

Advantages and Disadvantages of Grandfathering

What is grandfathering?

“Grandfathering” means that some plans are exempt from some Health Care Reform provisions.

Will Grandfathering help to keep my costs down? Yes and No

Yes: The primary exception permitted under a grandfathered plan is the full coverage of preventive services. Other exemptions allowed for grandfathered plans do not have a material impact on benefits and therefore are not expected to increase costs.

Yes: Non-Grandfathered plans are required to cover out-of-network emergency room services at the same copayment or coinsurance rate as in-network emergency room services. Non-Grandfathered plans are required to use the prudent layperson standard when paying emergency room claims and they will be prohibited from requiring referrals or prior authorization when a participant receives treatment at an in-network or out-of-network emergency room.

No: You will not be able to make substantial changes to your cost sharing or employee contributions which may lead to higher overall costs.

No: Most plans cover preventive services because they see the value of reducing overall costs by preventing serious illness. In fact, prevention leads to happier, healthier and more productive employees.

For example:

A typical employer wishing to remain grandfathered would not be able to:

- Increase any coinsurance amounts
- Significantly increase any copayment amounts

What health care reform provisions do I avoid by remaining grandfathered?

- Preventive services covered in full
- Coverage for individuals participating in clinical trials
- Reporting requirements to HHS
 - Financial
 - Quality of care
- Appeals process changes

What health care reform provisions are still mandated even if I am grandfathered?

- Prohibition on lifetime and annual limits
- Extension of dependent to Age 26 (Grandfathered plans do not have to provide dependent coverage until 2014 if the adult child has another offer of coverage of employer-based coverage aside from coverage through a parent.)
- No exclusion of pre-existing conditions
- Prohibition of excessive waiting periods
- No rescissions

HEALTHCARE REFORM PROVISION	GRANDFATHERED PLANS	NON-GRANFATHERED PLANS
• Prohibition of pre-existing condition exclusion	Does not apply on 9/23/10, except that no pre-existing can apply to participants under age 19.	Applies for Plan Years beginning on or after 9/23/10
• Coverage of recommended Preventative services covered in full	Does not apply.	Applies for Plan Years beginning on or after 9/23/10
• Coverage for individuals participating in clinical trials	Does not apply.	Applies for Plan Years beginning on or after 1/1/14
• Patient Protections - Access of Emergency care, gynecological care, choice of PCP	Does not apply.	Applies for Plan Years beginning on or after 9/23/10
• Reporting requirements to HHS (financial and quality of care)	Does not apply.	Applies for Plan Years beginning on or after 9/23/10
• Appeals Process – Plans must provide “external review” process	Does not apply	Applies for Plan Years beginning on or after 9/23/10
• Prohibition of Lifetime Limit and restricted annual limits	Lifetime limits must be removed and restricted annual limits may apply for Plan Years beginning on or after 9/23/10. Effective 1/1/14, Plans must remove all lifetime and annual limits.	Applies for Plan Years beginning on or after 9/23/10
• Extension of Dependent Coverage to Age 26	Applies for Plan Years beginning on or after 9/23/10 *	Applies for Plan Years beginning on or after 9/23/10
• Prohibition of rescissions-Plan can not rescind coverage except in the case of fraud or intentional misrepresentation	Applies for Plan Years beginning on or after 9/23/10	Applies for Plan Years beginning on or after 9/23/10
• Prohibition of excessive waiting periods, (in excess of 90 days)	Does not apply until 1/1/14	Does not apply until 1/1/14
• Uniform explanation of coverage (EOB)	Applies for Plan Years beginning on or after 9/23/10**	Applies for Plan Years beginning on or after 9/23/10**

* Until January 1, 2014 Grandfathered Plans may exclude from coverage those Dependents whom are eligible for other employer sponsored group coverage.

** The Department of Health and Human Services must establish the standards within 12 months of the date of enactment (March 23, 2010) and the summary must be provided within 24 months after the enactment (March 23, 2012)