

Health Care Reform Update— Grandfathered Status

The Departments of Labor, Health & Human Services and Treasury have jointly released Interim Final Rules relating to “grandfathered” health care plans under the Patient Protection and Affordable Care Act/Health Care and Education Reconciliation Act of 2010 – Health Care Reform (HCR).

What is a Grandfathered Plan?

A grandfathered plan refers to a group health plan or group health insurance coverage with respect to individuals enrolled on March 23, 2010. Plans with an effective date of March 24, 2010, and beyond are not grandfathered.

Grandfathering applies to each benefit option offered under the group health plan – each benefit package is treated as a separate grandfathered (or non-grandfathered) option. A group health plan may potentially have a combination of grandfathered and non-grandfathered plan options.

Requirements for Grandfathered and Non-Grandfathered Group Plans

For plan years beginning on or after 9/23/10

- Prohibition on lifetime dollar limits on essential health benefits
- Grandfathered plans must disclose, whenever a summary of benefits is provided, that the plan believes it's a grandfathered plan (see model disclosure on the last page) and must maintain records on the terms and conditions of the plan.
- Grandfathered plans must disclose, in plan materials prior to January 1, 2011, that the employer is required to notify Health Alliance if the premium contribution rate changes at any point during the plan year.
- Prohibition on pre-existing condition exclusions for members under age 19 (beginning 1/1/2014, prohibition applies to any age)
- Dependent child coverage to age 26. Until 1/1/2014, a grandfathered plan can exclude coverage if the dependent is eligible to enroll in an employer-sponsored group health plan other than that of a parent.
- Prohibition on rescissions except in the case of fraud or intentional misrepresentation of material fact
- Annual reporting on the percentage of premiums spent on reimbursement for medical care/activities that improve health quality/rebates to enrollees (insured plans)
- Automatic enrollment of employees under the plan (groups of 201 or more) –effective pending rules

For plan years beginning on or after 1/1/12

- Uniform explanation of coverage documents (4-page benefit summary) and standardized definitions

For plan years beginning on or after 1/1/14

- Elimination of waiting periods for coverage of longer than 90 days
- Individual requirements to obtain coverage
- Free choice vouchers
- Employer penalties

For plan years beginning on or after 1/1/18

- Excise tax on high-cost ("Cadillac") plans

Plans may impose annual limits on the dollar value of essential health benefits as follows.

- Plan years beginning on or after 9/23/2010 but before 9/23/2011: The annual dollar limit on essential benefits for each covered person can't be less than \$750,000.
- Plan years beginning on or after 9/23/2011 but before 9/23/2012: The annual dollar limit on essential benefits for each covered person can't be less than \$1.25 million.
- Plan years beginning on or after 9/23/2012 but before 1/1/2014: The annual dollar limit on essential benefits for each covered person can't be less than \$2 million.
- Annual dollar limits for essential benefits are prohibited beginning 1/1/2014.
- Grandfathered plans without existing annual limits can only impose them under certain conditions. Plans with an existing lifetime limit can impose an annual limit as long as it meets or exceeds the dollar value of the lifetime limit and is not less than the minimum allowable annual limits under HCR.

Requirements Not Applicable to Grandfathered Group Plans

For plan years beginning on or after 9/23/10

- 100% coverage of certain preventive health services
- Appeals process that includes both internal and external reviews
- Prohibiting discrimination in favor of highly compensated employees (fully-insured plans)
- Must cover emergency services without prior authorization and must cover services received out-of-network the same as in-network
- Allowing the designation of a participating PCP and pediatrician
- Prohibits an authorization or referral to OB/GYNs

For plan years beginning on or after 1/1/14

- Coverage for individuals participating in approved clinical trials
- Requiring "essential health benefits" for insurers in the individual and small group market (insured plans of employers with less than 100 employees)
- Prohibiting small group health plans from imposing a deductible greater than \$2,000 for self-only coverage or \$4,000 for any other coverage
- Prohibiting basing eligibility on health-status related factors (HIPAA non-discrimination provisions are still applicable)
- Certain premium rating limitations (limits factors that can be used to determine premiums)
- Guaranteed availability of coverage protections
- Guaranteed renewability of coverage protections
- Non-discrimination based on provider acting within his/her license

Plans Exempt from HCR Requirements

The rules clarify that HCR insurance market reforms **don't apply** to retiree-only plans and excepted benefit plans (e.g. limited scope dental and vision only plans). There's no exception from HCR for self-funded public employee plans (e.g. county, municipal and school employee plans).

Changes that Affect a Grandfathered Plan's Status

- A merger, acquisition or similar business restructuring done mainly to cover new individuals under a grandfathered plan.
- Transferring employees between grandfathered plans to keep grandfathered status
- Eliminating of all or substantially all benefits used to diagnose or treat a particular condition
- Increasing any coinsurance
- Increasing any fixed-amount copayment by a total percentage more than the sum of medical inflation plus 15 percentage points, or \$5 increased by medical inflation
- Increasing fixed-amount cost-sharing other than copayments (e.g. deductible, OOPM) by a total percentage more than the sum of medical inflation and 15 percentage points
- Decreasing the employer contribution rate, toward the cost of any tier of coverage, by more than 5 percentage points of the amount in effect on March 23, 2010.
- Making certain changes to the overall annual dollar limit
- Not disclosing in plan materials (model notice) that the plan believes it's a grandfathered plan
- Not maintaining records on the terms of the plan that were in effect on March 23, 2010.

Changes that Don't Affect a Grandfathered Plan's Status

- Adding family members of an enrolled individual
- Adding newly hired or newly enrolled employees
- Certain changes to premiums
- Changes to comply with Federal or State legal requirements
- Changing TPAs
- Changes to voluntarily comply with PPACA
- Changes subject to the transition rule
- Changes adopted during the grace period
- Ceasing coverage of one or more individuals enrolled on March 23, 2010, as long as the plan continuously covers at least one person
- Adding, terminating or allowing employees to transfer among benefit options
- Changing health insurance issuer
- Increasing cost-sharing (e.g. deductible, OOPM) because of an increase in employee compensation, as long as the percentage-of-compensation formula remains what it was on March 23, 2010.

Transitional Rule for Maintaining Grandfather Status

- Changes with an effective date after March 23, 2010, but that are pursuant to a legally binding contract entered prior to March 23, 2010;
- Changes to the terms of health insurance coverage with an effective date after March 23, 2010, pursuant to a filing before March 23, 2010, with a state insurance department;
- Changes pursuant to written amendments to a plan that were adopted prior to March 23, 2010, but have an effective date after March 23, 2010; or
- Changes made after March 23, 2010, and adopted before June 14, 2010, that would cause a loss of grandfathered status, as long as the charges are revoked or modified the first day of the plan year that begins on or after September 23, 2010.

Collectively-Bargained Plans

Both insured and self-funded health plan coverage maintained pursuant to one or more collective bargaining agreements (CBA) ratified before March 23, 2010, that wish to maintain grandfathered status are subject to the same requirements as other grandfathered plans and are not provided with a delayed effective date. In essence, these changes may need to be made to the health care coverage before the contract expires, just as they must be made to other grandfathered plans.

An insured plan is automatically grandfathered until at least the date on which the last CBA terminates. For collectively bargained plans, employers may make changes within the term of the agreement and retain grandfathered status. However, at termination of the agreement the terms and conditions must match that in effect on March 23, 2010, to further retain grandfathering status.

A self-funded plan receives no special treatment. There is no automatic grandfathered status through the date of CBA termination.

Model Grandfathering Disclosure

This [group health plan or health insurance issuer] believes this [plan or coverage] is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information].

For ERISA plans, insert:

[You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.]

For individual market policies and nonfederal governmental plans, insert:

[You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.]

This update includes summary information as provided in the recently released Interim Final Rules relating to “grandfather” status. Please work with your Health Alliance or HCH account representative for additional information related specifically to your plan.