



GRANDFATHERED PLAN REQUIREMENTS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

When policymakers were crafting the comprehensive health care reform legislation enacted as the Patient Protection and Affordable Care Act (PPACA, H.R. 3590) and the Health Care and Education Affordability Reconciliation Act of 2010 (H.R. 4872), an oft-repeated promise was “If you like your current coverage, you can keep it.” To fulfill that promise, the reform law establishes that individual and group plans that were in force on the date of enactment (March 23, 2010) have “grandfathered” status. This means that as long as a plan maintains this status, it will not have to comply with all of the new law’s insurance market provisions.

No new policies sold after March 23, 2010, will be considered grandfathered.

Advantages of Maintaining Grandfathered Status

Among the key provisions of the PPACA that will take effect in the next plan year following September 23, 2010 that will **not** apply to grandfathered health plans are:

- The application of Internal Revenue Code Section 105(h) to fully-insured group health plans, relating to discrimination in favor of highly compensated individuals.
- Certain mandated benefits relating to choice of providers, emergency services, coverage of clinical trials and internal and external review requirements.
- The requirement that certain preventive care benefits be covered at the first-dollar level.

Other provisions of the new law that are effective January 1, 2014 and will not apply to grandfathered plans include guarantee issue of coverage, modified community rating provisions and limits on plan deductibles and co-payments.

Provisions Applying to Grandfathered and Non-Grandfathered Plans

Grandfathered status does not exempt a health plan from any existing state or federal laws or requirements, nor does it exempt a plan from all of the PPACA’s provisions. Effective for plan years beginning after September 23, 2010, all private health insurance, including grandfathered plans, will be subject to the following new requirements:

- Lifetime limits on the dollar value of benefits for any participant or beneficiary are prohibited.
- Annual benefit limits on coverage will be limited to non-essential benefits (as defined by the Department of Health and Human Services) for plan years beginning prior to January 1, 2014. Annual limits will be prohibited entirely for subsequent plan years.
- The age of a dependent for health plan coverage purposes must be increased to age 26. Dependents can be married, and the group health insurance income tax exclusion will apply to the value of the benefits provided for these dependents. For grandfathered group health plans only, through January 1, 2014, coverage will only have to be extended to these dependents if they do not have another source of employer-sponsored health insurance.
- Rescissions of health plan coverage are prohibited except for cases of fraud or when enrollees make an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Coverage may not be cancelled without prior notice to the enrollee.
- Grandfathered **individual** health plans will have to cover preexisting conditions for children under age 19 for plan years beginning on or after six months after date of enactment. **Grandfathered status applies for group health plans only.**

In addition, grandfathered plans will be required to meet some PPACA provisions that come into effect at later dates, including the requirements that: 1) prohibit group plans from establishing employee waiting periods for coverage in excess of 90 days, 2) require the development of uniform explanation of coverage documents and the use of standard coverage definitions and 3) require an excise tax on high-cost plans.

The new law also establishes that individuals and employer group plans that wish to keep their current policy on a grandfathered basis can only make limited changes to coverage terms on the policy's annual renewal date. According to the statute, allowable plan changes include the addition or deletion of employees and dependents, as well as scheduled plan changes that are the result of a collective bargaining agreement for fully insured plans.

An interim final regulation jointly issued by the Internal Revenue Service, the Department of Health and Human Services and the Department of Labor published in the *Federal Register* on June 17, 2010, outlines in more detail what an individual or employer group plan may or may not do in order to retain grandfathered status. Fully-insured collectively bargained plans are exempt from these requirements until the end of the term of the collective bargaining agreement, as are retiree-only plans and HIPAA excepted benefit plans. A summary of the new requirements for all other plans to maintain their grandfathered status are as follows:

General Requirements

- Purchasing a product from a new health insurance carrier/changing health insurance carriers will result in the loss of grandfathered status, even if the plan's benefits remain the same, as no new health insurance products sold after March 23, 2010 have grandfathered status.
- If an employer offers multiple health insurance options, each option is treated separately in terms of its grandfathered status. For example, an employer offers three coverage options, two from carrier X and one from carrier Y. On renewal, the employer decides to replace carrier Y with carrier Z and make no changes to its two options from carrier X. The employer's options from carrier X would be grandfathered, but its carrier Z plan would not be.
- Overall plan premium increases or decreases, plan changes to comply with state or federal law, changes to voluntarily comply with provisions of the PPACA and changes of third-party administrators will not result in a plan losing its grandfathered status.
- To prevent abuse, if the principal purpose of a business merger, acquisition or restructuring is to add individuals onto a grandfathered plan, such plan will lose its status.
- Employers are also prohibited from transferring employees from one grandfathered health plan to another unless it is for bona fide employment reasons to prevent abuse of grandfathered status.
- The plan must notify participants through printed materials describing plan benefits that it believes itself to be grandfathered and provide contact information for beneficiary questions and complaints.
- The plan must maintain records of the level of benefits provided on March 23, 2010 and any subsequent plan changes they feel are within the bounds of the grandfathered status requirements.

Changes in Benefits

The plan may not eliminate or substantially eliminate benefits to diagnose or treat a specific illness and retain grandfathered status. For example, the plan cannot specifically exclude coverage of depression if it previously included mental health benefits that would have covered that disease. In addition, if the treatment for depression is counseling and medication and the plan ceased to cover counseling, it would also lose grandfathered status.

Coinsurance

The plan may not alter coinsurance levels in any way for covered items or services. For example, if a plan covers in-network office visits with 90/10% coinsurance, the coinsurance level may not be changed to 80/20% if the plan wanted to retain grandfathered status.

Fixed-Dollar Cost-Sharing (Deductibles, Out-of-Pocket Maximums, Copayments)

- The plan may make reasonable changes to fixed-amount cost-sharing requirements to keep pace with medical inflation.
- For fixed-amount cost-sharing requirements other than copayments, such as deductibles and out-of-pocket maximums, a plan will lose grandfathered status if the amount of the increase exceeds medical inflation plus 15% as measured from March 23, 2010. The regulation includes a complex formula in order to make this calculation.
- For copayments, the plan will lose grandfathered status if the increase exceeds the greater of a) medical inflation plus 15% as measured from March 23, 2010 or b) five dollars (adjusted for medical inflation). The regulation includes a complex formula in order to make this calculation.

Employer Contributions

- Employers will be limited in their ability to decrease employee contributions and retain grandfathered status.
- If the employer contribution is based on the cost of coverage or a formula (i.e. hours worked), grandfathered status will be lost if the employer decreases its contribution rate for any tier of coverage for similarly situated classes of individuals by more than five percent of what the contribution level was on March 23, 2010. For example, if an employer currently pays 75% of employee coverage and 50% of dependent coverage, but changes that to 100% contribution for employees and no contribution for dependents, the plan would lose its grandfathered status.

Annual and Lifetime Limits

- A plan that did not impose annual and/or lifetime limits on the dollar value of a benefit prior to March 23, 2010, will lose grandfathered status if it imposes any new annual limit on the dollar value of benefits.
- A plan that imposed a lifetime limit of dollar value of benefits on March 23, 2010, but no annual limits will lose grandfathered status if it adopts an overall annual limit that is lower than the dollar value of the lifetime limit in force on March 23, 2010. For example, if the plan originally had a \$1 million lifetime limit, then any new annual limit would have to be more than \$1 million or the plan would lose grandfathered status.
- A plan that imposed an annual limit on the dollar value of benefits on March 23, 2010, will lose grandfathered status if the plan decreases the dollar value of the annual limit (this applies regardless if the plan had a lifetime limit on March 23, 2010, or not).

The interim final regulation provides for transition relief for plans that made changes based on contracts or plan filings or amendments that were made before March 23, 2010, but not in force at that time. In addition, for plans that made routine changes to policies in between the enactment of PPACA and June 17, 2010, a good-faith compliance standard will be applied and changes that only modestly exceed any of the requirements listed above will be allowed for the current plan year. Plans that made significant changes prior to June 17, 2010, that would cause them to lose grandfathered status will also be allowed a grace period lasting until the start of the next plan year beginning after September 23, 2010, to bring their coverage terms in line with the requirements of PPACA and its resulting regulations. **Plans renewed after June 17, 2010 will have to comply with the terms of the regulation in its entirety without any grace period or good-faith compliance standard or lose their grandfathered status.**