

Healthcare Reform and Grandfathered Status

What Is A Grandfathered Health Plan?

A grandfathered health plan is a group health plan, including a self-insured plan, that provided coverage to members on March 23, 2010, the date that the Patient Protection and Affordable Care Act was enacted. Current employees, new hires and their dependents may continue to enroll in the plan. CoreSource offers the following summary of events that could cause a health plan to lose grandfathered status and what provisions these health plans would have to comply with.

How Could A Health Plan Lose Grandfathered Status?

According to interim final rules published on June 17, 2010, the following events will cause a plan to lose grandfathered status:

- 1 Any increase in coinsurance percentage.
- 2 Any increase in the deductible or out-of-pocket limit that exceeds "medical inflation" plus 15 percentage points, measured from March 23, 2010. Medical inflation is defined by referring to the overall medical care component of the Consumer Price Index.
- 3 Any increase in co-pays above the level in effect on March 23, 2010, by an amount that exceeds the greater of a) the sum of medical inflation plus 15 percent, or b) \$5 times medical inflation, plus \$5.
- 4 Any decrease in the employer's contribution rate of more than 5 percent of the contribution rate as of March 23, 2010.
- 5 Any elimination of all or substantially all benefits to diagnose or treat a particular condition (or the elimination of benefits for any "necessary element" to diagnose or treat a condition).
- 6 A merger, acquisition, or similar business restructuring, if the principal purpose of the action is to cover new individuals under the grandfather plan.
- 7 If the plan did not impose an overall annual or lifetime limit on the dollar value of benefits on March 23, 2010, the imposition of an overall annual limit on the dollar value of benefits.
- 8 If the plan imposed an overall lifetime limit on the dollar value of benefits but no overall annual limit on March 23, 2010, the imposition of an overall annual limit on the dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010.
- 9 If the plan imposed an overall annual limit on the dollar value of all benefits on March 23, 2010, any decrease in dollar value of the overall annual limit.

If, after March 23, 2010, a plan or policy made changes prior to June 14, 2010, that might otherwise cause the plan to cease being a grandfathered health plan, the plan or policy may still keep its grandfathered status if it revokes or modifies the changes as of the first day of the first plan year on or after September 23, 2010.

In addition, to maintain status as a grandfathered plan:

- 1 The policy or plan document must contain a statement about the plan's grandfathered status, what that means and information about whom an enrollee can contact with questions, including the insurer or plan administrator, the U.S. Department of Labor and the U.S. Department of Health and Human Services (HHS). The regulation includes "model language" to be used for this purpose.
- 2 The plan must retain records documenting the determination of a plan's grandfathered status, and these records must be available for examination by an enrollee or state or federal agency.

What Healthcare Reform Provisions Affect Grandfathered and Non-Grandfathered Plans?

For plan years beginning six months on or after enactment of healthcare reform:

- 1 No lifetime limits on essential health benefits.
- 2 Restrictions on annual limits on essential health benefits. (For group plans, no annual limits on essential benefits after Jan. 1, 2014.)
- 3 May not rescind coverage except in cases of fraud or intentional misrepresentation.
- 4 Must extend coverage for young adults until age 26, if the plan offered dependent coverage. (Prior to 2014, for group plans only if the individual is not eligible for employment-based health coverage.)
- 5 Pre-existing condition exclusions and limitations are prohibited for covered enrollees under age 19 (and for all enrollees under plan years beginning on or after Jan. 1, 2014).

Effective March 23, 2012:

- 1 Provide a summary of benefits and coverage to enrollees and applicants. The administrator of a self-funded plan is responsible for development of the summary.

Effective Jan. 1, 2014:

- 1 Waiting period may not exceed 90 days.

What If A Health Plan Loses Grandfathered Status?

By Sept. 23, 2010, the legislation requires that self-funded plans that lose grandfathered status MUST:

- 1 Provide coverage for designated preventive services without any cost-sharing.
- 2 Provide coverage for an adult child younger than 26 whether or not the dependent is eligible to enroll in an employer-sponsored health plan other than that of a parent.
- 3 Establish internal and external appeals processes.
- 4 Provide access to emergency medical services without prior authorization and from out-of-network providers, and allow members to designate an OB/GYN or pediatrician as a primary care provider.

By March 23, 2012, or sooner, depending on when regulations are published, self-funded plans that lose grandfathered status MUST:

- 1 Report to HHS and enrollees information about benefits and reimbursement structures that improve health outcomes, prevent hospital readmissions, improve patient safety and promote health and wellness.

Effective Jan. 1, 2014, self-funded plans that lose grandfathered status MUST:

- 1 Limit cost-sharing to certain maximum amounts.
- 2 Cover the costs for a qualified individual's participation in approved clinical trials.
- 3 Provide HHS, the state insurance department and the public with information about claim payment policies and procedures, financial disclosures, data on enrollment/disenrollment, data on claim denials, data on rating practices, information on cost-sharing, information on enrollee rights, and any other information deemed appropriate by HHS.

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