HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

Frequently Asked Questions Regarding Grandfathered Health Plans

The Patient Protection and Affordable Care Act (PPACA) includes provisions for the grandfathering of existing health insurance plans. Because most Americans had private health insurance coverage on PPACA's date of enactment, most Americans' health coverage is affected by the grandfathering provisions. The following will help determine the value of retaining your health plan's grandfather status and the requirements of preserving grandfathered status.

Q. What is a Grandfathered Plan?

A. To be a grandfathered plan, a health plan must have been in effect on March 23, 2010, the date of enactment. A grandfathered plan can be fully insured or self-insured and plan status is determined separately with respect to each "benefit package." The law generally allows a grandfathered plan to continue its operations without losing its grandfathered status. New employees may enroll in a grandfathered plan, and participants may reenroll or add dependents.

Q. What are the benefits of being a Grandfathered Plan?

A. Grandfathered plans are exempt from certain requirements. Following are immediate provisions (effective the plan year beginning after Sept. 23, 2010) that do **not** apply to grandfathered plans:

1. Grandfathered plans that are fully insured are not subject to nondiscrimination rules which prohibit discriminating in favor of highly compensated employees as to eligibility to participate or benefits provided. (Deferred pending further guidance.)
2. Grandfathered plans do not have to provide the specified preventive care with no cost-sharing that other group health plans must provide. **HMAA has voluntarily added this benefit to Grandfathered plans.**
3. Grandfathered plans do not have to provide emergency services without prior certification and do not have to allow out-of-network expenses under the same cost structure applicable to in-network emergency services.

In addition, maintaining Grandfathered Status will allow more control of future premium fluctuations because underwriting will continue to be based on your group's own utilization versus non-grandfathered plans that will be required to be community-rated based on strict guidelines.

Q. What changes *do* apply to grandfathered plans?

A. Except for the early implementation of full coverage of adult dependents, the following provisions are effective the first plan year beginning on or after Sept. 23, 2010 (Jan. 1, 2011 for calendar year plans):

1. All group health plans must provide coverage for adult dependent children up to age 26. Prior to Jan. 1, 2014, this rule applies to grandfathered plans only if the child is not eligible for coverage under another employer-sponsored plan.
2. All plans are prohibited from pre-existing condition exclusions for enrollees under the age of 19 and for all enrollees in 2014.
3. All plans may not rescind a participant's coverage except in the case of fraud or intentional misrepresentation by the participant.
4. All plans are prohibited from applying a lifetime limit on the value of "essential benefits" for any plan participant or beneficiary. The new law permits "restricted annual limits" (to be defined by future regulations) on the dollar value of essential benefits provided to a plan participant or beneficiary.

Q. What will cause group health plans to lose grandfathered status?

A. There are six actions that could cause a health plan to **lose grandfathered status** and become subject to the full brunt of PPACA mandates:

1. The elimination of all, or substantially all, benefits to diagnose or treat a particular condition.

COMP E-26 051612

2. An increase in percentage of a cost-sharing requirement, such as coinsurance, above the level at which it was on March 23, 2010.
3. An increase in a fixed-amount cost-sharing requirement other than co-pays, such as a $500 deductible or a $2,500 out-of-pocket limit, by a total percentage measured from March 23, 2010, that is more than the sum of medical inflation and 15 percentage points.
4. An increase in co-pays by an amount that exceeds the greater of:
   - A total percentage measured from March 23, 2010, that is more than the sum of medical inflation plus 15 percentage points, or
   - $5 increased by medical inflation measured from March 23, 2010.
5. A decrease in employer contribution (the percentage of premium expense borne by the employer) by more than 5 percentage points, measured from March 23, 2010.
6. A change in annual limits from March 23, 2010 such as:
   - An addition of an annual limit on the dollar value of benefits;
   - A decrease in limit for a plan with only a lifetime limit; or
   - A decrease in limit for a plan with an annual limit.

Changes that are not listed above, and certainly, adding enhancements to the plan, would not cause loss of grandfathered status.

Q. Is there any transitional relief for changes already made?

A. Yes. The Interim Final Rule provides transitional relief for employers that implemented plan changes that became effective after March 23, 2010, but prior to the publication of the Interim Final Rule in the Federal Register. The Interim Final Rule was issued on June 14, 2010, and publication typically occurs within a few days of issuance. The relief available depends on whether the change was adopted before or after March 23, 2010.

1. If an employer made changes to its group health plan before March 23, 2010, but such changes were not effective until after March 23, 2010, those changes will be treated as the terms of the plan as of March 23, 2010 in the following instances:
   - the change was pursuant to a legally binding contract entered into on or before March 23, 2010;
   - the change was pursuant to a filing on or before March 23, 2010 with a state insurance department; or
   - the change was pursuant to written amendments to a plan that were adopted on or before March 23, 2010.

In such case, the group health plan, as amended by such changes, is considered to be a grandfathered health plan.

2. If an employer made changes to its group health plan after March 23, 2010, but adopted the changes before publication of the Interim Final Rule, the plan is permitted to either revoke or modify such changes, as necessary, effective as of the first day of the first plan year beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans). If modified, the change must not exceed the standards described above in order for the plan to maintain its grandfathered status. To take advantage of this relief, the Interim Final Rule provides that the adopted changes must be effective either before the date of publication of the Interim Final Rule, or effective on or after that date, provided that such changes are pursuant to a legally binding contract entered into before that date, a filing with a state insurance department before that date, or written amendments adopted before that date.

Q. What changes can be made without losing grandfathered status?

A. The following events are permissible changes that will not cause a health plan to lose its grandfathered status:
   - Enrollment of family members (dependents and spouses)
   - Enrollment of new or existing employees who become eligible for coverage
   - Change in premiums (as long as it is not due to a decrease in employer contributions of more than permitted amounts)

- Change in third-party administrators
- Change to comply with federal or state law
- Voluntary changes to comply with PPACA
- Change in insurers (provided the plan continues to comply fully with the requirements listed in the regulations)
- Any changes other than the six actions specifically listed in the regulations.

Q. What disclosure, documentation and reporting requirements are needed to preserve grandfathered status for current plans?

A. In accordance with Department Labor regulations, grandfathered plans must complete two reporting and disclosure steps:

- Maintain records documenting the terms of the plan in connection with the coverage in effect on March 23, 2010, and any other documents necessary to verify, explain or clarify its status as a grandfathered plan. These records must be available for examination upon request.
- Issue a grandfathered plan disclosure statement that must be included in any plan materials provided to a participant or beneficiary. The statement must describe the benefits under the plan, explain that the plan believes that it is a grandfathered plan as defined by PPACA, and provide contact information for questions or complaints.

Q. How can HMAA assist you in this process?

A. We will assist with the following:

- Maintenance of records documenting the terms of your plan in connection with the coverage in effect on March 23, 2010, and any other documents necessary to verify, explain or clarify your status as a grandfathered plan. These records will be provided to you upon request.
- Including a grandfathered plan disclosure statement in any plan materials provided to a participant or beneficiary.

Q. How can I assist HMAA in this process?

A. For purposes of determining whether a plan is grandfathered, insurers and plan sponsors must communicate regarding changes to the group's employer contribution rate (the percentage of premium expense borne by the employer). Therefore, HMAA will implement the following:

- Upon renewal, we will require plan sponsors of grandfathered plans to make a representation regarding their employer contribution rate for the plan year covered by the renewal, as well as the contribution rate on March 23, 2010.
- We will require plan sponsors to notify us immediately if the employer contribution rate decreases by more than 5 percentage points at any time.

Important Note: Penalties may be imposed on employers and health plans that fail to adhere to the grandfathering provisions. HMAA will seek indemnification of penalties and damages from employers who trigger a loss of grandfather status and fail to inform HMAA within a reasonable amount of time to make the appropriate changes to their plan. If you have any questions, please feel free to contact your HMAA Account Manager.