

Healthcare Reform Bulletin

Grandfathered FAQs
August 10, 2010



Grandfathered Status under Patient Protection and Affordable Care Act Frequently Asked Questions

1. What is a grandfathered health plan?

A grandfathered group health plan is a group or individual plan in which an individual was enrolled on March 23, 2010. A grandfathered plan can be a single employer plan, a multi-employer plan, or a multiple employer plan. It can also be an insured or a self-insured arrangement.

2. Are all group medical plans that covered employees as of March 23, 2010 grandfathered?

Grandfathering applies to all group health plans that are welfare benefit plans under ERISA section 3(1) and all health insurance coverage to the extent that the plan or coverage provides medical care to employees and their dependents through insurance, reimbursement, or otherwise, even if coverage is offered through a medical service policy or an HMO offered by a health insurance issuer. The rules under the regulations apply separately to each benefit package made available under a group health plan or health insurance coverage.

3. What tax reform changes apply to grandfather plans?

Grandfathered Plans need to comply with the following provisions, effective on the first renewal date after September 23, 2010, except where noted.

- Coverage of Dependents to Age 26: Fully-insured and self-funded health plans that offer dependent coverage must permit children to stay on family policies until age 26 if the dependent is not eligible for employer coverage. (Prior to 2014, this will only apply to those dependents who cannot secure employer-sponsored coverage). Coverage provided to these dependents will not result in imputed income to the employee.
- Elimination of Lifetime Benefit Limits: For fully-insured and self-funded health plans, lifetime limits on the dollar value of benefits under all health insurance plans must be eliminated. Certain limits may be allowed on specific benefits as long as they are not considered Essential Health Benefits (yet to be defined).

- Restriction on Annual Benefit Limits: For fully-insured and self-funded health plans, the Authority for the Secretary of Health and Human Services ("HHS") is to define tight restrictions on annual limits placed on insurance plans. (Use of annual limits will be banned entirely in 2014 when the State Insurance Exchanges are operational.)
- No Rescissions of Coverage: Fully-insured and self-funded group health plans are prohibited from rescinding coverage once coverage has already been in place for that person, except in the event of fraud.
- Cost Ratio Requirements: Beginning January 1, 2011, health insurers must provide an annual rebate to each enrollee if the minimum loss ratio ("MLR") is not met. The MLR is 85% in the large group market (100+ employees) and 80% in the small group market (less than 100 employees). This provision will have no effect on self-funded plans.
- Elimination of Pre-Existing Condition Exclusions for Children: Pre-existing condition exclusions on self-funded or fully-insured health plans cannot apply to children. This provision will extend to adults as of 2014.
- Waiting Period Restriction (for plan years on or after January 1, 2014): Fully-insured and self-funded group health plans may not impose a waiting period in excess of 90 days for coverage.
- Distribution of Uniform Notice of Coverage: Plan administrators, plan sponsors and insurers must provide a summary of benefits and coverage explanation that describes benefits and coverage to participants prior to enrollment. The Uniform Notice of Coverage will be in addition to a Summary Plan Description, which is already required by ERISA. This requirement will extend to those plans exempted from ERISA.

The Secretary of HHS will provide specific standards for the summary. The summary must state if the plan provides Minimum Essential Coverage (yet to be defined) and if it pays less than 60% of the total cost of benefits provided under the plan. In addition, modifications to the group health plan must be summarized and sent to participants no later than 60 days prior to the change. There will be a penalty for willful non-compliance.

Grandfathered plans are exempt from mandatory compliance with many of the other new requirements imposed on new plans under the legislation.

4. What tax reform changes do not apply to grandfathered plans?

Grandfathered plans do not need to comply with: All provisions are effective on the first renewal date after September 23, 2010, except where noted.

- Information to the Secretary of HHS: Group Health Plans, both fully-insured and self-funded, must provide information regarding claims payment, enrollment data, number of claims denied, rating practices, non-network cost-sharing and enrollee and participant rights, among other data.
- Employer Annual Reporting Requirements regarding Quality of Care: An annual report must be supplied to participants at Open Enrollment that describes health care provider reimbursement rates that improve quality of care, including wellness activities. The Secretary of HHS is to collect this data and make it available on the Internet. Reporting requirements and regulations from HHS will be available by March 23, 2012.
- First Dollar Coverage for Preventive Services: All fully-insured and self-funded health plans will be required to provide first dollar benefits for Preventive Care Services, such as immunizations, screenings and routine care for adults and children.
- Mandated Patient Protections: PCPs, OB-GYNs, and Emergency Care: In fully-insured or self-funded health plans that require the designation of a Primary Care Physician ("PCP") members must be allowed to select any participating provider as their PCP.
- OB-GYNs and pediatricians: Women must be granted direct access to OB-GYN care without a referral and emergency services offered in a health plan must provide coverage at the in-network level, regardless of facility used and without need for prior-authorization.
- Code Section 105(h) Non-Discrimination Requirements for Fully-Insured Plans: Previously only applying to self-funded plans, group fully-insured health plans will be required to satisfy Section 105(h) non-discrimination requirements stating that employers must not establish any eligibility rules for health care coverage, or levels of coverage that has the effect of discriminating in favor of higher-wage employees.
- Mandated Claims Appeals Process: In addition to the existing ERISA internal claims appeals process for disputed claims, a new external claims procedure must be implemented in fully-insured and self-funded group health plans that will assure the review of disputed claims by a third party.
- Guaranteed Availability and Renewability of Coverage (for plan years on or after January 1, 2014): This provision requires insurance companies to make available health coverage for employers to

purchase for their employees. The Act does not address or guarantee that this coverage will be affordable, however. The provision prevents health insurers from canceling an employer's group plan in the event the plan has poor claims experience in a given year.

- No Discrimination Based on Health Status (for plan years on or after January 1, 2014): Both fully-insured and self-funded group health plans may not establish rules for eligibility to enroll based on health status factors. This same requirement was put forth by HIPAA in 1996.
- Mandated Cost-Sharing Limits (for plan years on or after January 1, 2014): Fully-insured and self-funded group health plans must limit cost-sharing amounts (deductibles, coinsurance and co-pays) to the limits applicable to high deductible health plans under Code Section 223. (For example, in 2010, the out of pocket limits on a high-deductible plan are \$5,950 for single and \$11,900 for family). Also, deductibles cannot exceed \$2,000 per single and \$4,000 per family.
- Mandated Coverage for Clinical Trials (for plan years on or after January 1, 2014): Both fully-insured and self-funded health plans must provide coverage for routine costs associated with clinical trials. An individual is eligible for coverage for clinical trials if his or her participating physician deems it appropriate with respect to the protocols of treatment of cancer or other life threatening diseases or conditions.

5. What changes can a plan sponsor or an insurance company make to a health plan and keep its grandfathered status?

Plan sponsors and insurance companies can make voluntary changes to increase benefits, to conform to required legal changes, add new employees and dependents as participants, change third party administrators, renew an insurance policy and to adopt voluntarily other consumer protections in health care reform.

6. What changes can a plan sponsor or an insurance company make to its health plan to cause it to lose grandfathered status?

A health plan will no longer be considered a grandfathered health plan if a plan sponsor or the insurance company:

- Eliminates all or substantially all benefits to diagnose or treat a particular condition. The elimination of benefits for any necessary element to diagnose or treat a condition is considered the elimination of all or substantially all benefits to diagnose or treat a particular condition;
- Increases a percentage cost-sharing requirement (such as coinsurance) above the level at which it was on March 23, 2010;

- Increases fixed-amount cost-sharing requirements other than copayments, such as a \$500 deductible or a \$2,500 out-of-pocket limit, by a total percentage measured from March 23, 2010 that is more than the sum of medical inflation and 15 percentage points;
- Increases copayments by an amount that exceeds the greater of: a total percentage measured from March 23, 2010 that is more than the sum of medical inflation plus 15 percentage points, or \$5 increased by medical inflation, measured from March 23, 2010;
- For a group health plan or group health insurance coverage, an employer or employee organization decreases its contribution rate by more than five percentage points below the contribution rate on March 23, 2010;
- With respect to annual limits:
 1. a group health plan, or group or individual health insurance coverage, that, on March 23, 2010, did not impose an overall annual or lifetime limit on the dollar value of all benefits imposes an overall annual limit on the dollar value of benefits;
 2. a group health plan, or group or individual health insurance coverage, that, on March 23, 2010, imposed an overall lifetime limit on the dollar value of all benefits but no overall annual limit on the dollar value of all benefits adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010; or
 3. a group health plan, or group or individual health insurance coverage, that, on March 23, 2010, imposed an overall annual limit on the dollar value of all benefits decreases the dollar value of the annual limit (regardless of whether the plan or health insurance coverage also imposes an overall lifetime limit on the dollar value of all benefits); or
- Enters into a new policy, certificate or contract of insurance with an insurance company.

For purposes of these regulations, "medical inflation" is defined by reference to the overall medical care component of the Consumer Price Index ("CPI") for all Urban Consumers, unadjusted, published by the Department of Labor.

7. What notice and record retainer of records requirement must a plan sponsor or an insurance company meet to retain its grandfathered status of its health plans?

To maintain status as a grandfathered health plan, a plan sponsor or a insurance company must include a statement, in any plan materials provided to participants or beneficiaries (Summary Plan Description) describing the benefits provided under the plan or

health insurance coverage, that the plan or health insurance coverage believes it is a grandfathered health plan and providing contact information for questions and complaints. The following model language can be used to satisfy this disclosure requirement:

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.]

In addition, to maintain status as a grandfathered health plan, a plan sponsor or insurance company must maintain records documenting the terms of the plan or health insurance coverage that were in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan. Such documents could include intervening and current plan documents, health insurance policies, certificates or contracts of insurance, summary plan descriptions, documentation of premiums or the cost of coverage, and documentation of required employee contribution rates. In addition, the plan or issuer must make such records available for examination. The plan sponsor or insurance company must also make such records available for examination. Accordingly, a participant, beneficiary, State or Federal agency official would be able to inspect such documents to verify the status of the plan or health insurance coverage as a grandfathered health plan.

8. What relief is provided under the regulations for a plan sponsor or an insurance company which makes a change to its health plan before March 23, 2010, but which is not effective until after March 23, 2010?

Transitional rules are provided for plan sponsors and insurance companies that made changes after the enactment of health reform pursuant to a legally binding contract entered into prior to March 23, 2010; made changes to the terms of health insurance coverage pursuant to a filing before March 23, 2010 with a State insurance department; or made changes pursuant to written amendments to a plan that were adopted prior to March 23, 2010. If a plan or insurance company makes changes in any of these situations, the changes are effectively considered part of the plan terms on March 23, 2010 even though they are not then effective. Therefore, such changes are not taken into account in considering whether the plan or health insurance coverage remains a grandfathered health plan. For purposes of enforcement, the Departments of the Treasury, Labor and Health and Human Services will take into account good-faith efforts to comply with a reasonable interpretation of the statutory requirements and may disregard changes to plan and policy terms that only modestly exceed those changes described in the regulations and that occur before publication of the regulations.

9. Is there any relief provided under the regulations to a plan sponsor or insurance company if it makes changes to the plan or contract after March 23, 2010 but before the publication of the regulations?

Plan sponsors and insurance companies are provided with a grace period within which to revoke or modify any changes adopted prior to the date of the publication of the regulations, where the changes might otherwise cause the plan or health insurance coverage to cease to be a grandfathered health plan. Under this rule, grandfather status is preserved if the changes are revoked, and the plan or health insurance coverage is modified, effective as of the first day of the first plan or policy year beginning on or after September 23, 2010 to bring the terms within the limits for retaining grandfather status in these regulations. For this purpose and for purposes of the reasonable good faith standard, changes will be considered to have been adopted prior to when these regulations are published if the changes are effective before that date; the changes are effective on or after that date pursuant to a legally binding contract entered into before that date; the changes are effective on or after that date pursuant to a filing before that date with a State insurance department; or the changes are effective on or after that date pursuant to written amendments to a plan that were adopted before that date.

10. How do the grandfather rules apply to collectively bargained plans?

Health insurance coverage maintained pursuant to one or more collective bargaining agreements that were ratified before March 23, 2010, are not subject to the insurance market reforms and coverage mandates of the Affordable Care Act and do not apply until the date on which the last collective bargaining agreement relating to coverage terminates. Before the last of the applicable collective bargaining agreements terminates, any health insurance coverage provided pursuant to the collective bargaining agreements is a grandfathered health plan, even if there is a change in insurance companies during the period of the agreement. The law refers solely to "health insurance coverage" and does not refer to a group health plan; therefore, these interim final regulations only apply this provision to insured plans maintained pursuant to a collective bargaining agreement and not to self-insured plans. After the date on which the last of the collective bargaining agreements terminates, the determination of whether health insurance coverage maintained pursuant to a collective bargaining agreement is grandfathered health plan coverage is made under the regulations.

Under the regulations, this determination is made by comparing the terms of the coverage on the date of determination with the terms of the coverage that were in effect on March 23, 2010. A change in insurance companies during the period of the agreement, by itself, will not cause the plan to cease to be a grandfathered health plan at the termination of the agreement; however, for any changes in insurance companies after the termination of the collective bargaining agreement, the issue of a new policy, certificate or contract of insurance will not be grandfathered. In addition any coverage amendments made pursuant to a collective bargaining agreement that amends the coverage to conform to health care reform will not cause the plan to lose its grandfathered status.

Collectively bargained plans (both insured and self-insured) that are grandfathered health plans are subject to the same requirements as other grandfathered health plans, and are not provided with a delayed effective date for changes under healthcare reform with which other grandfathered health plans must comply. Thus, the provisions that apply to grandfathered health plans apply to collectively bargained plans before and after termination of the last of the applicable collective bargaining agreement.

Providing consumers with access to reliable and trustworthy information will be vital to educated and informed decision making. Call us at 1-800-678-1700 to talk to your benefit advisor at Cornerstone Group for more information on how to communicate this important information to your employees.