

Grandfathered Plans

One of the most common questions employers have asked since the passage of health reform legislation is what changes can be made to a plan and still retain its “grandfathered status”. Employers will need to weigh the effect of the plan design restrictions that must be met to retain grandfathered status vs. the impact of health reform rules that must be implemented if a plan loses grandfathered status. We believe that many employers will find that the health reform related changes that would need to be adopted are relatively minor compared to the restrictions necessary to maintain grandfathered status. The primary reason an existing plan will find it advantageous to retain grandfathered status is if the plan does not meet the Section 105 nondiscrimination rules which now apply to fully-insured non-grandfathered plan (see below)s.

Changes that cause a loss of grandfathered status

Most of the plan changes that will cause a plan to lose its grandfathered status are related to reductions in benefits provided to employees. Plan will lose their grandfathered status if they make changes that exceed certain parameters when compared to the plans polices in effect on March 23, 2010. The following changes would cause a plan to lose grandfathered status:

A significantly cut or reduction in benefits for specific conditions. If a plan decides to eliminate “all or substantially all benefits to diagnose or treat a particular condition, for example to no longer cover care for people with diabetes, cystic fibrosis or HIV/AIDS.

Raising co-insurance that is based on a percentage. Plans may not raise the % charged for co-insurance benefits where coverage is expressed as a percentage of costs (for example raising the hospital co-pay from 20% to 30%).

Reducing employer contributions. To retain grandfathered status an employer may not decrease the percent of premiums the employer pays by more than 5%. This does not mean the employer must pick up the entire premium increase, but it must maintain the allowed % contribution to a plan (within 5%).

Example: On March 23, 2010 an employer contributes a flat \$300 toward a single plan with a total premium of \$500. This equals an employer contribution of 60%. Going forward the employer must always pay a minimum of 55% toward future premiums. For example, if the plan’s rate increases to \$600 the following plan year, the employer must contribute at least \$330 (55% of \$600) to retain grandfathered status. The contribution requirement applies to both single and family rates.

Reduction in annual limits. To retain their status as grandfathered plans, plans cannot reduce the annual dollar limit in place as of March 23, 2010. Plans that did 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.

Significantly raising deductibles or fixed co-payment charges. Deductibles and fixed-dollar co-payments cannot be raised more than a specified amount. New deductibles and co-payments will be compared to those in effect on March 23, 2010. To retain grandfathered status plans can increase deductibles and co-pays by no more than a fixed percentage or \$5 whichever is greater.

The allowed fixed percentage increase is calculated by adding medical inflation since March 23, 2010 plus 15%. The medical inflation is defined as the unadjusted increase since March 2010 in the overall medical care component of the Consumer Price Index for all urban consumers (CPI-U).

To calculate the % increase allowed subtract 387.142 (the CPI-U medical value for March 2010) from the highest CPI-U medical component value in the 12 months prior to the change then divide that total by 387.142. Monthly CPI-U medical components values are published by the Department of Labor Bureau of Labor Statistics (BLS) and can be found at <http://data.bls.gov/cgi-bin/surveymost>.

Example - Plan considering a deductible increase effective January 1, 2011

- Plan deductible = \$500 on March 23rd, 2010
- Highest CPI-U medical component value in prior 12 months = 387.762
- $387.762 - 387.142 = .62$
- $.62 \div 387.142 = 0.16\%$
- To retain grandfathered status the deductible can be raised to no more than \$578 (15.62% above the deductible in place on March 23, 2010).

Employers that offer multiple benefit options (i.e. giving employees a choice between a high deductible plan and a traditional PPO plan) will need to consider the grandfathered status of each option separately. Employer may find that changes will cause one option but not the other to lose grandfathered status.

Deciding if it matters that a plan loses grandfathered status

Possibly the most important question employers need to answer is does it even matter if their plan loses grandfathered status? While a number of health reform provisions do not apply to grandfathered plans, many may have a relatively small impact on plan design and administration depending on the current plan structure. The following health reform provisions do not apply to grandfathered plans. An attempt has been made to present them in order of likely impact on employer sponsored plans, however, we recognize that employer sponsored plans differ in many ways and employers may have different and may have different priorities so each employer must consider these in relation to their specific plans:

1. Section 105 non-discrimination rules - Non-grandfathered fully-insured plans will be subject to the Section 105 non-discrimination rules for the first time. These rules already apply to self-funded health plans so this change will not factor into an employer decision regarding grandfathered status for a self funded plan. The rule prohibits a plan from offering benefits in a manner that discriminated in favor of highly compensated employees. Penalties will be imposed on fully-insured plans which violate these rules so employers with benefit or eligibility rules that potentially favor highly compensated employees should have a qualified advisor review the rules prior to making any plan changes that would jeopardize grandfathered status. Additional Information on the Section 105 nondiscrimination rules is included below.
2. Preventive care coverage requirements - Group health plans must cover certain preventive services, immunizations, and screenings, without any cost sharing. 100% coverage for preventive services is common in many employer sponsored group plans. Plans without current 100% preventive coverage benefits should consider the cost implication of adding this coverage.
3. Adult child coverage to age 26 – Grandfathered plans must offer coverage to adult children to the age 26 if dependent coverage is offered. However until 2014 grandfathered plans do not need to offer coverage if the adult child is eligible for other employer sponsored coverage. Beginning in 2014 grandfathered plans will need to offer coverage to adult children even if they have other employer sponsored coverage available.
4. Appeal Process - Group health plans must provide an internal appeals process of coverage determinations and claims and comply with any applicable State external review process. For fully insured plans the appeals process will be principally the responsibility of the carrier.

5. Patient Protections - Group health plans which require or allow a participant to designate a primary care clinic must permit an individual to select a pediatrician as the primary care provider for children and must also provide direct access to obstetrical or gynecological care without a referral. Plans may not require prior authorization or increased cost sharing for out-of-network emergency services.
6. Coverage for individuals participating in approved clinical trials - Prohibits health insurance issuers from dropping coverage because an individual (who requires treatment for cancer or another life-threatening condition) chooses to participate in a clinical trial. Issuers also may not deny coverage for routine care that they would otherwise provide because an individual is enrolled in a clinical trial.

Disclosure to Participants and Documentation

Disclosure to participants

Grandfathered plans must include a disclosure in plan materials that the plan believes that it is a grandfathered plan and therefore is not subject to some of the provisions of the Affordable Care Act. The rules contain model language that can be used for this purpose and can be found at <http://www.dol.gov/ebsa/healthreform/>.

Documentation

Finally to maintain status as a grandfathered health plan, a group health plan must maintain records documenting the terms of the plan or health insurance coverage in connection with the coverage in effect on March 23, 2010.

Section 105(h) Nondiscrimination Rules

The requirement causing the most employers to consider retaining grandfathered status is the rule that non-grandfathered, fully insured plans must comply with the Section 105(h) nondiscrimination rules.

The Section 105(h) nondiscrimination rules are complex; however, there are a number of common benefit strategies that result in a plan being in compliance with, or in violation of, the rules. A quick review of these common strategies will likely answer the question for most employers as to whether they need to worry about the detailed nondiscrimination rules. If an employer has a more complicated situation or wishes to maintain a benefits strategy that may be discriminatory, a more detailed analysis must be conducted, and expert or legal advice should be sought.

It is also important to remember that employers are free to provide highly compensated employees with additional taxable income which the employee could use to pay for extra benefits. The Section 105 testing exists to assure that benefits provided to employees on a tax free basis are limited to plans that are non-discriminatory.

Background

The Section 105 nondiscrimination rules prohibit employers from offering health benefits in a manner that discriminates in favor of highly compensated employees. These rules have applied to self-funded employer sponsored health plans for many years.

The Affordable Care Act applies the 105 nondiscrimination rules to non-grandfathered, fully-insured health plans. The rule goes into effect on the first plan year which begins after September 23, 2010.

If a fully-insured plan is found to be discriminatory, a penalty will be imposed on the employer/plan sponsor. The potential penalty is discussed in detail below.

To pass the 105 nondiscrimination rules an employer must meet two separate tests:

1. The Benefits Test
2. The Eligibility Test

Penalty for Non-compliance

Self-funded employers who fail the Section 105 non-discrimination rules are required to treat benefits received by highly compensated employees as taxable income. However, for discriminatory fully insured plans the employer will pay an excise tax equal to \$100 per day per individual discriminated against. For example, an employer with 100 employees who discriminates in favor of 3 highly compensated individuals will be liable for an excise tax of \$9700 per day (\$100 x 97 individuals discriminated against.)

Highly Compensated Employees

The first thing an employer must determine is which employees are considered highly compensated individuals (HCI). Section 105 defines an HCI as:

- One of the five highest-paid officers
- A shareholder who owns more than 10% of the employer's stock
- An individual who is among the highest-paid 25% of all employees

Certain individuals can be excluded from the group of the highest 25% of paid employees and disregarded from the testing as long as they are not eligible to participate in the plan. Excluded individuals include:

- Employees who have not completed three years of service;
- Employees who have not attained age 25;
- Part-time (defined as less than 35 hours per week) or seasonal employees;
- Collectively bargained employees; and
- Nonresident aliens who receive no U.S. source earned income.

Perform a Quick Check

Before analyzing the 105 requirements in detail, an employer can consider these “quick check” criteria.

The Quick Check #1 – Employer Passes

Barring special circumstances, such as a plan being part of a common control group according to the IRS 414 rules, an employer who offers benefits in the following way would not violate the 105 nondiscrimination rules.

- An employer offers the identical health benefits to all employees, with the same contribution requirements regardless of age, years of service, or compensation.
- Employees covered by a collective bargain agreement, and not covered by the plan, can be ignored for testing purposes. These employees can be offered a separate plan with different benefits and different contribution requirements.

It is common and possible for an employer to offer health benefits in a manner that varies in terms of eligibility, coverage or contribution for different groups of employees. However, in this case the employer must consider and pass the Section 105 tests.

Quick Check #2 – Employer Fails

If an employer offers health benefits that clearly favor individuals in the highly compensated group (defined above) in terms of benefits, eligibility or contribution, the plan will likely fail the 105 rules based on the “benefits test” described below.

The most common reason for possible problems with the 105(h) rules is when an employer provides different health benefits or contributes more toward the health benefits for a select group of “management” or “executives”. In almost all of these cases the employer will be required to adjust their eligibility rules or contribution strategies.

The Section 105 Tests

1 - The Benefits Test

The benefits test has two components;

- Is the plan offered in a manner that is discriminatory on its face?
- Is the plan operated in a discriminatory manner?

The statute requires that “all benefits provided for [HCIs]...are provided for all other participants” ... and that “all the benefits available for the dependents of HCIs must also be available on the same basis for dependents of all non-HCI participants.”

A plan must meet the following four requirements to be considered nondiscriminatory on its face.

1. Required employee contributions must be the same for HCIs and non-HCIs for each benefit level.
2. The same type of benefits that are available to HCIs must be available to non-HCIs.
3. The maximum benefit level cannot vary based on age, years of service, or compensation.
4. HCIs and non-HCIs must have the same waiting periods.

Differences can exist in these areas between different classes of employees as long as the requirements of the eligibility test are met (discussed below). For example, an employer could have different contribution requirements for salaried employees vs. hourly employees, but not for “executives” vs. other employees.

2 - The Eligibility Test

An employer passes the eligibility test if it passes any one of three different tests.

- The 70% Test – At least 70% of employees must benefit from the plan.
- The 70%/80% Test - If at least 70% of all non-excludable employees are eligible, the plan benefits at least 80% of the eligible employees.
- The Nondiscriminatory Classification Test - The plan benefits a nondiscriminatory classification of employees. This test requires (1) eligibility based on a bona fide business classification, and (2) a sufficient ratio of benefiting non-HCIs to benefiting HCIs.

Summary

As mentioned earlier, actually running the 105(h) tests is complex. If an employer offers different health benefits, eligibility or employer contributions to different groups of employees the structure should be examined carefully by a qualified advisor to determine if discrimination exists according to the 105(h) rules.

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