

Hamilton News

SPECIAL EDITION: GRANDFATHERING

Grandfathering under Health Care Reform

President Obama has said on many occasions, beginning in June 2009 and as recently as September 2010, that if you have an employer-sponsored health care now and you like it, you'll be able to keep your health care plan. While there may be questions about that, it's grandfathering that is the key to meeting that promise.

A Grandfathered (GF) plan is "health coverage provided by a group health plan or an insurance issuer in which an individual was enrolled on March 23, 2010...and the status of the coverage is maintained as long as the plan continuously covers at least one person (not necessarily the same person) since that date."

This definition leaves open a number of questions and unresolved details about what plans are actually grandfathered and what might cause them to lose that status. Some of this necessary clarification has been addressed through the regulatory, not legislative, process. The Departments of Labor, Treasury, and Health and Human Services issued joint guidance on June 23, 2010 in the form of Interim Final Regulations (IFRs) published in the Federal Register

So what are *Interim Final Regulations*? This phrase, commonly describes rules issued without notice and comment, due to an extremely limited time frame provided by the enacted legislation, making it clear that Congress intended this rule to be issued without the time-consuming process of notice and comment. Use of the interim final regulation process means that agencies start by posting regulations, and then collect and analyze public comments after the regulations are posted. The IFRs for health care grandfathering provided a short comment period that expired on August 16, 2010. Any modifications that may arise from the comments have not yet been issued. This means that plan sponsors and issuers should rely on the regulations as issued to date, in conjunction with updated FAQs provided by the Departments. Updates to information are available on the "Understand the New Law" section of www.healthcare.gov.

This newsletter reviews the key aspects of the advantages of retaining a plan's GF status, what's required to keep it, the likelihood that you can maintain GF, and research into expected employer-sponsored trends on GF.

TABLE OF CONTENTS	
Impact of Plan Changes on GF'd Status	2
Can You Really "Keep the Health Plan You Have?"	3
Health Care Provisions and their Applicability to GF / Non-GF Plans	3
Hamilton Insurance Agency and HR Business Solutions	4

Employee Notice Requirements

The Patient Protection and Affordable Care Act (PPACA) requires employers to provide *annual* notices to all eligible employees, based on the status of their group health plan. These notices are:

All Plans (GF and Non-GF)*	Non-GF Plans Only	Current ERISA Requirements
<ul style="list-style-type: none"> • Grandfather Status • Coverage for Adult Children • Annual Limits on Essential Benefits • Lifetime Limits on Essential Benefits • Pre-Existing Condition Exclusions for Children Under Age 19 • Patient Protection from Rescission 	<ul style="list-style-type: none"> • Appeals Process* • Non-Discrimination Rules • First Dollar Coverage for Preventive Care • Patient Protection for Provider Designation 	<ul style="list-style-type: none"> • Women's Health and Cancer Rights Act • HIPAA (for self-insured plans) • CHIPRA (Children's Health Insurance Reauthorization Act) • Medicare Part D • Mental Health Parity Act

* Model notices now available on the Department of Labor website for requirements covering all plans and noted requirements for non-grandfathered plans.

With these changes, Non-grandfathered plans will now be required to provide 16 total notices to eligible employees, while Grandfathered plans will be required to provide 11 annual notices. These changes take effect the first plan year beginning after September 23, 2010.

Impact of Plan Changes on Grandfathered Status

Changes Causing Forfeiture of Grandfathered Status
The employer enters into a new policy, certificate or contract of insurance after enactment ⁽¹⁾ including situations where an employer changes insurer and retains the exact same terms of coverage. The DOL has indicated they may issue additional guidance defining certain circumstances when a GF'd group health plan could change carriers without losing its GF status.
The plan eliminates all or substantially all of its benefits for the diagnosis or treatment of a particular condition, including elimination of benefits for any necessary element to diagnose or treat a condition.
ANY increase, measured from the date of enactment, in a percentage cost-sharing arrangement (e.g., co-insurance on out-of-network coverage).
The coverage reflects an increase to a fixed amount, cost-sharing arrangement, other than co-payments, that is greater than medical inflation ⁽²⁾ plus 15 percentage points. Examples of these arrangement include out-of-pocket limits and deductibles. <i>The key challenge to complying with this measure is that the 15 percentage points are cumulative from the date of enactment and not an annual amount.</i>
An increase in fixed-amount co-payments exceeding the greater of: \$5 increased by the medical inflation rate, or Medical inflation rate as of the enactment date plus 15%. Assuming a medical inflation rate of 10% and a co-pay of \$25 on the date of enactment, the company could increase its co-payments to a maximum of \$31.25, which is the greater of: $\$5 \times 1.10 = \5.50 (max co-pay of $\$25 + \$5.50 = \mathbf{\$30.50}$) $10\% + 15\% = 25\%$ (max co-pay of $\$25 \times 1.25 = \mathbf{\$31.25}$) <i>The \$5 threshold and the 15 percentage points are cumulative from the date of enactment, and not an annual amount.</i>
An employer that decreases its contribution rate towards the cost of any tier of coverage for any class of similarly situated individuals by more than 5% below its rate at enactment ⁽³⁾ calculated as: $\frac{\text{Employer Contributions}}{\text{Total Cost of Coverage}}$
Employers cannot conduct a merger, acquisition or similar business restructuring, if the principal purpose is to cover individuals under the GF'd plan.
A group health plan that imposes or modifies annual limits as compared with its status as of the date of enactment by: Adopting a new annual limit on the dollar value of benefits, if it did not previously have either an annual or lifetime limit; Adopting an annual limit that is lower than a lifetime limit, if it previously had a lifetime, but no annual limit; or Lowering an annual limit if the plan previously had an annual limit. Group health plans continue to be subject to the prohibitions and restrictions on imposing lifetime and annual limits on "essential benefits" that take effect beginning Sept. 23, 2010.
Grandfathered Status Remains Intact
An employee who was previously not enrolled in a GF'd plan or is newly-eligible electing to enroll in that plan.
An employee's family member or newly-eligible dependent enrolling in a GF'd plan.
Renewal of an insurance policy that was in effect on the date the law was enacted.
Elimination of coverage for a class of employees and/or family coverage.
Implementation of changes necessary to comply with Federal or State laws or to voluntarily comply with non-required provisions of PPACA.
Certain modification may be allowable, as long they don't conflict with one of the restrictions noted above: <ul style="list-style-type: none"> •Changes in premiums, •Changes to provider networks, •Changes to third party administrators, and •Changes to prescription drug formularies (To ensure compliance, plan sponsors should pay particular attention to reviewing changes to drug formularies to ensure they are not eliminating all or substantially all of the coverage of treatment for a particular condition. <i>The Departments have not yet issued guidance as to how changes to plan structure, such as shifting from an insured product to a self-insured product, will impact GF status.</i>

- (1) "Enactment" refers to March 23, 2010, the date the Patient Protection and Affordable Care Act (PPACA) was signed into law.
- (2) "Medical Inflation" is the percentage increase in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) when compared to that CPI element for March 2010 (utilizing the 1982-1984 base of 100 as the foundation). It is expected that the government will publish medical inflation statistics specifically for the purpose of GF calculations.
- (3) The regulations do not yet address how employer contribution strategies to pay a percentage of the lowest cost plan offered or provide a salary-based contribution should be reviewed for compliance with this requirement.

Can You Really “Keep the Health Plan You Have?”

Many plan sponsors, when asked about the likelihood of keeping their grandfathered plans, have discovered that it simply will not be feasible for any extended period. Several of the requirements for maintaining GF status have one-time percentage increase limits that will, at least over the course of several years, be nearly impossible not to exceed, particularly the limits to fixed amount cost-sharing arrangements, such as out-of-pocket limits; fixed amount co-payments; or changes to the employer contribution percentage. Additionally, many carriers are opting only to provide non-grandfathered insured products, especially to their customers with fewer than 100 employees, leaving employers without access to a grandfathered option.

Hewitt Associates, an international benefits consultant, surveyed large U.S. companies in June and the results were clear - 90% expect to lose their grandfathering status by 2014, with just over half anticipating its loss in 2011. The primary reasons they see for the forfeiture are:

- Changes to health plan design;
- Changing insurance carriers; or
- Changes to company subsidy levels;
- Union negotiations.
- Consolidation of health plans;

The design changes that respondents anticipate making are: increasing the employee’s percentage of premium cost; raising out-of-pocket maximums and deductibles; increasing co-payments, particularly for specialist care; or shifting to a full-replacement consumer-directed health care plan (such as an HSA) as their only coverage option.

Ultimately, each plan sponsor must consider the options available to them, compare the costs and benefits, and assess the risk of not being able to fully comply. In most cases, the question has shifted from “Can we keep our GF status?” to “When do we lose it?”

Provision	Implementation Date ⁽¹⁾	Applies to GF Plans?
Ban on Annual and Lifetime Limits on “Essential Benefits”	1/1/2011	✓
Ban on Pre-Existing Condition Exclusion ⁽²⁾	1/1/2011	✓
Extended Coverage to Adult Children Up to Age 26 ⁽³⁾	1/1/2011-2014	✓
No Retroactive Rescissions, Except Fraud or Misrepresentation	1/1/2011	✓
New Nondiscrimination Rules for Insured Plans	1/1/2011	✗
Appeals Process Standards	1/1/2011	✗
Ban on Over the Counter Medication Reimbursement	1/1/2011	✓
Automatic Enrollment of FT Employees by Large Employers (200+ employees)	1/1/2014	✓
Advance Notice of Material Modifications (at least 60 days)	TBD	✓
First Dollar Coverage / Ban on Cost-Sharing for Immunizations and Preventive Care	1/1/2011	✗
Ban on Prior Authorization Requirements for Emergency Services or OB/GYN care	1/1/2011	✗
Limits on Ability to Rescind Coverage	1/1/2011	✓
Cost-Sharing Obligations for Out-of-Network Emergency Services	1/1/2011	✗
Participant Choice of Primary Care Physician / Pediatrician / Gynecologist	1/1/2011	✗
W-2 Health Coverage Cost Reporting Obligation	2011 W-2, issued in 2012	✓
New Internal and External Claims and Appeals Procedures	1/1/2011	✗
Annual Reporting on Healthcare Quality, Wellness Programs and Financial Disclosures	1/1/2014	✗

(1) Dates based on calendar year plans.

(2) For GF plans, the pre-existing condition exclusion applies only to individuals under the age of 19 until 2014, when it applies across-the-board.

(3) GF’d Plans have some transitional relief for implementation of this requirement, beginning in 2011 and ending 1/1/2014.



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