INSURANCE MANAGEMENT SERVICES

Patient Protection and Affordable Care Act (PPACA) - Grandfathered Plans

The long anticipated guidance on grandfathered plans was released Monday, June 14, 2010. The guidance clarifies how employers and employees may retain their current coverage.

What is a grandfathered plan?

A grandfathered plan is a group health plan or insurance coverage in which at least one individual was covered on March 23, 2010.

What changes can a plan make and still retain its grandfathered plan status?

- Enroll new employees and dependents of those employees, enroll dependents of previously enrolled employees, and re-enroll employees and dependents at open enrollment.

- Amend a plan to comply with other federal or state laws, such as the new Mental Health Parity/Addiction Equity Act.

- Add or enhance benefits.

- Make insignificant reductions in benefits.

    * Plans may not eliminate benefits for a specific condition or illness, or eliminate benefits for a treatment necessary to diagnose or treat a specific condition. For example, if a plan covers treatment of depression but eliminates benefits for all counseling, the plan has eliminated substantially all benefits for the treatment of depression.

- Increase the deductible or maximum out-of-pocket amount by no more than the permitted "maximum percentage increase."

    * The formula to calculate the "maximum percentage increase" phases out the increases permitted over time, allowing the largest increase to occur during the first year.

- Increase premiums. Employer contributions cannot be decreased more than 5% of the contribution rate in effect on March 23, 2010.

- Impose a new or modified annual limit in certain circumstances.

    * If a plan has a lifetime limit on all benefits and no annual limit on all benefits, the plan may impose an annual limit on all benefits of no less than the amount of the lifetime limit. For example, if the plan had a lifetime limit of $1 million on all benefits and no annual limit, the plan may impose an annual limit on all benefits of $1 million.

    * If a plan has an annual limit on all benefits, the plan may retain the annual limit but may not reduce the dollar amount of the limit (regardless of whether or not the plan also has a lifetime limit on all benefits).

    * Note: Restricted annual limits are permitted until January 1, 2014. Additional guidance is expected to clarify the application of these limits.

- Change administrators of the plan.

- The agencies recognize that most employers routinely make benefit changes from year to year, and some employers may have implemented benefit changes before these regulations were published. Accordingly, the interim final regulations outline the following transitional rules:

    * Plans will not lose grandfathered plan status if substantial benefit changes become effective after March 23, 2010 if: 1) the plan agreed to the benefit changes in a contract entered into before March 23; or 2) the plan adopted the amendment before March 23.

    * If plans make a good faith effort to comply with PPACA, benefit changes that modestly exceed those permitted under these newly published regulations and became effective before the date of publication, will not cause a loss of grandfathered plan status.

    * Benefit changes that would have caused a loss of grandfathered plan status may be revoked or modified to comply with these regulations, effective the first day of the plan year beginning on or after September 23, 2010. Plans will be deemed to comply if the changes are: 1) effective as of that date; 2) agreed upon in a contract entered into before that date; or 3) adopted by written amendment before that date.

The regulations also contain document retention and disclosure requirements for plans. Plans must maintain records to document the terms of coverage in effect on March 23, 2010 and other documents, as necessary, to verify status as a grandfathered plan. Records must be made available for inspection by plan participants, beneficiaries, or appropriate state or federal agencies. Plans must also disclose in plan materials provided to plan participants or beneficiaries that the coverage is intended to be a grandfathered health plan and contact information for questions and/or complaints. A model disclosure notice has been made available by Department of Labor.

What is the advantage of grandfathered plan status?

- Grandfathered plans are not required to meet the new preventive care requirements. Non-grandfathered plans must provide first dollar coverage for evidence-based services recommended for an “A” or “B” grade by the US Preventive Services Task Force, immunizations for all ages as recommended by the Centers for Disease Control and Prevention, and evidence-based preventive screening for infants, children, adolescents and women as recommended by the Health Resources and Services Administration. Effective for renewals occurring on or after 9/23/2010.

- Grandfathered plans are not required to adopt the new appeals process. Non-grandfathered plans must implement an internal appeal process consistent with existing claims review regulations, notice to participants in a culturally and linguistically appropriate manner, an opportunity for participants to review their file and offer testimony, and compliance with any State external review process or a similar process as allowed by regulations. Effective for renewals occurring on or after 9/23/2010.

- Grandfathered plans are not required to comply with the new patient protection requirements. Non-grandfathered plans must allow participants to select any participating provider as their primary provider, receive emergency care services without prior authorization and at the in-network benefit level, and receive obstetrical and gynecological care without the authorization or a referral from a primary care provider. Effective for renewals occurring on or after 9/23/2010.

- Grandfathered plans are not required to offer coverage in clinical trials. Non-grandfathered plans must cover the routine costs for participants eligible to participate in approved Phase I, II, III, IV clinical trials and deemed appropriate by their treating physician. Effective for renewals occurring on or after 1/1/2014.

- Grandfathered plans are not eligible for increased financial incentives if they offer a wellness program that requires the participant to satisfy a standard related to a health status factor. Non-grandfathered plans may increase the level of financial incentive from the current 20% to 30% of the total premium, or 50% if permitted by the agencies. Effective for renewals occurring on or after 1/1/2014.

- Grandfathered plans are not subject to cost-sharing limits. Non-grandfathered plans may not impose an annual out-of-pocket maximum or deductible in excess of the limits under IRC Section 223(c)(2)(A)(ii) for self-only and family coverage. For 2010, those limits include an annual out-of-pocket maximum of $5,950 for self-only and $11,900 for family coverage. Deductibles are limited to $2,000 for self-only and $4,000 for family coverage. These amounts are indexed and will increase each year. Effective for renewals occurring on or after 1/1/2014.

- Grandfathered plans are not required to meet the disclosure requirements for information on claims payment policies, financial disclosures, data on enrollment and denied claims, premium rating practices, cost-sharing, and payments to non-network providers. Effective for renewals occurring on or after 1/1/2014.

What must grandfathered plans comply with?

- Remove lifetime limits and annual limits. Restricted annual limits are permitted until 2014. Effective for renewals occurring on or after 9/23/2010.

- Extend coverage to adult dependent children up to the limiting age of 26, without regard to marital or full-time student status. Until the plan's renewal on or after January 1, 2014, plans may exclude the adult dependent child if he/she is eligible for their own employer-sponsored coverage. Plans are not required to cover the children and spouses of the adult dependent child. Effective for renewals occurring on or after 9/23/2010. See the IMS Memo on Healthcare Reform, Adult Dependent Children, for more information.

- Eliminate pre-existing condition exclusions for those enrollees under the limiting age of 19. Enrollee include dependent children, employees and spouses. Effective for renewals occurring on or after 9/23/2010.

- Distribute a new standardized summary explanation of coverage. The summary is limited to 4 pages, 12 point font, and should present information in a culturally and linguistically appropriate manner and in terminology easily understood by the average individual, effective 3/23/2012. Additional guidance is forth-coming.

- Provide a 60 day prior notice to plan participants of any “material modification” to the terms of the plan or coverage not reflected in the most recent summary explanation of coverage. Effective for plan years beginning on or after 3/23/2012. Additional guidance is forthcoming.

- Report requirements for various quality of care initiatives, information on hospital readmissions, patient safety, and wellness programs. HHS to publish reporting requirements by 3/23/2012.

- Eliminate pre-existing condition exclusions for all enrollees. Effective for renewals occurring on or after 1/1/2014.

- Eliminate any waiting period in excess of 90 days. Effective for renewals occurring on or after 1/1/2014

- Report to various agencies and employees on “minimum essential coverage” and “free choice vouchers.” Effective 1/1/2014. Additional guidance is forthcoming.

These interim final regulations provide welcome clarity for employers, as they implement benefit changes to keep their plans competitive in the ever-changing marketplace. Additional guidance is expected and IMS will provide its valued clients with further updates. If you have any questions or need more information, please contact your Account Manager.

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