Some Details on Grandfathered Status

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What Events Can Cause a Plan to Lose Grandfathered Status?

- Entering into a new insurance contract, certificate or policy after March 23, 2010;
- Eliminating all or substantially all benefits to diagnose or treat a particular condition;
- Any increase in percentage cost-sharing requirements (coinsurance);
- An increase in a fixed amount cost-sharing requirement above the maximum permissible percentage (deductibles, out-of-pocket limitations, and fixed amount copayments);
    - For copayments, the maximum permissible percentage is 15 percent plus medical inflation or $5 plus medical inflation (if greater);
    - For deductibles, the maximum permissible percentage is 15% plus medical inflation; and
    - For out-of-pocket limits, the maximum permissible percentage is 15% plus medical inflation.
- A decrease in the **employer's** contribution rate by more than 5 percentage points below the rate in place on March 23, 2010 (e.g., from 80% of the premium to 74%);
- A change in annual dollar limits for benefits, including any of the following:
    - addition of annual limits where there were no previous lifetime or annual limits;
    - if the plan had lifetime limits but no annual limits, introducing an annual limit that is lower than the old lifetime limit; or
    - a decrease in an existing annual limit.

What Requirements Apply Only to Non-Grandfathered Plans, Not to Grandfathered Plans?

- Employers must automatically enroll new employees for coverage unless they opt out. The effective date of this requirement remains unclear.
- Coverage must be provided for adult children through age 26, regardless of the child's marital, student or dependent status, with no exclusion of adult children who are eligible for another employer-sponsored health coverage.
- Preventive care must be provided without cost, i.e., no deductible, copayment, or coinsurance. This includes screenings, counseling and routine immunizations.
- **Insured** plans must comply with the requirements that prohibit discrimination in favor of highly compensated individuals with respect to eligibility or benefits (formerly just self-insured plans had to be nondiscriminatory).
- Emergency services must be provided without pre-authorization and without different costs for in-network versus out-of-network.

- Must be able to choose pediatricians (children) and obstetricians/gynecologists (women) as primary care providers.
- Internal claims/appeals requirements must be revised to meet additional new requirements.
- All plans will be subject to mandatory external review processes.
- Health care quality and wellness initiatives must be reported to the Department of Health and Human Services beginning in 2012.
- Limits on out-of-pocket and deductible expenses will go into effect in 2014; and
- Coverage of routine costs for patients who are part of clinical trials will be required beginning in 2014.

Health Care Reforms that Apply to <u>All</u> Plans, Regardless of Grandfathered Status

- No pre-existing condition exclusions for children under age 19 for plan years beginning on or after September 23, 2010 and no pre-existing condition for **any** participant starting January 1, 2014.
- Plans may not have waiting periods longer than 90 days beginning with plan years that start on January 1, 2014.
- Plans may not have lifetime dollar limits on “essential health benefits” for plan years starting on or after September 23, 2010.
- Plans may not impose annual dollar limits below certain specified levels beginning with plan years starting on or after September 23, 2010 and may not impose annual dollar limits on **any** “essential health benefits” after January 1, 2014.
- Retroactive rescission of coverage is prohibited except for fraud or intentional misrepresentation (or premium nonpayment).
- Coverage of adult children is required up to age 26, except that until 2014, a grandfathered plan may exclude an adult child who has coverage available under another employer-sponsored group health plan (other than parents' plan).
- Plans must provide a summary of benefits and coverage to employees prior to enrollment in a manner specified by the law and forthcoming guidance, no later than March 23, 2012.
- Sixty days' advance notice of material modifications must be provided to participants (beginning March 23, 2012) when a group health plan makes changes to the plan or coverage.
- Employers must notify new employees of the existence of health care exchanges, the standards for receiving a subsidy under the exchange, and the consequences of purchasing a policy through an exchange without an employer voucher, beginning January 1, 2013.
- If an employee chooses to opt out of the employer-sponsored plan, the employer must offer vouchers to qualified employees for use on an exchange, beginning January 1, 2014..

- Beginning January 1, 2018, if the value of employer-sponsored coverage exceeds a threshold amount ($10,200 for single coverage and $27,500 for family coverage), a 40% excise tax on the amount that exceeds the threshold will apply to coverage providers, including insurers of insured plans, administrators of self-insured plans or FSAs, and employers contributing to an HSA or Archer MSA.