



Legislative Brief

Health Care Reform: What are the Benefits Of Having a Grandfathered Plan?

What is a Grandfathered Plan?

Under the health care reform law signed into law on March 23, 2010, a grandfathered plan is essentially a health plan that existed before the health care reform legislation was passed. More specifically, a grandfathered plan is a group health plan or health insurance coverage in which an individual was enrolled on March 23, 2010.

If your company sponsored a health plan on March 23, 2010, you had a grandfathered plan. Whether your plan remains grandfathered depends on whether you made significant changes to the plan's benefits or costs since then. If you are considering changes to your health plan, you will need to consider whether it makes sense to try to retain grandfathered status for your plan.

Please contact Fickewirth & Associates with any questions on which changes a grandfathered plan can make without putting its grandfathered status at risk.

What are the Benefits of Having a Grandfathered Plan?

In considering whether to keep your plan's grandfathered status, it is important to keep in mind the benefits the health care reform law provides to grandfathered plans. Under health care reform, grandfathered plans do not have to comply with some provisions of the health care reform law. On the other hand, losing grandfathered status means that a plan would have to comply with additional health care reform requirements.

You should also keep in mind that grandfathered plans are restricted in the benefit and cost changes they can make. You may find that it makes sense for your company to give up grandfathered status, and comply with the additional rules, to be able to make more significant changes to your plan.

Which Health Care Reform Rules Can Grandfathered Plans Avoid?

Grandfathered health plans are exempt from the following health care reform requirements:

- **Coverage of Preventive Health Services.** Effective for plan years beginning on or after Sept. 23, 2010, group health plans and group or individual health insurance policies must cover certain preventive health services without imposing cost-sharing requirements.
- **Patient Protections.** Effective for plan years beginning on or after Sept. 23, 2010:
 - Enrollees must be allowed to choose any available primary care provider that participates in their plan or network (including a pediatrician for children).
 - Group health plans and group or individual health insurance policies that provide emergency services may not impose preauthorization requirements or increased cost-sharing on emergency services (in- vs. out-of-network).
 - Group health plans and group or individual health insurance policies that provide OB/GYN care may not require preauthorization or referral for that care.



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- **Nondiscrimination Rules for Fully Insured Plans.** Fully insured plans will have to satisfy the requirements of Internal Revenue Code section 105(h)(2). That section provides that a plan may not discriminate in favor of highly compensated individuals as to eligibility to participate and that the benefits provided under the plan may not discriminate in favor of participants who are highly compensated individuals. This provision will be effective sometime after regulations are issued. The regulations will specify the effective date.
- **Quality of Care Reporting.** Within two years of the date of enactment, reporting requirements will be developed for group health plans and health insurance issuers offering group or individual health insurance coverage. The reports will relate to benefit and reimbursement structures that are designed to improve health outcomes, prevent hospital readmissions, improve patient safety, reduce medical errors, and implement health and wellness activities.
- **New Appeals Process.** Effective for plan years beginning on or after Sept. 23, 2010, group health plans and health insurance issuers offering group or individual health insurance coverage must implement an effective appeals process for appeals of coverage determinations and claims. A grace period until plan years beginning on or after Jan. 1, 2012, has been granted for some elements of the process.
- **Insurance Premium Restrictions.** Effective for plan years beginning on or after Jan. 1, 2014, premiums charged for health insurance coverage in the individual or small group market may not be discriminatory and may vary only by individual or family coverage, rating area, age and tobacco use, subject to certain restrictions.
- **Guaranteed Issue and Renewal of Coverage.** Effective for plan years beginning on or after Jan. 1, 2014, health insurance issuers offering health insurance coverage in the individual or group market in a state must accept every employer and individual in the state that applies for coverage and must renew or continue the coverage at the option of the plan sponsor or the individual.
- **Nondiscrimination Based on Health Status.** Effective for plan years beginning on or after Jan. 1, 2014, group health plans and health insurance issuers offering group or individual health insurance coverage may not establish rules for eligibility or continued eligibility based on health status-related factors. Wellness programs must meet nondiscrimination requirements.
- **Nondiscrimination in Health Care.** Effective for plan years beginning on or after Jan. 1, 2014, group health plans and health insurance issuers offering group or individual insurance coverage may not discriminate against any provider operating within their scope of practice. However, this provision does not require a plan to contract with any willing provider or prevent tiered networks. Plans and issuers also may not discriminate against individuals based on whether they receive subsidies or cooperate in a Fair Labor Standards Act investigation.
- **Comprehensive Health Insurance Coverage.** Effective for plan years beginning on or after Jan. 1, 2014, health insurance issuers that offer health insurance coverage in the individual or small group market must provide the essential benefits package required of plans sold in the health insurance exchanges.
- **Limits on Cost-Sharing.** Effective for plan years beginning on or after Jan. 1, 2014, certain group health plans may not impose cost-sharing or out-of-pocket costs in excess of certain limits. Out-of-pocket expenses may not exceed the amount applicable to coverage related to HSAs, and deductibles may not exceed \$2,000 (single coverage) or \$4,000 (family coverage). These amounts are indexed for subsequent years.
- **Coverage for Clinical Trials.** Effective for plan years beginning on or after Jan. 1, 2014, group health plans and health insurance issuers offering group or individual insurance coverage must permit certain enrollees to participate in certain clinical trials, must cover routine costs for clinical trial participants and may not discriminate against participants.

Please contact Fickewirth & Associates with any questions about grandfathered plans.

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