



Health Care Reform

★★★ FREQUENTLY ASKED QUESTIONS

June 21, 2010

Grandfathered Health Plan Coverage

Overview

Health Care Reform applies differently to grandfathered health plan coverage. This FAQ will address the following:

- What is grandfathered health plan coverage?
- What documentation and disclosure requirements apply to grandfathered health plan coverage?
- What Health Care Reform requirements apply to grandfathered health plan coverage?
- What causes a plan or insurance coverage to lose its grandfathered health plan coverage status?
- Are there any special grandfathering rules for plans maintained pursuant to a collective bargaining agreement?

Q1 What is Grandfathered health plan coverage?

A1 *General Rules on Grandfathered Status*

- Grandfathered health plan coverage is coverage provided by a health insurance issuer or a group health plan in which an individual was enrolled on the date of Health Care Reform enactment, March 23, 2010. A group health insurance coverage or a group health plan does not lose grandfathered status merely because one or more (or even all) individuals enrolled in the plan or coverage on March 23, 2010 cease to be covered, as long as the coverage or plan has continuously covered someone since March 23, 2010.
- The grandfathering rules are applied separately to each benefit package made available under a health insurance coverage or a group health plan (e.g., the rules would apply separately to the PPO and HMO options available to a member).
- Grandfathered health plan coverage includes coverage of family members of an individual member enrolled in the health insurance coverage or group health plan on March 23, 2010 who enroll in the member's coverage or plan after March 23, 2010.
- Grandfathered health plan coverage status also extends to newly hired or newly enrolled employees/members and their families enrolling in group health insurance coverage or a group health plan after March 23, 2010. For example, a member can switch from one grandfathered health plan coverage option offered by an employer to another grandfathered health plan option offered by the employer without causing either coverage option to lose grandfathered status. In addition, an employee who had previously declined coverage prior to March 23, 2010 can enroll him- or herself and eligible family members in grandfathered health plan coverage after such date.

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- Health insurance products sold to new entities or individuals after March 23, 2010 will not be considered grandfathered health plan coverage, even if those products were offered in the group or individual market before March 23, 2010. Therefore, insurers wishing to maintain grandfathered products will have to keep existing policies separate from newly-sold policies, and new policies will not receive grandfathered health plan protection.

Q2 Are there any documentation or disclosure requirements in order to retain grandfathered status?

A2 In order to maintain grandfathered health plan coverage status, health insurance issuers and group health plans must do the following:

- Disclose Grandfathered Status in Member Communications:** Any plan materials provided to a member describing the benefits provided under a plan or health insurance coverage must include a statement that the plan or coverage believes it is grandfathered health plan coverage as defined in Health Care Reform. The plan or coverage must also provide contact information for questions and complaints in any such materials. It appears that the disclosure must be included in all materials describing benefits, such as the certificate of coverage, summary plan description, enrollment materials, and schedule of benefits. The following disclosure, provided in agency guidance, will satisfy this disclosure requirement (however, the current guidance indicates that changes may be made to this model statement after public comments to the rules are reviewed):

This **[group health plan or health insurance issuer]** believes this **[plan or coverage]** is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your **[plan or policy]** may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at **[insert contact information]**. **[For ERISA plans, insert:** You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] **[For individual market policies and nonfederal governmental plans, insert:** You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.]

- Maintain Documents Evidencing Grandfathered Status:** The health insurance coverage or group health plan must maintain records documenting the plan or policy terms in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as grandfathered health plan coverage. This includes insurance policies/contracts/riders, certificates of coverage, plan documents, summary plan descriptions, information on premiums and cost-of-coverage levels, and employer contribution rates. These documents and records must be kept for as long as the insurance coverage or plan takes the position that coverage remains grandfathered and must be available upon request to members, policyholders, beneficiaries, and government regulators.

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Q3 What health care reform rules apply to grandfathered health plan coverage?

A3 Grandfathered health plan coverage must comply with the following Health Care Reform requirements:

Grandfathered Individual Policies

- Prohibition on excessive waiting periods [1/1/2014]
- Prohibition on lifetime limits [9/23/2010]
- Prohibition on rescission [9/23/2010]
- Coverage of dependents to age 26 who do not have other employer-sponsored coverage [9/23/2010] (and coverage of dependents to age 26 regardless of eligibility for other employer-sponsored coverage [1/1/2014])
- Use of uniform explanation of coverage documents and standard definitions [HHS has until 3/23/2011 to come up with the standard summary of benefits and coverage, and plans and insurers have until 3/23/2012 to provide the summaries]
- Medical loss ratio requirements (fully-insured plans) [HHS has until 12/31/2010 to establish reporting definitions, and rebates of premium payments are to begin no later than 1/1/2011]

Grandfathered Group Policies/Group Health Plans

- Prohibition on excessive waiting periods [1/1/2014]
- Prohibition on lifetime limits [9/23/2010]
- Prohibition on annual limits (applies to group health insurance coverage and group health plans only; does not apply to grandfathered individual policies) [9/23/2010, with limited delay prior to 1/1/2004, depending on agency guidance]
- Prohibition on rescission [9/23/2010]
- Coverage of dependents to age 26 who do not have other employer-sponsored coverage [9/23/2010] (and coverage of dependents to age 26 regardless of eligibility for other employer-sponsored coverage [1/1/2014])
- Use of uniform explanation of coverage documents and standard definitions [HHS has until 3/23/2011 to come up with the standard summary of benefits and coverage, and plans and insurers have until 3/23/2012 to provide the summaries]
- Medical loss ratio requirements (fully-insured plans) [HHS has until 12/31/2010 to establish reporting definitions, and rebates of premium payments are to begin no later than 1/1/2011]
- No pre-existing condition exclusions (applies to group health insurance coverage and group health plans only; does not apply to grandfathered individual policies) [1/1/2014, but for enrollees under 19, effective 9/23/2010]
- No discrimination based on health status (most requirements already applied to group health insurance and group health plans pre-Health Care Reform pursuant to HIPAA; does not apply to grandfathered individual health insurance coverage) [1/1/2014]

Q4 What health care reform rules do NOT apply to grandfathered health plan coverage?

A4 The following Health Care Reform requirements do not apply to grandfathered health plan coverage (mandates are effective for plan years beginning on or after the date noted in brackets):

- Required first-dollar coverage for preventive health services [9/23/2010]
- Internal appeals and external review process [9/23/2010]
- No discrimination in favor of highly compensated individuals (applies to insured group insurance coverage only) [9/23/2010]

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- Individual choice of primary care physician (and of pediatrician as child's primary care physician) [9/23/2010]
- Individual choice of gynecologist or obstetrician without referral [9/23/2010]
- Emergency services without preauthorization and requirement to treat emergency services as in-network [9/23/2010]
- Premium rate limitations [1/1/2014]
- Guaranteed issue requirements [1/1/2014]
- Guaranteed renewability requirements (already in effect for most group health insurance and group health plans pre-Health Care Reform pursuant to HIPAA; Health Care Reform extends requirement to insured individual plans) [1/1/2014]
- Required to provide essential benefits (certain fully-insured plans) [1/1/2014]
- Coverage of dependents to age 26, regardless of other employer-sponsored coverage [9/23/2010] (does not apply to grandfathered health plans until 2014)
- Cost sharing and deductible limits [1/1/2014]
- No discrimination against individuals participating in clinical trials [1/1/2014]
- No discrimination with respect to health care providers acting within the scope of their license and applicable state law [1/1/2014]
- No discrimination based on health status (most requirements already applied to group health insurance and group health plans pre-Health Care Reform pursuant to HIPAA; does not apply to grandfathered individual health insurance coverage) [1/1/2014]
- No pre-existing condition exclusions (applies to group health insurance coverage and group health plans only; does not apply to grandfathered individual policies) [1/1/2014, but for enrollees under 19, effective 9/23/2010]
- Prohibition on annual limits (applies to group health insurance coverage and group health plans only; does not apply to grandfathered individual policies) [9/23/2010, with limited delay prior to 1/1/2004, depending on agency guidance]
- Required disclosure of enrollee, claims information, and cost-sharing amounts to government regulators, and must be made available to enrollees [9/23/2010]
- Required reporting on initiatives and programs to improve health outcomes [HHS has until 3/23/2012 to develop reporting requirements and regulations for determining whether a reimbursement structure is subject to reporting, and plans and insurers must report annually once that is done]

Q5 What types of changes will result in loss of grandfathered health plan coverage status?

A5 Situations Ending Grandfathered Status

- Entering into a new policy, certificate, or contract of insurance with the plan's issuer causes a group health plan to lose grandfathered status.
- Except with respect to insured collectively bargained employee plans, changing the insurance issuer of a group health plan causes the plan to lose grandfathered status. However, if a plan has three benefit options, and the plan only changes the issuer of one of the options, the coverage under the option that has a new issuer is no longer grandfathered health plan coverage. The remaining two benefit options remain grandfathered health plan coverage so long as the options do not otherwise lose grandfathered status. The guidance does not address whether changing a stop loss insurer would cause a plan to lose grandfathered status, although this seems unlikely.

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- If the principal purpose of a merger, acquisition, or similar business restructuring arrangement is to cover new individuals under grandfathered health plan coverage, the plan or insurance coverage ceases to be a grandfathered health plan.
- Changing eligibility rules in order to transfer members from one grandfathered plan to another grandfathered plan will cause a loss of grandfathered status for both plans if (i) there is no bona fide employment-based reason for transferring members into the new grandfathered plan, and (ii) the old grandfathered plan would have lost grandfathered health plan status if it was amended to provide the same benefits as the new grandfathered plan.
- Although changes to one coverage option generally would not cause another coverage option to lose grandfathered status, elimination of a coverage option could cause the remaining coverage options to lose grandfathered status if individuals in the terminated coverage option are transferred to other coverage options and there is no bona fide employment-based reason for the elimination of the coverage option. Changing the terms or cost of coverage is not considered a bona fide employment-based reason.

Impermissible Changes

The following changes cause a plan or coverage to lose grandfathered status:

- A change to eliminate all or substantially all benefits to diagnose or treat a particular condition, or to eliminate benefits for any necessary element to diagnose or treat a condition.
- Any increase in a percentage cost-sharing requirement (e.g., coinsurance), measured from March 23, 2010.
- An increase in a fixed-amount cost-sharing requirement, other than a copayment (e.g., a deductible or out-of-pocket limit), if the total percentage increase in the cost-sharing requirement exceeds the “maximum percentage increase” (the increase in the overall medical care component of the Consumer Price Index for All Urban Consumers [CPI-U] plus 15 percentage points), measured from March 23, 2010.
- An increase in a fixed-amount copayment, if the total increase in exceeds the greater of (i) \$5 increased by medical inflation measured from March 23, 2010, or (ii) the “maximum percentage increase” (the increase in the overall medical care component of the Consumer Price Index for All Urban Consumers [CPI-U] plus 15 percentage points), measured from March 23, 2010.
- A decrease in the employer or employee organization’s contribution rate toward the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percentage points. The contribution rate means the amount of contributions made by an employer or employee organization compared to the total cost of coverage, expressed as a percentage. The cost of coverage is determined in the same way the premium is calculated for COBRA continuation coverage purposes.
- A decrease in or addition of a new annual limit on the dollar value of benefits (however, plans with an existing lifetime limit are permitted to adopt an overall annual limit at a dollar value that is lower than the dollar value of the plan’s lifetime limit, subject to agency guidance regarding restrictions on annual limits).

Q6 What types of changes can be made without losing grandfathered health plan coverage status?

- A6 The following changes do not cause a plan or coverage to lose grandfathered status:
- Enhancing or adding to existing benefits.
 - Changes to premiums amounts.

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- Voluntary changes to increase benefits, to conform to required legal changes (including Health Care Reform mandates), and to voluntarily adopt Health Care Reform requirements.
- Changes to a self-insured plan's third party administrator.
- Coverage changes effective after March 23, 2010 made pursuant to a filing with a State insurance department made on or before March 23, 2010.
- Plan or coverage changes effective after March 23, 2010 made pursuant to a legally binding contract entered into on or before March 23, 2010.
- Plan changes effective after March 23, 2010 made pursuant to written amendments to a plan that were adopted on or before March 23, 2010.
- Plan or coverage changes adopted prior to June 14, 2010 that would otherwise cause the plan or insurance coverage to lose grandfathered health plan status, if such changes are revoked or modified effective as of the first day of the first plan year on or after September 23, 2010.
- Other actions not specifically prohibited in the guidance (e.g., amending plan documents or insurance policies to incorporate modified administrative procedures).

In addition, recognizing that health insurance issuers and group health plans may have made design changes since March 23, 2010, the informal guidance states that changes made in good faith compliance with the Health Care Reform grandfathering requirements prior to June 14, 2010 may be disregarded by government regulators for enforcement purposes if the changes only modestly exceed the permitted changes described above. However, health insurance issuers and group health plans should not rely on this good faith compliance argument because it is not included in the formal, binding guidance; to ensure retention of grandfathered status, changes made between March 23, 2010 and June 14, 2010 that would cause the coverage or plan to lose grandfathered status should be revoked as described above.

Q7 How do the grandfathering rules apply to collectively-bargained plans?

A7 Insured health plan coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before March 23, 2010 is grandfathered health plan coverage at least until the date the last of the collective bargaining agreements relating to the coverage in effect on March 23, 2010 terminates (the "Termination Date"). A coverage amendment made to conform to a requirement added by the market reform provisions added in Health Care Reform is not treated as a termination of the collective bargaining agreement. As an exception to normal grandfathering rules, changing the insurance issuer during the period of a collective bargaining agreement will not cause a loss in grandfathered health plan status. After the Termination Date, the coverage is treated as grandfathered health plan coverage until it loses grandfathered status under one of the situations described above in this FAQ. The determination of grandfathered status is made by considering changes to the terms of the coverage since March 23, 2010. Therefore, changes made during the period of a collective bargaining agreement could cause the plan to lose grandfathered status immediately upon the Termination Date.

There is no special grandfathering rule for self-insured collectively bargained plans. Therefore, a self-insured plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers is only a grandfathered health plan to the extent that it satisfies the requirements described above and does not make any changes that result in the loss of grandfathered health plan status.

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There is no delayed effective date for Health Care Reform requirements that apply to non-collectively bargained plans. The guidance clarifies that grandfathered collectively bargained health plans are subject to the same requirements as other grandfathered health plans and must comply with the requirements at the same time as non-collectively bargained plans. Therefore, changes may be required to bring a collectively bargained health plan into compliance with Health Care Reform in the middle of a collectively bargaining agreement period.

References to "Health Care Reform" in this FAQ are to the Patient Protection And Affordable Care Act (as amended by the Health Care and Education Reconciliation Act of 2010) and implementing guidance. This FAQ may be modified or replaced in the future to reflect on-going developments and other clarifications relating to implementation of Health Care Reform.

This information has been compiled for informational purposes only and is being provided in an effort to identify some of the benefit changes and other reforms that may be required as a result of the Patient Protection and Affordable Care Act ("PPACA"), otherwise known as Health Care Reform. This is not intended to serve as legal advice. If you have any questions about how to comply with the PPACA, you should consult your legal counsel. Regulations and guidance on specific provisions of the PPACA have been and will continue to be provided by the U.S. Department of Health and Human Services ("HHS") and/or other agencies. The information provided reflects Wellmark's understanding of the most current information and is subject to change without further notice. Please note that plan benefits and rates are subject to change and may be revised based on guidance and regulations issued by HHS or other agencies. Wellmark makes no representation as to the impact of plan changes on a plan's grandfathered status or interpretation or implementation of any other provisions of PPACA. Any questions about Wellmark's approach to the PPACA may be referred to your Wellmark account representative.