

**LEGISLATIVE BRIEF:**

**NEWS RELATED TO THE PATIENT PROTECTION AND AFFORDABLE CARE ACT  
PLAN DESIGN REQUIREMENTS FOR GRANDFATHERED  
AND NON-GRANDFATHERED PLANS UNDER PPACA**

The Patient Protection and Affordable Care Act (PPACA) includes certain mandated benefits, some of them taking effect for plan years beginning after September 23, 2010. This includes employer plans, although the requirements differ for “grandfathered plans” versus plans that are not grandfathered. As a reminder, a “grandfathered plan” is any group health plan or individual coverage that was in effect on March 23, 2010, the date of the new law’s enactment.

No information exists yet on what might cause plans to lose their grandfathered status. Until this is known, employers should proceed carefully with plan changes.

**Mandates for Plans Starting after September 23, 2010, Including Grandfathered Plans**

- » **Adult dependent coverage:** Plans must cover children until their 26th birthday. Plans must provide a 30-day open-enrollment period to qualified dependents and may not require qualified dependents to pay more for coverage than similarly situated dependents. For grandfathered plans only, this requirement will not apply to adult children eligible for their own employer plan, but this special rule is set to expire in 2014. The value of adult dependent coverage is excluded from the employee’s income through the end of the taxable year in which the child turns 26, and the IRS is allowing amendments to cafeteria plan elections to allow pre-tax payment of adult child premiums.
- » **No lifetime dollar limits:** Lifetime limits on coverage will be prohibited.
- » **Annual limits restricted:** Except as provided by the Secretary of Health and Human Services (HHS) via regulations, no annual dollar limits on “essential health benefits” that includes at least the following:
  - › Ambulatory patient services
  - › Hospitalization
  - › Laboratory services
  - › Emergency services
  - › Maternity and newborn care
  - › Prescription drugs
  - › Pediatric services, including oral and vision care
  - › Rehabilitative and habilitative services and devices
  - › Preventive and wellness services and chronic disease management
  - › Mental health and substance abuse services, including behavioral health services
  - › Annual limits will be altogether prohibited beginning in 2014.
- » **Pre-existing conditions exclusions for children:** Plans may not limit coverage for pre-existing conditions for children under age 19 beginning six months after enactment.
- » **No Rescissions:** Plans may not rescind coverage except for fraud or misrepresentation.

**Additional Mandates for Non-Grandfathered Plans Starting after September 23, 2010**

- » **Coverage of Preventive Care:** Plans must cover certain preventive services without cost sharing.
- » **Clinical Trials:** Plans must cover clinical trials for life-threatening diseases subject to a plan’s normal restrictions on benefits and out-of-network providers.
- » **Internal and External Appeals:** Plans must abide by internal and external appeals standards to be determined by regulations.
- » **Nondiscrimination:** Nondiscrimination rules that currently apply to self-funded plans will apply to insured plans. Grandfather applies but not to newly promoted executives.
- » **Choice of Provider:** Plans must allow a child to designate a pediatrician as a primary care provider and may not require authorization for an OB-GYN.
- » **Emergency Care:** Must be covered without prior authorization and treated as in network.



## Longer Term Provisions Impacting Benefit Design for Grandfathered Plans

- » **FSA Limits:** Employee salary reduction contributions to FSAs limited to \$2,500 effective January 1, 2013, and indexed thereafter.
- » **Retiree Drug Subsidy:** Employers lose deductibility for Medicare Part D retiree drug program subsidies effective January 1, 2013.
- » **Waiting periods:** Waiting periods cannot exceed 90 days without penalty effective January 1, 2014.
- » **Pre-existing conditions:** Exclusions all out prohibited January 1, 2014.
- » **Wellness Rewards:** Wellness incentives may increase from 20 to 30 percent, with HHS having the authority to increase to 50 percent after January 1, 2014.
- » **Excise Tax:** A 40 percent excise tax on high cost benefits takes effect January 1, 2018.

## Benefit Provisions for Non-Grandfathered Plans after 2014

- » **Cost sharing limits:** Limits cost-sharing to the HSA qualified high deductible health plan out-of-pocket maximums (currently \$5,000/\$10,000).
- » **Deductible Limits:** Small group deductibles cannot exceed \$2,000 for individual coverage and \$4,000 for family coverage which may be increased by maximum health FSA contributions.
- » **Health Status:** Plans will not be able to discriminate based on health status.
- » **Essential Benefits and Rating Restrictions:** Small group, individual and exchange plans must cover certain benefits and abide by rating restrictions.

**If you have questions about your plan's compliance with these requirements or how to implement them, please contact your attorney.**

## Additional Resources:

- » New Interim Final Regulations: <http://www.dol.gov/ebsa/pdf/dependentcoverage.pdf>
- » Fact Sheet: <http://www.dol.gov/ebsa/newsroom/fsdependentcoverage.html>
- » Frequently Asked Questions: <http://www.dol.gov/ebsa/faqs/faq-dependentcoverage.html>

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