO and PPO A would retain grandfathered status but PPO B would no longer be a grandfathered plan.

The regulations do not address whether other changes in a plan such as changes to plan structure, changes in provider network or changes to a prescription drug formulary could result in loss of grandfathered status. Comments on these issues and others are invited with the possibility of additional guidance being released in the near future. AFSCME believes substantial changes in networks and formularies, and the implementation of changes such pre-authorization for specialty care or the implementation of "gatekeeper" features, should cause a plan to lose grandfathered status. However, according to comments made in October 2010 by Kevin Knopf, attorney adviser in the Office of Benefits Tax Counsel at the Treasury Department, changes in a plan's formulary or network would not cause a plan to lose grandfathered status.

There are certain actions that will not cause a plan to lose its grandfathered status. For instance, the plan may add new family members or employees, add new benefits to the health plan, change the terms of the plan to comply with state or federal requirements (including PPACA), voluntarily adopt consumer protections that they are not required to adopt, and/or make modest adjustments in benefits or cost-sharing and raise premiums. Also, self-insured plans may change its plan administrator without losing its status.

An amendment to the grandfather rule was released on November 15, 2010. Reversing guidance included in the interim final regulations, this amendment allows an insured health plan to retain its grandfather status even if it changes its carrier, provided that other changes (indicated above) are not made that would affect the plan's status. This revision is prospective and only applies to changes that are effective on or after November 15, 2010.

## **Collectively Bargained Plans**

Collectively bargained plans (both fully and self-insured) in place on March 23, 2010 are grandfathered health plans. As such they are subject to the same requirements as other grandfathered health plans and must comply with the reform provisions indicated above. The collective bargaining provisions of PPACA effect only fully insured, and not self-insured plans. Changes made to a fully insured collectively bargained plan during the term of any of the collective bargaining agreements ratified prior to March 23, 2010 that maintain the plan would not cause the plan to lose grandfathered status immediately. Upon the termination date of the last agreement, the terms of coverage are compared with the terms of coverage that were in effect on March 23, 2010. Changes in coverage that would cause a plan to lose grandfathered status under the regulations would cause a collectively bargained plan to lose grandfathered status once the last agreement expires.

## **Transitional Rules**

Grandfathered status will not be lost if a plan or health insurance issuer has made changes to coverage after March 23, 2010 in accordance with:

- a) a legally binding contract entered into on or before March 23, 2010;
- b) a filing with a State insurance department on or before March 23, 2010; or
- c) written amendments to a plan that were adopted on or before March 23, 2010.

For plans adopting routine changes after March 23, 2010 but before these regulations were issued, the Departments will take into account good-faith efforts to comply with a reasonable interpretation of the statutory requirements, disregarding changes to plan and policy terms that only modestly exceed changes that would cause a plan to lose its grandfathered status. In addition, there is a grace period provided to employers and health insurance issuers to revoke or modify any significant changes adopted before these regulations were issued where the changes would cause loss of grandfathered status (changes must be revoked effective the first day of the first plan year beginning on or after September 23, 2010 to bring the terms within the limits for retaining grandfathered status).

## **Additional Requirements to Maintain Grandfathered Status**

To maintain grandfathered status, the plan or health insurance coverage must include a notification to plan participants that the plan believes it is a grandfathered plan and must provide contact information for questions and complaints. (View model language here: <http://www.dol.gov/ebsa/grandfatherregmodelnotice.doc> ) In addition, records documenting the terms of the plan/coverage in place on March 23, 2010 must be maintained as well as any other documents necessary to verify, explain or clarify its status as a grandfathered health plan. These records must be available for examination upon request.

It should be noted that retiree-only and “excepted benefits” such as dental plans, vision plans, long-term care insurance or Medigap, are exempt from PPACA insurance reforms.

For further information, contact Steven Kreisberg or Mary Meeker at AFSCME’s Department of Research and Collective Bargaining Services.

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