

Legislative Brief

Health Care Reform: Grandfathered Plans

Updated November 2010



EXECUTIVE SUMMARY

In March 2010, President Obama signed sweeping health care legislation into law. The health care reform law contains many provisions that will affect your business and your employees. The extent of the impact will depend, in part, on whether you maintained a health care plan on March 23, 2010, the date the primary legislation was enacted. If your company sponsored a plan on that date, it is considered a “grandfathered” plan.

- Grandfathered plans are group health plans or health insurance coverage in which an individual was enrolled on March 23, 2010, the date of enactment of the legislation.
- These plans can avoid many of the new health care reform provisions.
- The “grandfathered” protections still apply even if family members join current coverage or new employees join a current plan.
- Plans can lose grandfathered status if they make significant changes to benefits or costs.

This The Barnett Group Legislative Brief provides information to help you understand what makes a plan “grandfathered.” It also describes the provisions that do not apply to grandfathered plans, as well as major provisions that do apply. Please read below for more information.

HOW HEALTH CARE REFORM AFFECTS GRANDFATHERED PLANS

Grandfathered Plans

The new 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 legislation refers to these plans as “grandfathered health plans.” The law states that a grandfathered plan will retain its grandfathered status even if the covered individual renews the coverage after March 23, 2010, family members are allowed to enroll or new employees (and their families) are allowed to enroll.

Regulations issued by the Departments of Health and Human Services (HHS), Labor and Treasury on June 14, 2010, clarify which additional changes can be made to grandfathered plans. 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 consumers. Losing grandfathered status means that a plan would have to comply with the health care reform requirements that do not apply to grandfathered plans, such as first-dollar coverage of recommended prevention services and patient protections such as guaranteed access to OB-GYNs and pediatricians.

Specifically, the prohibited changes 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 copayments 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.
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- **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% to 25%).
- **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 November 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 November 15, 2010. Also, to maintain grandfathered status, the plan must provide documentation of the plan's terms to the new issuer.

Health Care Reform Rules that Do Not Apply to Grandfathered Plans

The grandfathering provision of the health care reform law specifically exempts grandfathered plans from certain requirements of the law. Grandfathered health plans are exempt from the following requirements:

- **Coverage of Preventive Health Services.** Effective for plan years beginning on or after September 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.
- **Patient Protections.** Effective for plan years beginning on or after September 23, 2010, the health care reform law puts the following rules in place 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).
 - 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.** Effective for plan years beginning on or after September 23, 2010, fully insured plans must satisfy the requirements of Internal Revenue Code section 105(h)(2). That 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.
- **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

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- 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 September 23, 2010, group health plans and health insurance issuers offering group or individual health insurance coverage must implement an effective appeals process for appeals of coverage determinations and claims.
- **Insurance Premium Restrictions.** Effective for plan years beginning on or after January 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 January 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 January 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 January 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 January 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 January 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.

Special Rule for Collectively Bargained Plans

The regulations provide 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 in insurers or one of the other changes that would otherwise terminate a plan's grandfathered status. This rule does not apply to self-funded collectively bargained plans. They will need to comply with the restrictions on grandfathered plans right away.

Contrary to what many expected, 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 exempted from complying with the rules that apply to grandfathered plans.

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

Major Health Care Reform Rules that Do Apply to Grandfathered Plans

The Health Care and Education Reconciliation Act of 2010 (the Reconciliation Bill) repealed some of the exemptions that were originally intended for grandfathered plans. Therefore, the provisions described below apply to both grandfathered *and* new 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 September 23, 2010, group health plans must provide coverage for adult dependent children up to age 26 if the child is not eligible to enroll in other employer-provided coverage (other than in a grandfathered plan). Effective March 30, 2010, employer-provided health insurance coverage provided to these adult children is tax-free to employees.
- **Elimination of Lifetime and Annual Limits.** Effective for plan years beginning on or after September 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 September 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 September 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 January 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.** Beginning 24 months after enactment of the health care reform law, insurers and plans sponsors of self-funded plans must provide a summary of benefits to participants and applicants. The law sets out specific content and format guidelines.
- **Reporting Medical Loss Ratio.** Effective for plan years beginning on or after September 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 January 1, 2011, insurers must provide rebates if more than the applicable percentage is spent on non-claims costs.

This The Barnett Group Legislative Brief is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.

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