

Health Care Reform Update: What grandfathered status means and how it impacts your health plan.

Dear Employer,

The Patient Protection and Affordable Care Act (PPACA) distinguishes between health plans that existed before PPACA was enacted on March 23, 2010 and those that came into existence after that date.

Grandfathered plans are group health plans that existed before the law's enactment. Non-grandfathered plans are new health plans or plans modified after the law's enactment. This distinction is important because grandfathered health plans are, in some cases, exempt from certain PPACA requirements.

The Department of Health and Human Services recently released regulations that further define grandfathered plans and how health plans can lose their grandfathered status. There may be additional grandfathering guidelines and regulations from the federal government in the near future.

Please read the enclosed brochure, which provides an overview of grandfathering for employer groups. This brochure can help you decide if you'd like your plan to be grandfathered. If you would like to retain your health plan's grandfathered status, please contact your HMSA account representative within 30 days. If you do not contact your HMSA representative within 30 days, your health plan will automatically become a non-grandfathered plan.

As always, HMSA will continue to inform you of any changes and update you with the latest information on how national health care reform affects your employees' health plan.

For additional information on how PPACA may affect your health plan's grandfathered status, visit www.healthreform.gov/about/grandfathering.html.

Visit hmsa.com/reform to learn more and to read HMSA's health care reform blog. You can also share your thoughts, concerns and suggestions on Twitter @LetsTalkReform.

Sincerely,



Antonio J. Saguibo Jr.
Vice President
Account Management & Sales

Enc.

Health Care Reform



Grandfathering: An Employer Overview

HMSA



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Grandfathering and Employers: An Overview

The Patient Protection and Affordable Care Act (PPACA) distinguishes between health plans that existed before the March 23, 2010, PPACA enactment and those that came into existence afterward. This distinction is important because grandfathered health plans are, in some cases, exempt from certain PPACA requirements. The Department of Health and Human Services (HHS) recently released regulations that further define grandfathered plans and in what cases health plans can lose their grandfathered status.

- **Grandfathered plans** are group health plans that existed before the law was enacted.
 - At least one person must have been covered by the benefit plan option on or before March 23, 2010, for the plan to be considered grandfathered.

– Grandfathering status is determined at a benefit plan level. This means that your PPO, HMO, or any other plans you offer are evaluated separately.

- **Non-grandfathered plans** are new health plans or plans modified after the law's enactment.

HMSA is committed to keeping you informed about the latest developments in health care reform and how it will affect a health plan's grandfathered status. For additional information on PPACA, visit www.healthcare.gov. HMSA's website, hmsa.com/reform, has updated information about health care reform.

Grandfathering: Employers' Compliance Requirements

You have grandfathered status and can maintain your existing health plan coverage if it took effect on or before March 23, 2010. Grandfathered plans are exempt from certain requirements and can make routine health plan changes that include:

- Cost adjustments to keep pace with medical inflation.
- Adding new benefits.
- Making modest adjustments to existing benefits.
- Voluntarily adopting new patient-protection policies under the new law, or making changes to comply with state or other federal laws.

However, grandfathered health plans are restricted from making certain changes. Grandfathered plans CANNOT:

- Reduce or change employer contributions based on the cost of coverage or a formula of more than 5 percent below the contribution rate on March 23, 2010.
- Eliminate all or substantially all benefits to diagnose or treat health conditions.
- Increase coinsurance charges above March 23, 2010, levels.
- Increase fixed amount cost-sharing, such as deductibles and out-of-pocket maximums, by more than medical inflation plus 15 percent from March 23, 2010, levels.
- Increase copayment amounts that exceed: (1) a total percentage (measured from March 23, 2010) that is more than medical inflation plus 15 percent, or (2) \$5, increased annually by medical inflation.

- Reduce an overall annual dollar limit or add a new overall annual dollar limit, compared to the limit effective March 23, 2010.

If a group loses its grandfathered status due to significant benefit changes or increased costs to employees, then employees in these plans will gain additional new benefits, including:

- Coverage of recommended prevention services with no cost sharing.
- Patient protections, such as guaranteed access to ob/gyns and pediatricians.

In accordance with Department of Labor regulations, grandfathered health 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 health 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 provided under the plan, explain that the plan believes that it is a grandfathered health plan as defined by PPACA, and provide contact information for questions or complaints.

Important Note

Penalties may be imposed on employers and health plans that fail to adhere to the grandfathering provisions. HMSA will seek indemnification of penalties and damages from employers who trigger a loss of grandfather status and fail to inform HMSA within a reasonable amount of time to make the appropriate changes to their plan.

The regulations governing grandfathered plans are complex and employers may not be able to maintain such plans if they make certain changes. Please consult a professional tax adviser or lawyer for details and further explanation of the regulations.

What HMSA is Doing to Comply with Health Care Reform

Applies to GRANDFATHERED AND NON-GRANDFATHERED Health Plans:

Annual Dollar Limits

- Prohibits annual dollar limits on essential benefits.
- “Per beneficiary” annual limits are permissible for items and services that are not part of the essential health benefits.
- Prior to 2014, restricted annual limits may be permitted. Restricted limits on essential health benefits are as defined by the HHS.

Lifetime Dollar Limits

- Prohibits lifetime dollar limits on essential benefits.

Rescissions

- Prevents plans from dropping health care coverage for reasons other than fraud, intentional misrepresentation, or failure to pay timely dues.

Medical Loss Ratios (MLRs)

- Requires health plans to report their MLRs on a federal website.
- Provides rebates for MLRs below required levels starting in 2011 (80 percent for individuals and small groups; 85 percent for large groups).
- Requires the National Association of Insurance Commissioners to establish uniform definitions and standards for MLR calculations.

HMSA is working with the Blue Cross and Blue Shield Association to comply with these requirements. HMSA believes that our plans meet MLR levels required by law.

Internet Portal

- Requires HHS to establish a website that helps individuals and small employers identify affordable health care coverage options.

HMSA provided the required information for the website to HHS before the July 1 deadline and will provide additional information before the next deadline in September 2010.

Pre-Existing Conditions

- Prohibits plans from imposing pre-existing condition exclusions on children under age 19 for plan years beginning on or after Sept. 23, 2010. This requirement will extend to all individuals beginning in 2014.

Applies to NON-GRANDFATHERED Health Plans only:

Preventive Health Services

Requires coverage of the following preventive services with no cost sharing:

- U.S. Preventive Services Task Force rated “A” or “B” recommendations.
- Immunizations recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices.
- Preventive care and screenings provided in guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents.
- Additional preventive care and screenings for women provided in HRSA guidelines.

HMSA already provides many of the preventive services required by reform at no cost sharing. We will determine how to provide additional preventive services to members.

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Transparency and Disclosure

- Requires plans to submit certain information to HHS and the state insurance commissioner and make it available to the public.

HMSA is working to determine the best way to provide this information and is waiting for further guidance from HHS.

Access to Providers

- Plans that require individuals to designate a primary care provider (PCP) can choose any available participating PCP or pediatrician.
- Plans must provide direct access to ob/gyns.

HMSA already complies with these requirements.

Emergency Services

- Requires plans to cover emergency care without prior authorization for plan years beginning on or after Sept. 23, 2010.
- Copayments and coinsurance for out-of-network providers will be no more than that for in-network providers.
- Members may be required to pay the difference between what the out-of-network provider charges and what HMSA is required to pay under federal regulations.

Appeals

- Requires plans to have an internal claims and appeals process that incorporates Department of Labor procedures.
- Plans must also meet additional external review requirements.

HMSA has examined the current appeals processes and is making changes to comply with the law.

This information is based on Blue Cross and Blue Shield Association's review of the national health care reform legislation and is not intended to impart legal advice. Interpretations of the reform legislation vary, and efforts will be made to present and update accurate information.

This overview is intended as an educational tool only. It does not replace a more rigorous review of the law's applicability to individual circumstances and attendant legal counsel and should not be relied upon as legal or compliance advice.

Analysis is ongoing and additional guidance is also anticipated from the Department of Health and Human Services.

Additionally, some reform regulations may differ for particular members enrolled in certain programs such as the Federal Employee Program. Those members are encouraged to consult with their benefit administrators for specific details.



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