GENERAL BOARD OF PENSION AND HEALTH BENEFITS
OF THE UNITED METHODIST CHURCH

Caring For Those Who Serve

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Health Care Reform: Grandfathered Plan Rules and UMC Health Plans

Introduction

The Patient Protection and Affordable Care Act (PPACA) amends provisions of the Public Health Service Act (PHSA) relating to group health plans. The PPACA adds §9815(a)(1) to the Internal Revenue Code, which makes certain provisions of the PHSA applicable to insured and self-insured group health plans, *including church plans*. Section 1251 of the PPACA specifies that certain plans existing on March 23, 2010 (i.e., "Grandfathered Plans") are subject to only select provisions of the PPACA and PHSA (the "Acts"). This document addresses some of the implications of "grandfathered" plan status compared with non-grandfathered status.

For example, Grandfathered Plans must comply with the elimination of lifetime limits and coverage of dependent children up to age 26. On the other hand, Grandfathered Plans do not have to comply with the PPACA's requirements about the provision of preventive health services without any cost sharing, mandatory uniform appeals processes and government reporting requirements. Appendix A (at the end of this article) provides a list of the PPACA's provisions and their applicability to Grandfathered Plans. Additionally, the Department of Labor (DOL) has published a chart of PHSA provisions applicable to Grandfathered Plans [**www.dol.gov/ebsa/pdf/grandfatherregtable.pdf**].

Interim Final Regulations

On June 14, 2010, the Department of Health and Human Services, DOL and Internal Revenue Service (collectively, the "Departments") released *Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the PPACA* (the "Regulations"). The Regulations describe how to determine whether a plan is a Grandfathered Plan, what provisions of the Acts do *not* apply to Grandfathered Plans, and how a plan maintains or loses its status as a Grandfathered Plan.

The Regulations establish rules that generally allow plan improvements while prohibiting reductions in benefits or excessive passing of costs to participants. Plans may make reasonable routine changes (for example, increasing or adding benefits) conforming to required legal changes, and adopting voluntarily other consumer protections in the PPACA. In contrast, a plan will cease to be a Grandfathered Plan if it makes changes that significantly reduce the benefits covered, materially increase cost sharing by participants, or substantially increase the cost of coverage borne by participants.

Grandfathered Plans

A group health plan is considered a Grandfathered Plan with respect to individuals enrolled on March 23, 2010. The Regulations apply separately to each benefit package or option [e.g., health maintenance organization (HMO) and preferred provider organization (PPO)] made available under a group health plan; therefore, a group health plan may contain both Grandfathered Plans (benefits packages) and non-grandfathered plans (benefits packages). For example, an annual conference

plan could have adopted a new benefit option for its group health plan after March 23, 2010, such as a consumer-driven health plan (CDHP), and kept its existing PPO—in this case, the PPO would be a Grandfathered Plan and the CDHP would not. However, the administrative and operational burden to a plan sponsor of maintaining both a Grandfathered Plan and a non-grandfathered plan may be significant.

Retiree-Only Plans and Limited-Scope Benefits

According to the Regulations, retiree-only plans (plans with no actively at-work employees) and limited-scope dental and vision plans are exempt from the health reform coverage and cost-sharing standards in the Acts—including the bans on lifetime limits and annual dollar limits.

Disclosure Statement and Record Retention

A Grandfathered Plan must include a statement that the plan believes it qualifies as a Grandfathered Plan and must provide contact information for questions and complaints. This statement and contact information must be included in plan materials provided to participants. The DOL has published model language, which can be found at **www.dol.gov/ebsa/healthreform**. A Grandfathered Plan must also maintain records documenting its terms in effect on March 23, 2010 to verify its status as a Grandfathered Plan and make such records available to participants and government officials.

New Participants

Family members of an individual enrolled as of March 23, 2010 may enroll in the plan after March 23, 2010 without jeopardizing the plan's status as a Grandfathered Plan. A Grandfathered Plan may also enroll new employees (whether newly hired or newly eligible to enroll) and their families after March 23, 2010. An employee can switch from one Grandfathered Plan offered by the employer to another, e.g., during open enrollment, without causing either plan to lose grandfathered status. Although employees may choose to move between Grandfathered Plans and from Grandfathered Plans to non-grandfathered plans, employers are prohibited from transferring employees from one Grandfathered Plan to another Grandfathered Plan.

Plan Changes

The Regulations establish rules for changes to the terms of a plan that would cause the plan to lose its grandfathered status. Changes that would annul grandfathered status include:

- *If an insured plan changes insurers or if a self-insured (self-funded) plan becomes insured.* It is unclear, however, whether a plan ceases to be a Grandfathered Plan if it changes from "insured" to "self-insured."
- *If a plan eliminates substantially all benefits to diagnose or treat a particular condition* (or any necessary element to diagnose or treat a condition).
- *If a plan makes* ***any*** *increase in co-insurance.*
- *If a plan increases a fixed-amount cost-sharing requirement other than a co-payment* (i.e., a deductible or out-of-pocket limit) by more than an amount equal to medical inflation (defined by the DOL) plus 15%. (This sum is called the "Maximum Percentage Increase.")
- *If a plan increases a co-payment* by more than the greater of (i) the Maximum Percentage Increase or (ii) $5 plus the medical inflation rate. This second amount accounts for low-dollar co-payment amounts.
- *If an employer or employee organization's contribution rate toward the cost of any tier of coverage for any class of individuals decreases by more than 5%.* The contribution rate means the amount of contributions made by an employer or employee organization compared to the total cost of coverage, expressed as a percentage. For plans that make contributions based on a formula, such as number of hours worked, the contribution rate is the same as the formula. The cost of coverage is the "full premium" (i.e., the employer portion plus employee portion, or the COBRA/continuation coverage premium).

- *If a plan decreases or imposes a new annual limit on the dollar value of benefits.* Plans with existing lifetime limits (which will be eliminated in 2011 under separate regulations that the Departments have issued) are permitted to adopt an overall annual limit at a dollar value that is lower than the dollar value of the plan's former lifetime limit. You can read more about elimination of lifetime limits here: **www.gbophb.org/TheWell/Root/HFLX/4080.pdf**.

A plan may make the following changes without losing Grandfathered Plan status:

- increase premiums (but not increasing the percentage share borne by participants by more than the allowed amount);
- increase co-payments and fixed cost-sharing amounts by less than the Maximum Percentage Increase (described above);
- add or increase benefits;
- make changes to comply with federal or state legal requirements (including, but not limited to, the Mental Health Parity Act and its regulations);
- make changes to voluntarily comply with provisions of the Health Reform Acts; and
- change third-party administrators.

Generally, plan changes adopted in writing before March 23, 2010, with an effective date after that date will not cause a loss of Grandfathered Plan status. If a plan has made changes since March 23, 2010 that would cause the plan to lose its Grandfathered Plan status, the plan may reverse those changes before January 1, 2011 to preserve its Grandfathered Plan status.

Plan Impact on United Methodist Church

Each of an annual conference plan's benefit options—an HMO, PPO or carved-out prescription drug plan —is subject independently to application of the Regulations and may each be a Grandfathered Plan. Plans may be able to preserve Grandfathered Plan status for some benefit options longer than others. However, managing both grandfathered and non-grandfathered benefits options may become an administrative burden of its own because of the need to maintain separate benefit structure and processes. The disclosure and record-keeping requirements of maintaining a Grandfathered Plan do not appear to be a significant burden for annual conference plans.

The Regulations' exclusion of the vision, dental and retiree-only plans from most of the PPACA reforms may ease the compliance burden for annual conferences. Please note that some participants in annual conference "retiree" plans may be actively working employees who have reached age 65 and qualify for Medicare through the Medicare Secondary Payer Small Employer Exception program.

Annual conferences with insured plans cannot change insurers without losing Grandfathered Plan status.

Because many United Methodist annual conference plans are multiple-employer plans with many participating local churches, some uncertainty exists in the Regulations about whether adding new employers to the plan will end a plan's grandfathered status. At a White House meeting on June 16, 2010, representatives of the Departments suggested to church plan representatives that adding new employers to a multiple-employer plan would not disrupt Grandfathered Plan status (barring abusive situations); however, that informal advice has not been confirmed by the Departments.

Employees may not be switched from one Grandfathered Plan to another to avoid the plan design change restrictions. Therefore, if an annual conference changes benefits from a non-co-insurance plan (such as an HMO) to a plan with co-insurance (such as a PPO or CDHP) without preserving the HMO for participants to choose, the plan will no longer be a Grandfathered Plan. The same would apply to

an annual conference switching from one similar benefit option to another with a change in deductible that exceeds the Maximum Percentage Increase.

The most significant risk for annual conference plans is that the Regulations restrict changes in the proportionate share of the cost of coverage (premium) borne by individual participants. The plan may not have control over the contribution rates of local churches toward the cost of health coverage for individual participants (other than clergy). The annual conference may be unable to prevent local churches from decreasing their proportionate share of the cost of coverage by more than 5%. Church plan representatives conveyed concerns about this restriction to the Departments at the White House meeting.

Annual conferences, like other plan sponsors, will need to carefully assess the costs and benefits of maintaining Grandfathered Plan status. Although such status exempts plans from certain provisions of the PPACA (which carry administrative and financial burdens), preserving Grandfathered Plan status also carries costs, such as restricted increases in cost-shifting and changes in plan design, as well as burdens, including disclosure and record-keeping.

HealthFlex Plan Sponsors

The General Board is evaluating the impact of the Regulations on the HealthFlex plan and will provide additional information soon about whether HealthFlex will remain a Grandfathered Plan.

For More Information

If you have questions about the impact of health care reform, please send your inquiry to: **healthcarereform@gbophb.org**.

You can also find additional information on the Web sites for the Department of Labor's Employee Benefit Security Administration [**www.dol.gov/ebsa/healthreform**], the Department of Health and Human Services' Office of Consumer Information and Insurance Oversight [**www.hhs.gov/ociio/regulations/index.html**] and at **www.healthcare.gov**.

Appendix A

Health Reforms in the PHSA Applicable to Grandfathered Plans

- **§2704** Prohibition of pre-existing condition exclusion or other discrimination based on health status (not applicable to grandfathered individual health insurance)
- **§2708** Prohibition on excessive waiting periods
- **§2711** No lifetime or annual limits (not applicable to grandfathered individual health insurance)
- **§2712** Prohibition on rescissions
- **§2714** Extension of dependent coverage until age 26[1]
- **§2715** Development and utilization of uniform explanation of coverage documents and standardized definitions
- **§2718** Bringing down cost of health care coverage (for insured coverage only).

Health Reforms in the PPACA not Applicable to Grandfathered Plans

- **§2713** Coverage of certain immunizations and preventive care services without cost-sharing
- **§2715A** Provision of additional information (reporting requirement)
- **§2719** Appeals processes
- **§2719** Patient protections
- **§2717** Quality of care reporting requirement
- **§2707** Cost sharing limits
- **§2706** No discrimination against providers
- **§2709** Coverage of clinical trials

[1] For a Grandfathered plan before January 1, 2014, PHSA section 2714 is applicable in the case of an adult child only if the adult child is not eligible for other employer-sponsored health plan coverage.

This update is provided by the General Board of Pension and Health Benefits as a general informational and educational service to its plan sponsors, the annual conferences, plan participants and friends across The United Methodist Church. It should not be construed as, and does not constitute, legal advice nor accounting, tax, or other professional advice or services on any specific matter, nor does this message create an attorney-client relationship. Readers should consult with their counsel or other professional advisor before acting on any information contained in this publication.

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