

# Health Care Reform

## Simplifying Reform - Regulations Issued on Grandfathered Plans

**Health Care Reform was signed into law by President Obama on March 30, 2010**

### **EXECUTIVE SUMMARY**

The health care reform law passed earlier this year brings many changes to employers and health plans. The extent of the impact will depend, in part, on whether you maintained a health care plan on March 23, 2010, the date the primary legislation was enacted. If your company sponsored a plan on that date, it is considered a "grandfathered" plan. Grandfathered plans are exempt from certain health care reform requirements.

On June 14, 2010, the Departments of Health and Human Services (HHS), Labor and Treasury issued regulations regarding grandfathered plans. Importantly, it clarifies what types of changes can be made to existing plans that will allow them to retain their "grandfathered" status.

### **SUMMARY OF THE REGULATIONS**

The regulations essentially state that plans will lose their grandfathered status if they choose to significantly cut benefits or increase out-of-pocket spending for consumers.

#### **Permitted Changes**

Grandfathered health plans will be able to make routine changes to their policies and maintain their status. These routine changes include cost adjustments to keep pace with medical inflation, adding new benefits, making modest adjustments to existing benefits, voluntarily adopting new consumer protections under the new law, or making changes to comply with state or other federal laws. Premium changes are not taken into account when determining whether or not a plan is grandfathered.

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## Prohibited Changes

Plans will lose their grandfathered status if they choose to make significant changes that reduce benefits or increase costs to consumers. Specifically, making the following changes would cause a plan to lose its grandfathered status:

*Significantly Cutting or Reducing Benefits.* For example, if a plan decides to no longer cover care for people with diabetes, cystic fibrosis or HIV/AIDS.

*Raising Co-Insurance Charges.* Typically, co-insurance requires a patient to pay a fixed percentage of a charge (for example, 20 percent of a hospital bill). Grandfathered plans cannot increase this percentage.

*Significantly Raising Co-Payment Charges.* Frequently, plans require patients to pay a fixed-dollar amount for doctor's office visits and other services. Compared with the copayments in effect on March 23, 2010, grandfathered plans will be able to increase those co-pays by no more than the greater of \$5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15 percentage points. For example, if a plan raises its copayment from \$30 to \$50 over the next two years, it will lose its grandfathered status.

*Significantly Raising Deductibles.* Many plans require patients to pay the first bills they receive each year (for example, the first \$500, \$1,000 or \$1,500 a year). Compared with the deductible required as of March 23, 2010, grandfathered plans can only increase these deductibles by a percentage equal to medical inflation plus 15 percentage points. In recent years, medical costs have risen an average of 4-5 percent so this formula would allow deductibles to go up, for example, by 19-20 percent between 2010 and 2011, or by 23-25 percent between 2010 and 2012. For a family with a \$1,000 annual deductible, this would mean if they had a hike of \$190 or \$200 from 2010 to 2011, their plan could then increase the deductible again by another \$50 the following year.

*Significantly Reducing Employer Contributions.* Many employers pay a portion of their employees' premium for insurance and this is usually deducted from their paychecks. Grandfathered plans cannot decrease the percent of premiums the employer pays by more than 5 percentage points (for example, decrease their own share and increase the workers' share of premium from 15% to 25%).

*Adding or Tightening an Annual Limit on What the Insurer Pays.* Some insurers cap the amount that they will pay for covered services each year. If they want to retain their status as grandfathered plans, plans cannot tighten any annual dollar limit in place as of March 23, 2010. Moreover, plans that do not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit (which is more protective of high-cost enrollees).

*Cannot Change Insurance Companies.* If an employer decides to buy insurance for its workers from a different insurance company, this new insurer will not be considered a grandfathered plan. This does not apply when employers that provide their own insurance to their workers switch plan administrators or to collective bargaining agreements.

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### **Additional Requirements for Grandfathered Plans**

The regulations also contain additional requirements to keep health plans from using the grandfather rule to avoid providing important consumer protections.

To promote transparency, the regulations require a plan to disclose to consumers, every time it distributes materials, whether the plan believes that it is a grandfathered plan and therefore is not subject to some of the additional consumer protections of the health care reform law. This allows consumers to understand the benefits of staying in a grandfathered plan or switching to a new plan. The plan must also provide contact information for enrollees to have their questions and complaints addressed.

The regulations also provide that a plan's grandfathered status may be revoked if it forces consumers to switch to another grandfathered plan that, compared to the current plan, has less benefits or higher cost sharing as a means of avoiding new consumer protections. Grandfathered status may also be revoked if a plan is bought by or merges with another plan simply to avoid complying with the law.

### **Special Types of Health Plans**

Fully-insured health plans subject to collective bargaining agreements will be able to maintain their grandfathered status until their agreement terminates. After that point, they are subject to the same rules as other health plans; in other words, they will lose their grandfathered status if they make any of the substantial changes described above. Retiree-only and "excepted health plans" such as dental plans, long-term care insurance, or Medigap, are exempt from the health care reform insurance reforms.

### **Health Care Reform Rules that Do Not Apply to Grandfathered Plans**

The grandfathering provision of the health care reform law specifically exempts grandfathered plans from certain requirements of the law. Grandfathered health plans are exempt from the following requirements:

**Coverage of Preventive Health Services.** Effective for plan years beginning on or after September 23, 2010, group health plans and health insurance issuers offering group or individual health insurance coverage must provide coverage for certain preventive health services without imposing cost-sharing requirements.

**Patient Protections.** Effective for plan years beginning on or after September 23, 2010, the health care reform law puts the following rules in place for patients:

Group health plans and health insurance issuers offering group or individual health insurance coverage that require designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children).

Group health plans and health insurance issuers offering group or individual health insurance coverage that provide emergency services may not impose preauthorization or increased cost-sharing for emergency services (in or out of network).

Group health plans and health insurance issuers offering group or individual health insurance coverage that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for obstetrical/gynecological care.

**Nondiscrimination Rules for Fully-Insured Plans.** Effective for plan years beginning on or after September 23, 2010, fully insured plans must satisfy the requirements of Internal Revenue Code section 105(h)(2). That section provides that a plan may not discriminate in favor of highly compensated individuals as to eligibility to participate and that the benefits provided under the plan may not discriminate in favor of participants who are highly compensated individuals.

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**Exclusion for Dependents with other Employer-Provided Health Plan (Extension of Dependent Coverage)** Although the extension of dependent coverage to age 26 applies to all plans, there is an exclusion (until January 1, 2014) for grandfathered plans if the child is eligible to enroll in other employer-provided coverage.

**Quality of Care Reporting.** Within two years of the date of enactment, reporting requirements will be developed for group health plans and health insurance issuers offering group or individual health insurance coverage. The reports will relate to benefit and reimbursement structures that are designed to improve health outcomes, prevent hospital readmissions, improve patient safety, reduce medical errors and implement health and wellness activities.

**New Appeals Process.** Effective for plan years beginning on or after September 23, 2010, group health plans and health insurance issuers offering group or individual health insurance coverage must implement an effective appeals process for appeals of coverage determinations and claims.

**Insurance Premium Restrictions.** Effective for plan years beginning on or after January 1, 2014, premiums charged for health insurance coverage in the individual or small group market may not be discriminatory and may vary only by individual or family coverage, rating area, age and tobacco use, subject to certain restrictions.

**Guaranteed Issue and Renewal of Coverage.** Effective for plan years beginning on or after January 1, 2014, health insurance issuers offering health insurance coverage in the individual or group market in a state must accept every employer and individual in the state that applies for coverage and must renew or continue in force the coverage at the option of the plan sponsor or the individual.

**Nondiscrimination Based on Health Status.** Effective for plan years beginning on or after January 1, 2014, group health plans and health insurance issuers offering group or individual health insurance coverage may not establish rules for eligibility or continued eligibility based on health status-related factors. Wellness programs must meet nondiscrimination requirements.

**Nondiscrimination in Health Care.** Effective for plan years beginning on or after January 1, 2014, group health plans and health insurance issuers offering group or individual insurance coverage may not discriminate against any provider operating within their scope of practice. However, this provision does not require a plan to contract with any willing provider or prevent tiered networks. Plans and issuers also may not discriminate against individuals based on whether they receive subsidies or cooperate in a Fair Labor Standards Act investigation.

**Comprehensive Health Insurance Coverage.** Effective for plan years beginning on or after January 1, 2014, health insurance issuers that offer health insurance coverage in the individual or small group market must provide the essential benefits package required of plans sold in the health insurance exchanges.

**Limits on Cost-Sharing.** Effective for plan years beginning on or after January 1, 2014, group health plans may not impose cost-sharing or out-of-pocket costs in excess of certain limits. Out-of-pocket expenses may not exceed the amount applicable to coverage related to HSAs and deductibles may not exceed \$2000 (single coverage) or \$4000 (family coverage). These amounts are indexed for subsequent years.

**Coverage for Clinical Trials.** Effective for plan years beginning on or after January 1, 2014, group health plans and health insurance issuers offering group or individual insurance coverage must permit certain enrollees to participate in certain clinical trials, must cover routine costs for clinical trial participants and may not discriminate against participants.

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