Grandfathered Health Plans

Grandfathered health plans are group health plans which were in existence on the date of enactment of the health reform law (March 23, 2010). Interim final rules concerning grandfathered plans were issued in June 2010 and interim final rules regarding some of the requirements for new plans were also issued in June 2010.

Certain requirements within the health reform law are *not* applicable to grandfathered plans; the lists below outline the different requirements applicable to both grandfathered and new plans, as well as requirements that are applicable only to new plans or to plans that lose their grandfather status:

Requirements that are applicable to all plans[1], including grandfathered plans:

In the first plan year after September 23, 2010 (for calendar year plans, the compliance date is January 1, 2011)

- All health insurance plans will not be allowed to rescind coverage, except in cases of fraud or abuse[2]
- All group health insurance plans will not be permitted to restrict coverage for children under age 19 based on health status conditions (in 2014, this provision will apply to all individuals regardless of age)
- All health insurance plans that offer dependent coverage will be required to offer coverage for dependents up to age 26 (with some exceptions for grandfathered plans; for more information see section "Extension of Dependent Coverage to Age 26")
- All health insurance plans will not be allowed to set lifetime dollar limits on benefits
- All health insurance plans will face restrictions on imposing annual limits on essential benefits (in 2014 all annual limits will be prohibited). Prior to 2014, the restricted annual limits may not be less than the following amounts[3]:
  - $750,000 for plan years beginning on or after September 23, 2010 but before September 23, 2011
  - $1.25 million for plan years beginning on or after September 23, 2011 but before September 23, 2012
  - $2 million for plan years beginning on or after September 23, 2012 but before January 1, 2014

Other changes applicable to all plans

- In 2011, the penalty for withdrawals from Health Savings Accounts for non-medical expenses increases to 20 percent
- In 2011, Flexible Spending Accounts, Health Reimbursement Arrangements and Health Savings Accounts will only be permitted to reimburse for over-the-counter drugs if the participant has a prescription
- In 2012, all health insurance plans will be required to provide uniform explanations of coverage using standardized definitions

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[1] Retiree-only plans are exempt from all of the new group health plan standards added by the Affordable Care Act.

[2] Rescission is a practice where insurance companies rescind an individual's existing health insurance policy when s/he becomes ill as a way to avoid covering the individual's health care costs.

[3] If complying with these annual limits would cause a significant reduction in access to plan benefits or a significant increase in premiums, plans are allowed to request a waiver of these annual limits rules.

- In 2012, employers will be required to report the cost of health insurance coverage on employees' W-2 forms
- In the first plan year ending after September 30, 2012, all health plans (insured and self-insured) will be required to pay a fee to fund comparative effectiveness research (the fee is phased out in 2019)
- In 2013, annual Flexible Spending Account contributions are capped at $2,500 a year
- Beginning in January 2014, all plans must limit eligibility waiting periods to 90 days
- Employers with more than 200 full-time employees will be required to automatically enroll full-time employees into employer health insurance plans, although employees may choose to opt out of the plans (effective date presumably in 2014, but may be implemented sooner)

Requirements that are *not* applicable to grandfathered plans; applicable only to new plans (plans created after March 23, 2010) or plans that lose their grandfather status:

Beginning in the first plan year after September 23, 2010

- Plans must cover certain preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children and adolescents and preventive care and screenings for women without beneficiary cost sharing requirements
- Plans cannot require prior authorization or referral for obstetrical or gynecological care
- For emergency care, plans must not require prior authorization and must not impose increased cost sharing for care received from out-of-network providers
- For group health plans that require the designation of a primary care physician, plans must allow participants and dependents to select any primary care provider or pediatrician
- Plans must offer coverage that at least meets the essential health benefits package, to be defined by the HHS Secretary (grandfathered plans are assumed to provide coverage that meets these requirements)
- Fully-insured group health plans are prohibited from discriminating in favor of highly compensated individuals (previously only applied to self-insured plans)
- Plans must establish a process for internal appeals and external review of claims
- Plans must comply with certain financial, quality of care and other data disclosure reporting requirements

Beginning in 2014

- Group health plans and health insurance issuers may not discriminate against health care providers acting within the scope of their licenses
- Cost-sharing and deductibles limits based on Health Savings Accounts maximums
- Wellness incentives/penalties on individuals can be increased to 30% (or more) of costs
- For individuals participating in clinical trials, plans must maintain coverage for routine services
- Additional information reporting requirements

For further details about provisions that are applicable and inapplicable to grandfathered plans, see www.dol.gov/ebsa/pdf/grandfatherregtable.pdf.

Losing Grandfather Status[4]

Existing group plans can lose their grandfathered status if a plan sponsor or issuer makes any of the following plan changes:

- Eliminates all or substantially all benefits related to diagnosing or treating a particular health condition
- Increases a percentage cost-sharing requirement, such as co-insurance, by any amount
- Increases in fixed-amount cost sharing, such as deductibles or out-of-pocket expenses (but not copayments) that exceed the rate of medical inflation since March 23, 2010 plus 15 percentage points
- Increases in copayments by an amount exceeding the greater of: a) the rate of medical inflation since March 23, 2010 plus 15 percentage points or b) $5, increased by the rate of medical inflation since March 23, 2010
- Reductions in the employer contribution share of the cost of coverage by more than 5 percentage points
- Implementing certain changes in the plan's annual benefit limits

A grandfathered plan can enroll new employees and their families without losing grandfather status. Plans will also not lose grandfathered status if they raise premiums or implement changes to comply with state or federal requirements, including complying with the health reform law. Additionally, self-insured plans are permitted to change third party plan administrators and not lose grandfather status. If a plan believes it is a grandfathered plan, plans must indicate this in the plan materials.

Some plans may eventually find it financially burdensome to remain grandfathered and/or determine that implementing the provisions that the health reform law requires for new plans would not be particularly burdensome or that they already meet the required standards.

Collectively bargained plans in place on March 23, 2010, both insured and self-insured, are considered grandfathered. For further details on collectively bargained plans and additional information about how certain changes implemented after March 23, 2010 may or may not affect a plan's grandfather status, please see AFSCME's fact sheet on grandfathered status (listed under Additional Resources).

[4] The original interim final rules stated that plans would lose grandfather status if they changed health insurance carriers or entered into a new policy, certificate or contract of insurance; however on 11/17/10 HHS issued an amendment stating that employers are permitted to switch insurance companies and maintain grandfather status as long as entering into the new policy does not result in any of the other changes that cause plans to lose grandfather status.

Additional Resources

American Federation of State, County, and Municipal Employees (AFSCME). "Patient Protection and Affordable Care Act: Grandfathered Status—What Is It and How Does a Plan Lose It?" http://www.afscme.org/issues/health-care/resources/document/Grandfather_Status_alert.pdf

Families USA. "Grandfathered Plans under the Patient Protection and Affordable Care Act." August 2010. http://www.familiesusa.org/assets/pdfs/health-reform/Grandfathered-Plans.pdf

The Segal Company. "Regulations on Grandfathering under the Affordable Care Act." June 2010. http://www.segalco.com/publications/bulletins/june2010GFregs.pdf