

## Grandfather Plans

*Updated 11.17.10 due to grandfather clause amendment*

(Balance of objectives of preserving the right to maintain existing coverage with the goals of expanding access to and improving the quality of health coverage)

Eligibility for Grandfather status: no elimination of substantial benefits, no plan structure changing (such as switching from a health reimbursement account to a major medical coverage) no changes in provider network, increase percentage of cost share requirements (20% estimate), increase in copayments, employer decreases contribution rate, increase in deductible, insurance company change, change in drug formulary, HIPAA Title I and Healthcare Reform hierarchy has not been established.

*Amendment: applies to changes to group health insurance coverage that are effective on or after November 15, 2010. The amendment does not apply retroactively to changes to group health insurance coverage that were not effective before November 15, 2010. Although, grandfathered plan can now change policies or issuers without automatically losing grandfathered status, the plan will still cease to be a grandfathered plan if the new policy includes changes that are prohibited by the regulations.*

Healthcare Reform Plan Compliance Requirements	Healthcare Reform Plan Options until 2014
Prohibition of Lifetime Maximums	Reasonable and allowable annual limits on essential benefits is allowed as long as limits are <b>NOT</b> less than: <ul style="list-style-type: none"> <li>• \$750,000 for policy years beginning on or after September 23, 2010;</li> <li>• 1.25 million for policy years beginning on or after September 2011 but before September 23, 2012; or</li> <li>• \$2 million for policy years beginning on or before January 1, 2014</li> </ul>
<ul style="list-style-type: none"> <li>➤ Extension of pre-tax coverage up to the attainment of age (26) for dependents/non-dependents who are not eligible for employer sponsored healthcare benefits. <b>Prior to 2014 compliance will be mandated.</b></li> </ul>	
<ul style="list-style-type: none"> <li>➤ No Calendar Year Dollar Maximums on Essential Benefits defined as: <ul style="list-style-type: none"> <li>• ambulatory patient services</li> <li>• emergency services</li> <li>• hospitalization</li> <li>• maternity</li> <li>• newborn care</li> <li>• mental health and substance use disorder</li> <li>• services including behavioral health treatment</li> <li>• rehabilitative and habilitative services and devices</li> <li>• laboratory services</li> <li>• preventive and wellness services</li> <li>• chronic disease management</li> <li>• pediatric services including oral and vision care (pediatric services defined as up to age 21)</li> </ul> </li> </ul>	
Prohibition of pre-existing limitation applied for individuals under the age of 19 years of age	<ul style="list-style-type: none"> <li>➤ Preventive/Wellness: no covered individual cost-share. (Estimated Cost 4-7%)</li> <li>➤ Preventive/Wellness no covered individual network cost share/US Preventive Services Task Force. Examples of such benefits include: <ul style="list-style-type: none"> <li>• Preventive Services: Colon cancer screenings, prenatal screenings, screenings for diabetes, cholesterol and blood pressure testing and tobacco cessation counseling</li> <li>• Routine Vaccines: Immunizations</li> <li>• Prevention for Children: Pediatrician visits, vision and hearing screenings, developmental assessments, immunizations, and screening and counseling to address obesity and help children maintain a healthy weight.</li> <li>• Preventive care to Women: biennial mammograms at age 40,</li> </ul> </li> </ul>

Healthcare Reform Plan Compliance Requirements	Healthcare Reform Plan Options until 2014
	<p>pap smears at least every three years, genetic counseling for breast cancer risk, screening for osteoporosis in women age 65 and older, breastfeeding education</p> <ul style="list-style-type: none"> <li>• Other: STD, smoking cessation, weight management, evidence based screenings such as: depression, obesity, STD infection, visual impairment, lipid disorders, phenylketonuria, cervical cancer anemia, rubella, HIV, HEP A, syphilis, autism, sickle metabolic and hearing screenings</li> </ul>
Compliance with uniform explanation of coverage documents and standardized definitions	<ul style="list-style-type: none"> <li>➤ Standard Appeal Process (TAT)/maintain data 6 years, stating 24 hour Turnaround Time.</li> <li>➤ <b>Rules set process for claims appeals:</b> For plan years beginning on or after September 23,               <ol style="list-style-type: none"> <li>(1) Must give claimants up <b>to four months to request an external review</b> after an adverse claim or benefit decision.</li> <li>(2) A preliminary review of that request must be conducted within <b>five business days of it receipt.</b></li> <li>(3) Plan must issue a <b>written notification of its decision to the claimant</b> within one business day of completing the preliminary review.</li> <li>(4) If the preliminary review finds an <b>external review</b> is needed, the request must be referred to an independent review organization <b>accredited by URAC</b> or similar nationally recognized accrediting organization, which <b>has 45 days</b> to render a final coverage decision.</li> <li>(5) <b>Self-insured plans must contract with at least three accredited review organizations.</b></li> <li>(6) Claimant can request an expedited review for a medical condition that could seriously jeopardize life, health or the ability to regain maximum function IRO must complete an expedited review within <b>72 hours.</b></li> </ol> </li> </ul>
Compliance with previous past HIPAA portability and nondiscrimination requirements and the genetic information	Nondiscrimination in health care
Prior Notification for OB-GYN and Emergent Care Prohibits	Discrimination based on salary
Emergency Care visits (network and non-network) paid at same benefit level	<ul style="list-style-type: none"> <li>➤ Discrimination on health status</li> <li>➤ Coverage for eligible services within clinical trials</li> </ul>
Over the Counter Medications paid under Section 125 and HRA plans must have a prescriber prescription.	Fair health insurance premiums
2012 Employer notice to employees about Health Insurance Exchange	Guaranteed availability of coverage
2014 Prohibited waiting periods in excess of 90 days	Guaranteed renewability of coverage
Prohibition on rescissions	Ensuring quality of care
Each Plan can be independently grandfathered if an employer provides more than one plan option	Emergency services
If the employer creates a different premium tier as long as employers subsidy is not greater than a 5% differential, grandfather status should not be lost	Patient protections
	Non-essential wellness benefits (ambiguous)
	Comprehensive health insurance coverage (applicable to issuers in the individual and small group markets)

Plan Document must include a statement, in any plan materials provided to participants or beneficiaries describing the benefits provided under the plan or the health insurance coverage plan, stating compliance with grandfathered health plans within the meaning of section 1251 of the Affordable Care Act and providing contact

information for questions and complaints. Please verify interpretation and implementation guidelines with employer's legal counsel.

**Comments:**

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