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Overview of Grandfathered Plans

The health care reform law contains many provisions that affect the health coverage you provide for your employees. The extent of the law's impact depends, in part, on whether you maintain a "grandfathered" health plan. Grandfathered plans can avoid a number of the health care reform provisions.

This National Insurance Services, Inc. Legislative Brief provides an overview of grandfathered plans, including information to help you understand what makes a plan "grandfathered." It also includes a summary of the health care reform provisions that are applicable to grandfathered plans and those that are inapplicable to grandfathered plans.

GRANDFATHERED STATUS

What Is a Grandfathered Plan?

The health care reform law provides that certain provisions of the law will not apply to group health plans or health insurance coverage in which an individual was enrolled on March 23, 2010, the date the legislation was passed. The law refers to these plans as "grandfathered" plans. The law states that a grandfathered plan will retain its grandfathered status even if covered individuals renew their coverage after March 23, 2010, family members are added to coverage or new employees (and their families) enroll for coverage.

A plan may retain its grandfathered status even after Jan. 1, 2014, when many health care reform changes, such as the employer "pay or play" penalty, become effective. Regulations issued by the Departments of Health and Human Services, Labor and Treasury (Departments) provide guidance on how plans lose their grandfathered status. 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 participants.

Losing grandfathered status means that a plan must comply with the health care reform requirements that do not apply to grandfathered plans, such as first-dollar coverage of recommended preventive health services and patient protections (for example, guaranteed access to OB-GYNs and pediatricians).

What Are the Permitted and Prohibited Changes?

Grandfathered health plans may make **routine changes** to their coverage and maintain their grandfathered status. These routine changes include making cost adjustments to keep pace with medical inflation, adding new benefits, making modest adjustments to existing benefits, voluntarily adopting new consumer protections under the health care reform 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.

The prohibited changes that will cause a plan to lose its grandfathered status include the following:

- *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*. Compared with the co-payments 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.
- *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.
- *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 percent to 25 percent).
- *Adding or Tightening an Annual Limit*. 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).

The regulations initially provided that changing insurance companies or policies would cause a health plan to lose grandfathered plan status. However, on Nov. 15, 2010, the Departments released an amended rule. Under the amendment, a group health plan will not lose grandfathered status merely because of a change in the plan's insurance policy, certificate or contract of insurance, as long as the coverage under the new policy is effective on or after Nov. 15, 2010. Also, to maintain grandfathered status, the plan must provide documentation of the plan's terms to the new issuer.

Is There a Special Rule for Collectively Bargained Plans?

The regulations provide a special rule for insured plans that are maintained pursuant to one or more collective bargaining agreements in place before March 23, 2010. These plans are considered grandfathered until the last collective bargaining agreement terminates, even if there is a change that would otherwise terminate a plan's grandfathered status.

This rule does not apply to self-funded collectively bargained plans. They were required to comply with the restrictions on grandfathered plans right away.

This special rule does not provide a delayed effective date for collectively bargained plans to comply with the health care reform requirements. Rather, it extends the time these plans can be considered grandfathered. Also, these plans are not exempt from complying with the rules that apply to grandfathered plans.

After the last collective bargaining agreement expires, whether the plan is grandfathered is determined by comparing the plan in existence on the expiration date with the plan as it existed on March 23, 2010.

What Are the Notice and Recordkeeping Requirements?

To maintain grandfathered plan status, a plan administrator or health issuer must include a statement of the plan's grandfathered status in plan materials provided to participants describing the plan's benefits (such as the summary plan description (SPD) and open enrollment materials). The notice informs participants that their plan may not include certain consumer protections that apply to non-grandfathered plans, such as the requirement to cover certain preventive health services without any cost-sharing.

The Department of Labor has provided a model grandfathered plan notice, which is available at: www.dol.gov/ebsa/healthreform/.

In addition, a grandfathered health plan must document its terms on March 23, 2010. This documentation, plus any additional records needed to support the plan's grandfathered status (for example, plan documents or insurance certificates or policies), must be retained for as long as the plan holds onto its grandfathered status.

HEALTH CARE REFORM PROVISIONS

Which Health Care Reform Rules Do Not Apply to Grandfathered Plans?

The health care reform law specifically exempts grandfathered plans from certain requirements of the law. Grandfathered health plans are not required to comply with the following health care reform provisions:

- *Coverage of Preventive Health Services*. Effective for plan years beginning on or after Sept. 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. Additional preventive health services for women must be covered without cost-sharing effective for the plan year beginning on or after Aug. 1, 2012.
- *Patient Protections*. Effective for plan years beginning on or after Sept. 23, 2010, the health care reform law requires the following protections 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); and
    - 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*. Fully insured plans will have to satisfy the requirements of Internal Revenue Code section 105(h)(2). This 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. This provision will be effective sometime after regulations are issued. The regulations will specify the effective date.
- *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 Sept. 23, 2010, group health plans and health insurance issuers offering group or individual health insurance coverage must implement an improved appeals process and meet minimum requirements for external review. A grace period until plan years beginning on or after Jan. 1, 2012, has been provided for some elements of the process.
- *Insurance Premium Restrictions*. Effective for plan years beginning on or after Jan. 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 Jan. 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 Jan. 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 Jan. 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 Jan. 1, 2014, certain 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. There is some confusion regarding which plans will be subject to these rules and whether they will apply outside the individual and small group markets. Further guidance would be helpful.
- *Coverage for Clinical Trials*. Effective for plan years beginning on or after Jan. 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.

Which Major Health Care Reform Rules Do Apply to Grandfathered Plans?

The provisions described below apply to both grandfathered and non-grandfathered health plans. Keep in mind that this is a description of major provisions that affect health plans, not an exhaustive list of how health care reform might affect your company.

- *Extension of Dependent Coverage*. Effective for plan years beginning on or after Sept. 23, 2010, group health plans must provide coverage for adult children up to age 26. Grandfathered plans may exclude an adult child under age 26 from coverage if the adult child is eligible to enroll in an employer-sponsored health plan, other than a group health plan of a parent.
- *Elimination of Lifetime and Annual Limits*. Effective for plan years beginning on or after Sept. 23, 2010, group health plans and health insurance issuers offering group or individual health coverage may not establish lifetime limits on the dollar value of essential benefits. Group health plans may also not establish unreasonable annual limits. In 2014, all annual limits are eliminated.
- *Elimination of Pre-existing Condition Exclusions*. Effective for plan years beginning on or after Sept. 23, 2010, pre-existing condition exclusions may not be applied to enrollees under age 19. Pre-existing condition exclusions are eliminated for all enrollees in 2014.

- *Limits on Rescissions*. Effective for plan years beginning on or after Sept. 23, 2010, coverage may not be rescinded, except in the case of fraud or intentional misrepresentation of material fact. Policyholders must be notified prior to cancellation.
- *Limits on Waiting Periods*. Effective for plan years beginning on or after Jan. 1, 2014, group health plans and health insurance issuers offering group or individual health insurance coverage may not require a waiting period of more than 90 days.
- *Summary of Benefits and Coverage*. Beginning 24 months after enactment of the health care reform law, plans and issuers must provide a summary of benefits and coverage to participants, beneficiaries and applicants. There are specific content and format guidelines for the summary. The compliance deadline for providing the summary has been delayed. Issuers must start providing the summary to health plans by Sept. 23, 2012. For participants and beneficiaries who enroll or re-enroll in plan coverage during an open enrollment period, plans and issuers must start providing the summary with the open enrollment period that begins on or after Sept. 23, 2012. For participants and beneficiaries who enroll in plan coverage other than through an open enrollment period, the summary must be provided starting with the plan year that begins on or after Sept. 23, 2012.
- *Reporting Medical Loss Ratio*. Effective for plan years beginning on or after Sept. 23, 2010, health insurance issuers offering group or individual health insurance coverage must annually report the percentage of premiums spent on non-claim expenses. Beginning Jan. 1, 2011, insurers must provide rebates if more than the applicable percentage is spent on non-claims costs.

MORE INFORMATION

More information on grandfathered plans is available through www.healthcare.gov/law/features/rights/grandfathered-plans/index.html.