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ADMINISTRATIVE NOTICE: 2013-06

Date: December 11, 2013

To: All Health Insurance Carriers / Providers

From: Insurance Commissioner

Subject: Documentation and Maintenance of Grandfathered Plans and Policies

The new health care reform allows for certain group health insurance plans and individual policies to be exempt from many changes required under the Affordable Care Act. These "grandfathered" plans and policies are defined as an individual or group health plan in which one or more individuals was enrolled on or before March 23, 2010 and has not undergone significant changes in benefits covered or costs to the consumer.[1] These plans and policies under grandfathered status are subject to strict regulations.[2] This notice has been issued to ensure that all CNMI health insurance carriers are fully aware of the requirements to maintain a grandfathered plan or policy.

To maintain grandfathered status, a plan must look at its benefits and contribution levels as of March 23, 2010 and must not:

- Eliminate all or substantially all benefits to diagnose or treat a particular condition[3]
- Increase cost-sharing percentages[4]
- Increase fixed-amount cost-sharing other than co-pays, such as deductibles or out of pocket limits, by more than medical inflation (currently 9.5 percent) plus 15 percentage points[5]
- Increase fixed-amount co-pays by more than medical inflation plus 15 percentage points, or by $5 plus medical inflation, whichever is greater[6]
- Decrease the employer contribution rate towards the cost of coverage by more than 5 percentage points for any tier of coverage for any class of similarly situated individuals[7]
- Impose an annual limit on the dollar value of all benefits below specified amounts[8] (Annual limits will be prohibited completely for grandfathered group plans for plan years beginning on or after January 1st, 2014, and lifetime limits are currently prohibited for all grandfathered plans and policies.[9])

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[1] 45 C.F.R. § 147.140(a)(1)
[2] See 45 C.F.R. § 147.140 for complete regulations governing grandfathered plans and policies.
[3] 45 C.F.R. § 147.140(g)(1)(i)
[4] 45 C.F.R. § 147.140(g)(1)(ii)
[5] 45 C.F.R. § 147.140(g)(1)(iii)
[6] 45 C.F.R. § 147.140(g)(1)(iv)
[7] 45 C.F.R. § 147.140(g)(1)(v)
[8] 45 C.F.R. § 147.140(g)(1)(vi)
[9] Public Health Service Act § 2711

The plan also must:

- Include a notice about the plan's grandfathered status[10] in any plan materials describing the benefits under the plan or coverage, such as enrollment materials and summary plan descriptions, and provide contact information for questions and complaints. (The notice does not need to be included with the SBC or EOBs.) A model notice is available at: www.dol.gov/ebsa/grandfatherregmodelnotice.doc and is also listed in regulation at 45 C.F.R. § 147.140(a)(2)(ii).
- Maintain records of its plan design and contribution levels as of March 23, 2010 and any changes since that date which are sufficient to verify its status as a grandfathered health plan, and make these records available upon request.[11] These records must be maintained for as long as the carrier takes the position that the plan is a grandfathered plan.

Please note that grandfathered plans or policies must still comply with several provisions of the Patient Protection and Affordable Care Act (PPACA). Some of these provisions are already in effect, while others go into effect for plans or policy years beginning on or after January 1, 2014. The PPACA made amendments to the Public Health Service Act and under these amendments:

All grandfathered plans in the individual and group insurance market must:

- extend dependent coverage until age 26 (§ 2714);
- comply with uniform explanation of coverage documents and standardized definition requirements (i.e., Summary of Benefits and Coverage) (§ 2715);
- not include lifetime limits on the dollar value of essential health benefits (§ 2711);
- not rescind coverage except in the case of fraud or intentional misrepresentation (§ 2712);
- comply with the medical loss ratio provision (§ 2718); and,
- comply with parity requirements in mental health and substance use disorder benefits (§ 2726).

In addition to the above provisions, all grandfathered plans sold in the group market must:

- not use pre-existing condition exclusions* (§ 2704);
- comply with new provisions regarding wellness programs* (§ 2705(j));
- not apply any waiting period in excess of 90 days* (§ 2708); and
- not establish annual limits on the dollar value of essential health benefits*[12] (§ 2711).

*For plans with an effective date of January 1, 2014 or later

[10] 45 C.F.R. § 147.140(a)(2)(i)
[11] 45 C.F.R. § 147.140(a)(3)
[12] Lifetime limit prohibition is currently in effect.