Health Care Reform Update: Grandfathered Plans

As your resource for employee benefits, our goal is to provide you with the information you need to navigate the Patient Protection and Affordable Care Act (PPACA.) In this special report, I will cover what we know as of today regarding grandfathered plans, and how they will impact you and your clients going forward.

President Obama went to great lengths to promise the millions of Americans who liked their current plans that they would be able to keep them under the new regulations. These reassurances helped achieve the necessary support to pass the legislation, and many Americans sighed with relief when the regulations were written to include provisions for grandfathering the plans that were in existence on the day he signed the bill into law.

We now know that the reality is that very few group plans will be able to maintain their grandfathered status over the next two years. This is because the rising cost of healthcare in a struggling economy will force changes to be made to these health plans that will cause them to lose their status. Now that we have the written guidelines for grandfathered plans, what does that really mean? And should we be concerned?

First, let's look at what it takes to be a grandfathered plan:

In order to qualify as a grandfathered plan, the plan must have been in place on March 23, 2010. Any group who has changed their health insurance carrier since that time, even if they made no changes whatsoever to their benefits, has already lost this status and their plan must comply with all of the regulations under the PPACA according to the implementation timeline. It is important to note that the rules do state that self insured plans are allowed to change administrators, as long as the plan itself and any insurer remains the same.

The following changes will also disqualify a group plan from maintaining its status as grandfathered:

Raising Co-Insurance Percentages: For example, an employer cannot modify the benefits to reduce the plan's coinsurance from 90% to 80%, even if he also modifies the stop loss to keep the maximum out of pocket the same.

Raising Co-Payments "Significantly": Compared with the co-payments in place on March 23, 2010, grandfathered plans will be able to increase doctor's office co-pays by no more than the greater of $5 (which will be adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15 percentage points. According to the Department of Health and Human Services (HHS,) medical costs have risen an average of 4-5% annually over the last few years. Assuming that remains consistent, this would mean that **in** the course of one year, a co-payment of $30 could increase by no more than 20% (5% plus 15%) or $6.00 in order to maintain grandfathered status.

Increasing Deductibles "Significantly": Compared with the deductible in place as of March 23, 2010, grandfathered plans can only increase the plan's deductible by a percentage equal to medical inflation plus 15 percentage points. Using the 5% medical inflation above, this formula would allow deductibles to go up, for example, by 20% between 2010 and 2011. Since this is cumulative, using the same 5% annual medical inflation numbers, the plan's deductible could go up by no more than 25% between 2010 and 2012.

Let's look at what that would mean for a plan with an April 1, 2010 renewal, that **on** March 23, 2010 had a $1,000 annual deductible, but made no plan change in 2010. Let's also assume a 5% medical inflation in each of the next two years. So with the 15% you may add to the medical inflation, the following limits would apply:

- The maximum increase allowable on the plan's next renewal, April 1, 2011 would be 20% of the deductible that was in place on March 23, 2010. ($1,000 times 20% = $200, so the maximum allowable plan deductible would be $1,200.)
- The maximum increase allowable on April 1, 2012 would be 25% of the deductible that was in place on March 23, 2010, or $250. This means that if the plan had in fact increased its deductible to $1200 in 2011, the maximum allowable increase in 2012 would be $50, due to the cumulative restriction.

Realistically, how many plans will offer the incremental deductibles that would be necessary to keep the increases below the required thresholds? While it is possible that carriers will modify their portfolios to include more options, given all of the other changes that they are being forced to make, it is unlikely that they will have the available resources that would be necessary to administer the number of options that would be required to allow groups to maintain their status.

The same formulas apply to overall out-of-pocket on the plans, leading me to my conclusion that these two restrictions are the ones most likely to cause groups to lose grandfathered status over the next two years.

"Significantly" Lowering Employer Contributions: An employer who wishes to maintain his plan's grandfathered status cannot decrease contributions towards the group health plan by more than five percentage points. This is calculated by tier, not overall contribution and is once again based on the plan as it stood on March 23, 2010. (In the case of a self funded plan, the contribution rate is based on the COBRA valuation of the premium.) This means that if an employer was paying 80% of his employees' premium, and 60% of their dependents' premium on March 23, 2010 and subsequently decreases his contribution for dependent premium to 50% (a change of 10%,) the plan would no longer be grandfathered. This is true even if the employer simultaneously increases his contributions to the employees portion of the premium. Once again, given that the employers' hands are virtually tied with plan design, and knowing that premiums have to rise in order to implement the newly required benefits to all plans, how can an employer be expected to make no changes to his contributions to the plan over the next few years?

Adding or Tightening an Annual Limit: This is an area that the fully insured employer has no control over; which would be for the plan to reduce the annual benefits for certain covered services by placing a lower dollar limit on the benefit. In addition, plans that do not have annual dollar limits for covered charges cannot add new ones, unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit. In other words, the inside limits on a plan cannot be reduced in order to maintain grandfathered status of the plan. Additionally, the plan may not remove a benefit that previously existed, which means that if the insurance carrier were to move the employer to a plan with an additional exclusion, regardless of the fact that all other benefits remained exactly the same, the plan would lose grandfathered status.

Fact or Fiction - if you like your plan, you can keep it!

The Department of Health and Human Services (HHS,) as posted on the www.healthreform.gov website, estimates that between 58% and 80% of all small employers will remain covered under grandfathered plans through 2011. These estimates fall to between 20% and 51% by 2013. I disagree, and believe the actual numbers will be much lower, much sooner. This is because, based on the rules outlined above, almost every step an employer currently takes to control his healthcare costs will be prohibited in order to maintain grandfathered status.

The real question:

The real question is does that matter? Will the employer or his employees lose much when they lose grandfathered status? In most cases, the answer is no, because so much of the regulation pertains to all plans regardless of grandfathered status.

Let's walk through what must be included in all plans, regardless of grandfathered status, when they renew on or after September 23, 2010, and the impact this is expected to have on premiums going forward:

Lifetime limits must be removed: Most group health plans currently have in-network lifetime limits of $2,000,000 or more, and very few insured individuals ever exceed these amounts. Therefore, this should have a nominal impact on the premium for plans where the PPO utilization is strong.

Annual limits must be removed: This provision states that there may be no monetary caps on benefits that the HHS considers to be essential benefits, which have not yet been clearly defined. We have already seen some carriers conclude that a cap on the number of visits is allowable, and many have initiated the process to modify their plans accordingly. We expect that there will be little or no impact on the premium for plans that are able to make these changes. If the annual cap on visits is deemed unacceptable, and/or if the definition of essential benefits is more expansive than anticipated, this could have an impact on the plans' premiums. Unfortunately, we are all still waiting to learn more about this one, as so many of the rules are yet to be written for so much of the new law.

Rescission: This is really very similar to the regulations that are already on the books with HIPAA and various state insurance laws regarding guaranteed renewability and restrictions governing policy rescissions. In most cases today, a plan may only rescind coverage for fraud or intentional misrepresentation of a material fact. The new legislation tightens up the language, and adds new notification requirements.

Coverage of preexisting conditions for children up to age 19: This is fairly self explanatory for groups; on the individual side there is also a provision for guaranteed issue for new applicants who meet this age criterion, which is a change.

Keep in mind that in 2014, this "protection" extends to all individuals for plan years beginning on or after January 1, 2014. Carriers are still trying to determine the impact this will have on their claims costs, therefore the impact it will have on premiums going forward. They had hoped that an individual mandate would not only require all Americans to have health insurance, but would have enough teeth in it (penalties for non-compliance) to cause most Americans to enroll. This would include those who are young and healthy, and would therefore allow the law of large numbers to work. Not only do the penalties for non-compliance appear to be much too low, several states are challenging the constitutionality of such a mandate to purchase insurance. One way to help ease those concerns would be a provision to add an annual open enrollment period, which would be the only time each year that the insurance carriers would be required to issue coverage to all applicants with no pre-existing condition limitations. (This would be in addition to all of the current requirements to accept timely enrollees on group plans.) Otherwise, there is valid concern that individuals will simply jump on and off of health insurance as they need medical services, which would spell disaster for private and public insurance plans alike. This is already happening in Massachusetts. Can you imagine being able to modify your automobile insurance policy from liability-only coverage to add comprehensive coverage the day after you were at fault in an accident that totaled your car? And have it retroactively cover the damages? The ability to pay a very small penalty until you have a need for the coverage would amount to the same thing. Here is a link to a great article from CNN Money that discusses exactly what is happening in Massachusetts and what we can all expect once these provisions are in place under the PPACA. http://money.cnn.com/2010/06/15/newsieconomy/massachusetts healthcare reform.fortune/index.htm

Extension of eligibility for adult children: The law mandates that adult children remain eligible for coverage on their parent's plans until they are 26 years old, regardless of their marital, student, or dependent status. Plans who have had a covered adult child "age out" under the current eligibility rules in the six months leading up to the enactment of this provision will be required to allow those individuals to come back on to the plan at that time.

For the first three years, the only criterion that a plan may use to determine eligibility of an adult child will be whether or not they have group health insurance available to them through their own employer or through their spouse. As of 2014, non-grandfathered plans will have to offer coverage regardless of whether or not the adult child has group coverage available to them through another source, while grandfathered plans will be able to continue to deny that small subset of adult children.

The following are provisions of the act that only apply to non-grandfathered cases, as they issue or renew on or after September 23, 2010:

Preventive Care Services: Preventive care services, which have yet to be clearly defined, must be covered with no cost sharing on the part of the insured. This means no co-pays, no deductibles, no coinsurance, and no caps. The impact this will have on premiums will depend on the plan's current benefit structure for preventive care services, and which services are included in the final regulations.

Emergency Services: Plans will not be allowed to require precertification and will no longer be able to apply out-of-network benefit levels to emergency care, regardless of the network affiliation of the hospital's emergency room facility and medical personnel. Most of the plans we represent already provide this level of benefit in a true emergency. The real change lies in the way that usual and customary expenses can be handled going forward on these plans. The regulations require that covered charges for the emergency services must be the greater of three amounts: 1) the median of negotiated in-network rates, 2) the generally applicable out of network cost, or 3) the Medicare rate. Once the greater of the three has been used to establish the plan's covered charges, the plan may apply in-network levels of coinsurance to determine the plan's benefits. Ultimately I believe that the primary expense to the plans due to this regulation will be the administrative requirement to determine these three amounts for every emergency service. An additional concern in this category will be the final definition of emergency care.

New Appeals Procedures: New procedures must be implemented for both internal and external appeals for claims. Internally, all group plans will be required to incorporate the U.S. Department of Labor's claims and appeals procedures, and update them to reflect standards that will be established by the Secretary of Labor. Individual plans will be held to standards which will be established by the Secretary of the HHS. Externally, at a minimum, the plans will be required to comply with consumer protections which are included in the NAIC Uniform Review Model Act.

Primary Care Physicians: Plans that require an insured to choose a primary care physician will be required to allow more flexibility for an insured member to choose a pediatrician, obstetrician, or gynecologist. This is going to apply primarily to HMO plans, and the majority of those plans already allow for these providers to be considered a primary care physician, so the impact is expected to be minimal.

Non-Discrimination Testing: Under the PPACA, non-grandfathered plan may not "discriminate in favor of highly compensated individuals" with respect to eligibility for, or benefits under, the plan using non-discrimination rules similar to those described in the United States Internal Revenue Code at 26 U.S.C. § 105(h.) This provision will cause the great concern for certain groups, as it prohibits management carve outs. This means that if you have a client who is currently carving out his management team for health benefits, he must keep his grandfathered status, or he will lose the ability to do so. It also means that if an employer is currently contributing different levels of premium by class of employment, he could be forced to change these practices. There are also implications that relate to multiple plan options, even if each employee has the right to choose from either plan. I will go through this one in more detail later.

There are other provisions that apply in 2014 to non-grandfathered groups which do not apply to grandfathered groups. These include community rating (a nightmare,) limits on plan deductibles, out-of-pocket cost sharing, and restrictions on waiting periods for benefit eligibility. The real question is whether any groups will remain grandfathered by that time. I just don't see how there will be, given the rules as we know them today. Individual policies perhaps, but groups?

In any event, as you can see, for the next three and a half years, the benefits to an employer of maintaining grandfathered status will mostly come down to a couple of benefit changes and the impact to the fully insured employers who will have to apply the 105(h) nondiscrimination rules to their fully insured plans. These rules require that a plan not discriminate in favor of "highly-compensated individuals" with regard to both contributions and benefits. For purposes of these rules, a "highly-compensated individual" is an employee who 1) is one of the 5 highest-paid officers, 2) owns more than 10% of the value of the employer's stock, or 3) is among the highest 25% of employees ranked by pay. Accordingly, roughly 25% of employees (including most closely-related domestic affiliates) will be classified as "highly compensated" under this definition, regardless of how much compensation they earn.

Having different waiting periods for different classes of employees, or varying employer premium contributions for different classes of employees could cause a plan to fail its annual 105(h) nondiscrimination test. A plan with two or more benefit options could fail nondiscrimination testing if the highly-compensated individuals tend to elect the benefit option with the better benefit and the non-highly-compensated individuals elect the other option. If any of these circumstances apply to a plan, compliance with the 105(h) nondiscrimination rules could have a significant impact. Those employers who wish to continue to use health benefits to attract key employees without having to offer similar coverage to all employees will be forced to take whatever measures possible to absorb the increases in cost over the next few years without making changes that will cause them to lose their grandfathered status. I don't envy them the challenge.

In conclusion:

I realize that there are going to be groups who do not want to make any changes to their plans this year so that they can hold onto their grandfathered status. This is a good/bad thing. Clearly if you are the agent of record, and the employer can afford to keep their plan intact, it is much easier to renew a case than to rewrite it. So, perhaps this will help with persistency for a time. On the other hand, if you are attempting to write new business, I hope that you will be able to use the information in this document to walk an employer through the pros, the cons, and the future challenges of keeping the health plan they had on March 23, 2010.

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