IMPLEMENTING HEALTHCARE REFORM

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Healthcare Reform

In Focus: *Grandfathered Status*

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 Affordable Care Act (ACA) was enacted. The rules apply separately to each benefit package made available under group health plan coverage. 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 grandfathered 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.

Provisions Affecting Grandfathered and Non-Grandfathered Plans

The chart below summarizes ACA provisions that impact grandfathered and non-grandfathered health plans.

Provision	Applies to Grandfathered Plans	Applies to Non-Grandfathered Plans	Effective for Plan Years On or After:
Removal of lifetime dollar limits for Essential health Benefits (EHBs)	Y	Y	9/23/10
Restricted annual dollar limits on EHBs	Y	Y	9/23/10
Coverage for dependents up to age 26, regardless of standard eligibility criteria	Y, however, for plan years prior to 1/1/14, may exclude children with access to employer-sponsored coverage other than through parent	Y	9/23/10
No pre-existing condition exclusions for individuals younger than age 19	Y	Y	9/23/10
No rescissions except for fraud or intentional misrepresentation	Y	Y	9/23/10
Coverage for specified preventive services without cost-sharing to participants if provided in-network	N	Y	9/23/10
Expanded claim and appeal rights including external review	N	Y	9/23/10
No prior authorization or increased cost-sharing for emergency services whether in or out of network and OB/GYN or pediatrician may be designated as participant's primary physician	N	Y	9/23/10
Provide a Summary of Benefit and Coverage (SBC) document	Y	Y	3/23/12
Waiting periods may not exceed 90 days	Y	Y	1/1/14
Out-of-pocket amounts may not exceed limits permitted for qualified high-deductible health plans	N	Y	1/1/14
Coverage for routine costs otherwise covered under the plan for patients participating in clinical trials	N	Y	1/1/14
No pre-existing condition exclusions for adults	Y	Y	1/1/14
Removal of annual dollar limits for EHBs	Y	Y	1/1/14

PLEASE NOTE: This document is designed to provide a high-level overview of aspects of the Affordable Care Act (ACA), as modified by the Health Care and Education Reconciliation Act. It is not comprehensive and does not constitute legal or tax advice for healthcare reform implementation. Please consult a professional benefit adviser or legal counsel regarding how the law may impact your specific benefit plan.

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Visit www.coresource.com/healthcarereform for more information on the ACA.

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