

# Grandfathered Health Plans

Guidance defining a “grandfathered health plan” has been issued by the U.S. Department of the Treasury, U.S. Department of Labor, and the Department of Health and Human Services. Various requirements apply differently to grandfathered health plans than to non-grandfathered plans. This information provided on the following pages is intended to act as a general resource and not as legal guidance.

## What is a “grandfathered health plan”?

A grandfathered health plan is coverage which was in existence on March 23, 2010. Grandfathered health plan coverage includes coverage where members have been continuously enrolled in the group health plan or health insurance coverage since the grandfather date.

The grandfathering rules are applied separately to each benefit package made available under a group health plan or health insurance coverage. Subject to special rules for collectively bargained plans, health insurance products sold to new entities or individuals after the grandfather date will not be grandfathered, even if those products were offered in the group or individual market before the grandfather date.

## Which plans are affected by which provisions and when?

Most provisions are effective for the plan year beginning on or after September 23, 2010 with certain exceptions. Exceptions apply to grandfathered health plans, however, all provisions apply to new plans and to any plan after losing its grandfathered status. The table below provides guidance.

Provision	Effective	Applies to New Plans	Applies to Grandfathered Plans	Applies with Loss of Grandfathered Status
Annual Limits Regulated	9/23/10	Yes	Yes	Yes
Appeals Process	9/23/10	Yes	No	Yes
Emergency Coverage	9/23/10	Yes	No	Yes
Lifetime Limits Prohibited	9/23/10	Yes	Yes	Yes
OAD Coverage (no other coverage avail.)	9/23/10	Yes	Yes	Yes
Plan Rescissions	9/23/10	Yes	Yes	Yes
Pre-Authorization	9/23/10	Yes	No	Yes
Pre-Existing Conditions (children under 19)	9/23/10	Yes	Yes	Yes
Preventive Care	9/23/10	Yes	No	Yes
Primary Care Provider	9/23/10	Yes	No	Yes
Non-Discrimination	9/23/10	Yes	No	Yes
Notice of Material Changes	3/23/12	Yes	Yes	Yes
Annual Limits Prohibited	1/1/14	Yes	Yes	Yes
OAD Coverage (other coverage avail.)	1/1/14	Yes	Yes	Yes
Pre-Existing Conditions (all individuals)	1/1/14	Yes	Yes	Yes
Auto Enrollment	TBD	Yes	Yes	Yes

## What if a plan does not comply?

The basic penalty for failure to comply, for example, with the mandates and prohibitions that go into effect for plan years beginning on or after September 23, 2010, is a non-deductible excise tax of \$100 per failure per affected individual per day. Generally, this penalty is capped at \$500,000 per year for a single employer plan and the amount may be reduced for timely corrections and for failures that are due to reasonable cause and not willful neglect.

# Provisions

- **Annual and Lifetime Limits (model notice)**

Effective for plan years beginning on or after September 23, 2010, the Rule prohibits a lifetime or annual limit on the dollar amount of benefits for an individual. This provision does not prevent a plan from excluding all benefits for a particular condition.

For plan years beginning before January 1, 2014, an annual dollar limit may be imposed with respect to benefits that are essential health benefits, but the annual limit may not be less than:

- \$750,000 for plan years beginning on or after September 23, 2010 but before September 23, 2011
- \$1,250,000 for plan years beginning on or after September 23, 2011 but before September 23, 2012
- \$2,000,000 for plan years beginning on or after September 23, 2012 but before January 1, 2014

The term “essential health benefits” is defined in Section 1302 of the Act and includes at minimum, items and services in the following categories: ambulatory patient services; emergency services; hospitalization, maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Further guidance is still expected.

- **Appeals Process**

The Healthcare Reform Law requires the receipt of benefits during the appeals process be guaranteed and also to require an external review process. Regulations will hopefully address the scope of the continued benefits requirement during an appeal.

- **Coverage of Emergency Services**

Effective for plan years beginning on or after September 23, 2010, the Acts prohibit non-grandfathered plans from requiring prior approval for emergency services. If a group health plan or health insurance coverage provides any benefits for emergency services, coverage must be provided:

- without the need for prior authorization, even if the services are provided on an out-of-network basis;
- without regard to whether the health care provider is a participating provider;
- for out-of-network services, without imposing limitations on coverage that are more restrictive than those provided for emergency services provided in-network; and
- without imposing a copayment or coinsurance rate for out-of-network services that exceeds the rate imposed for in-network services.

- **Overage Dependent Coverage for Young Adults (model notice)**

Effective for plan years beginning on or after September 23, 2010, the Rule provides that coverage be provided up to age 26 when the adult child is not eligible to enroll in a qualified employer-sponsored plan. For plan years beginning on or after January 1, 2014, coverage must be provided up to age 26 even when the adult child is eligible to enroll in other employer-sponsored coverage.

- **Plan Rescissions Prohibited**

Effective for plan years beginning on or after September 23, 2010, coverage may not be rescinded once the individual becomes covered under the plan unless the individual performs an act, practice, or omission that constitutes fraud, or the individual makes an intentional misrepresentation of material fact.

- **Preexisting Condition Exclusions**

The Rule prohibits a preexisting condition exclusion from being imposed. This provision is generally effective for plan years beginning on or after January 1, 2014, however, it is effective for plan years beginning on or after September 23, 2010 for enrollees under 19 years of age.

- **Preventive Services**

Effective for plan years beginning on or after September 23, 2010, plans are required to cover preventive services, such as screenings and immunizations, with no employee cost-sharing requirements. Grandfathered plans are exempt from this mandate. Further guidance is expected.

- **Primary Care Provider Designation (model notice)**

The Rule provides guidance on the patient protections provided by the Acts. Note that grandfathered plans are not required to provide these protections. However, for non-grandfathered plans, these rules are generally effective for plan years beginning on or after September 23, 2010.

If a group health plan or health insurance coverage requires designation of a primary care provider, the covered individual must be allowed to designate any participating primary care provider who will accept the individual, including a pediatrician for a covered child. A plan or issuer must provide notice of the terms of the plan regarding the designation.

- **Highly Compensated Employees**

Discrimination in favor of a company's highly compensated employees (HCEs) is prohibited. This applies only to new employer health plans, or to those losing grandfathered status, established on or after March 23, 2010. Individuals are considered HCEs if they are: one of the five highest paid officers of a company; a shareholder of more than 10 percent of the company's shares; one of the highest paid 25 percent of all the company's employees.

- **Prior Authorization/Referral (model notice)**

The Rule provides guidance on the patient protections provided by the Acts. Note that grandfathered plans are not required to provide this protection. However, for non-grandfathered plans, this rule is generally effective for plan years beginning on or after September 23, 2010.

A group health plan or issuer of health insurance coverage may not require authorization or referral with respect to female participants seeking coverage for obstetrical and gynecological care from a participating health care professional that specializes in obstetrics or gynecology. The plan or issuer must notify participants that it may not require such authorization.

- **Auto Enrollment**

Employers that employ more than 200 full-time employees will be required to automatically enroll new full-time employees in the plan, pursuant to forthcoming regulations. The effective date is unclear but is likely to be effective upon the issuance of guidance by the DOL.

# Maintaining Grandfathered Status

## What changes are permissible?

- **Change in Premium**  
Change in premiums to a plan or policy are deemed permissible and will not impact grandfathered status.
- **Federal and State Compliance**  
Changes to comply with Federal or State legal requirements, such as Mental Health Parity, are deemed permissible and will not impact grandfathered status.
- **Provider Networks**  
Changes within a provider network will not impact grandfathered status.
- **Drug Formulary**  
Changes within a prescription drug formulary are deemed permissible and will not impact grandfathered status.
- **Plan Enhancements**  
Plans may voluntarily enhance benefits, including adopting some of the consumer protections set forth in the PPACA early, without losing grandfathered status.
- **Changing Third-Party Administrators**  
Plan sponsors who elect to change third party administrators (administering a self funded product) will not lose their grandfathered status provided the benefit changes do not exceed the standards set forth.
- **New Hires or Newly Enrolled**  
New employees (whether newly hired or just newly enrolled) and their dependents who enroll in a grandfathered health plan after March 23, 2010, do not affect the grandfathered status of the plan.
- **Mergers, Acquisitions or Similar Business Restructure**  
Changes to accommodate mergers and acquisitions are deemed permissible as long as the primary purpose for the restructure is not to cover new individuals under a grandfathered health plan.
- **Disclosure and Recordkeeping Requirement (model notice)**  
To maintain grandfathered status, a plan must include a statement in plan materials, provided to a participant and beneficiary, describing the benefits provided under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan within the defined meaning and must provide contact information for questions and complaints.

In addition, a plan must, for as long as the plan takes the position that it is a grandfathered health plan, maintain records documenting the terms of the plan in connection with the coverage in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan; and make such records available for examination upon request.

## Is there a transition period for complying?

Under special transition rules, if an employer: (a) made changes to its plan after March 23, 2010, pursuant to a contract entered into before that date, or (b) adopted amendments prior to March 23, 2010, that were effective after that date, the changes may be considered part of the plan's terms as of March 23, 2010. Other changes made after March 23, 2010, and adopted before June 14, 2010, if revoked before the first day of the plan year beginning on or after September 23, 2010, will not cause the plan to lose grandfathered status.

# Losing Grandfathered Status

## What changes will cause a loss of status?

- **Changing Insurance Carriers**  
Changing fully-insured carriers will result in a loss of coverage.
- **Elimination of Benefits**  
The elimination of all or substantially all benefits to diagnose or treat a particular condition.
- **Increase in Cost-Sharing Requirement**  
Any increase, measured from March 23, 2010, in a percentage cost-sharing requirement (such as coinsurance) will result in a loss of status.
- **Increase in a Fixed-Amount Cost-Sharing Requirement (other than a copayment)**  
Any increase in a fixed-amount cost-sharing requirement (such as deductible or out-of-pocket maximum), by a total percentage measured from March 23, 2010, that exceeds the sum of medical inflation plus 15% will result in a loss of status.\*
- **Increase in a Fixed-Amount Copayment**  
Any increase in a fixed-amount copayment, by a total percentage measured from March 23, 2010, that exceeds the sum of medical inflation plus 15% OR \$5 increased by medical inflation will result in a loss of status.\*
- **Decrease in Contribution Rate**  
A decrease of the employer contribution, toward any tier of coverage for any class, by more than 5% below the contribution rate in effect on March 23, 2010, will result in a loss of status.
- **Changes in Annual limits**  
1-Imposing an annual limit on the dollar value of benefits, if an annual or lifetime limit was not in effect for said benefits on March 23, 2010, will result in a loss of status.  
  
2-Imposing an overall annual dollar limit of all benefits that is lower than the lifetime limit in effect on March 23, 2010, will result in a loss of status.  
  
3-Decreasing the dollar value of the annual limit previously imposed on all benefits as of March 23, 2010, will result in a loss of status.
- **Mergers, Acquisitions or Similar Business Restructure**  
If the principal purpose of a merger, acquisition, or similar business restructuring is to cover new individuals under a grandfathered health plan, the plan ceases to be a grandfathered health plan.
- **Disclosure (model notice)**  
Loss of status will occur if a plan sponsor does not disclose to a participant and beneficiaries that the plan or coverage believes itself to be a grandfathered health plan.

\* Assumes medical inflation at 4%