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What Are the Benefits of Having a Grandfathered Plan?

A grandfathered plan is essentially a health plan that existed on March 23, 2010 (the day the Affordable Care Act (ACA) was enacted) and has not had certain prohibited changes made to it since then. This Legislative Brief summarizes the benefits of having a grandfathered plan.

WHAT DOES GRANDFATHERED STATUS MEAN?

Grandfathered plans do not have to comply with some ACA provisions. On the other hand, losing grandfathered status means that a plan would have to comply with additional ACA requirements.

Employers should keep in mind that they are restricted in the benefit and cost changes they can make to grandfathered plans. Significant changes that reduce a plan's benefits or increase costs for participants will cause the plan to lose its grandfathered status. A plan may maintain its grandfathered status even after Jan. 1, 2014, when many key health care reform changes became effective.

> At each renewal, employers will need to decide whether to make significant changes to plan benefits and costs and lose grandfathered status, or to skip or minimize those changes and retain grandfathered status. An employer may find that it makes sense to give up grandfathered status and comply with the additional ACA requirements to be able to make more significant changes to its health plan.

WHICH ACA RULES CAN GRANDFATHERED PLANS AVOID?

Grandfathered health plans are exempt from the following ACA 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. Additional preventive health services for women must be covered without cost-sharing effective for plan years beginning on or after Aug. 1, 2012.
- ***Patient Protections***. Effective for plan years beginning on or after Sept. 23, 2010, the ACA requires the following protections for patients:
    - 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); and
    - Group health plans and group or individual health insurance policies that provide OB/GYN care may not require preauthorization or referral for that care.
- ***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***. 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.
- ***Improved 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 improved internal appeals process and meet minimum requirements for external reviews.
- ***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 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, group health plans must comply with a cost-sharing limit with respect to their coverage of essential health benefits. This cost-sharing limit is an overall annual limit (or an out-of-pocket maximum) for self-only coverage and family coverage, which is subject to annual adjustment for inflation. The out-of-pocket maximum applies to all non-grandfathered health plans. This includes, for example, self-insured health plans and insured health plans of any size.
- ***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.

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