# MARKET REFORMS (ACA & HIPAA) GRANDFATHERED PLAN PROVISIONS

## Self-Funded, Non-Federal Governmental Group Health Plans / Compliance Checklist

Note: This chart is a summary of certain provisions applicable to grandfathered, **self-funded, non-Federal governmental group** health plans, and is not an exhaustive list of all legal requirements.

| Federal Law Citations | Summary of the Provision | Notes | Links to Guidance/FAQs/Resources | Contract Compliant? |
|---|---|---|---|---|
| **Opt-Out Elections:** PHS Act § 2722(a)(2) (42 U.S.C. § 300gg-21(a)(2)) | | | | |
| 45 C.F.R. § 146.180<br><br>**Effective Date:**<br>Plan years beginning on or after September 23, 2010. | Sponsors of self-funded, non-Federal governmental plans are permitted to elect to exempt those plans ("opt out") from the following provisions of title XXVII of the Public Health Service (PHS) Act:<br>1. Standards relating to benefits for newborns and mothers (Newborns and Mothers Health Protection Act of 1996);<br>2. Parity in the application of certain limits to mental health and substance use disorder benefits (Mental Health Parity and Addiction Equity Act of 2008);<br>3. Required coverage for reconstructive surgery following mastectomies (Women's Health and Cancer Rights Act of 1998);<br>4. Coverage of dependent students on a medically necessary leave of absence Michelle's Law, 2008.<br><br>If a self-funded, non-Federal governmental plan correctly complies with the requirements for electing and maintaining an opt-out, it will **not** be considered out of compliance with the provisions from which it is exempted. | **FYI only:**<br>Prior to the enactment of the ACA, sponsors of self-funded, non-federal governmental plans could opt out of seven provisions of the PHS Act. In addition to the four provisions enumerated in the summary section, sponsors of these plans could opt out of:<br>1. Limitations on pre-existing condition exclusion periods;<br>2. Requirements for special enrollment periods;<br>3. Prohibitions against discriminating against individual participants and beneficiaries based on health status.<br><br>The regulation (45 CFR §146.180) was updated on March 21, 2014 to clarify that these plans may no longer opt out of these provisions. If a plan document includes an exemption from all seven PHS Act provisions, it is out of compliance with the regulation.<br><br>**Notice Requirement:** | CCIIO webpage:<br>https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/non_federal_governmental_plans_04072011.html<br><br>Regulations and Guidance:<br>http://www.gpo.gov/fdsys/pkg/FR-2014-03-21/pdf/2014-06134.pdf<br><br>https://www.cms.gov/CCIIO/Resources/Files/Downloads/opt_out_memo.pdf<br><br>https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/hipaa-exemption-guidance-7212014.pdf<br><br>https://www.cms.gov/CCIIO/Resources/Files/hipaa_exemption_election_instructions_04072011.html | ☐ YES<br>☐ NO<br><br>Opted out of:<br>☐ NMHPA<br>☐ MHPAEA<br>☐ WHCRA<br>☐ Michelle's |

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| | | Plan administrators must annually provide enrollees notice that they opted out of the PHS Act provisions. Notice language is provided in the regulation, and should be provided to enrollees in the plan document or in a separate mailing.<br><br>**Electronic Opt-Outs:**<br>All opt outs must be made electronically via the HIOS NonFed module as described in the updated regulation, and in the guidance (see link to the right). | | |
| **Grandfathered Status:** Affordable Care Act §1251 | | | | |
| 45 C.F.R. § 147.140<br><br>**Effective Date:**<br>Plan years beginning on or after March 23, 2010. | Section 1251, as implemented in 45 C.F.R. §147.140, preserves the enrollee's right to maintain coverage existing as of March 23, 2010, (the date of enactment of the Affordable Care Act) as long as it meets the below criteria. If a self-funded, non-Federal governmental plan meets the criteria to qualify for grandfathered status, it is subject only to a subset of the otherwise applicable ACA market rules, as described in this checklist.<br><br>To qualify as a grandfathered plan the self-funded, non-Federal, governmental plan must have:<br>• At least one individual enrolled on March 23, 2010; | The plan does not have to continuously cover the same individual from March 23, 2010, through the present: it must only cover at least one individual throughout that period.<br><br>Plan or sponsor does not cease to be grandfathered if it enters into a policy, certificate, or contract of insurance with a new issuer, as long as the plan maintains the benefits in accordance with the regulations.<br><br>"Maximum percentage increase" is defined as medical inflation (defined in 45 C.F.R. § 147.140(g)(3)(i) expressed as a percentage plus 15 percentage points. | CCIIO webpage:<br>https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Grandfathered-Plans.html<br><br>Regulations and Guidance:<br>Final Rule:<br>https://www.federalregister.gov/articles/2015/11/18/2015-29294/final-rules-for-grandfathered-plans-preexisting-condition-exclusions-lifetime-and-annual-limits | ☐ YES<br>☐ NO |

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| | • At least one individual covered continuously since March 23, 2010;<br><br>To maintain grandfathered status, the plan must not make the following changes, known as "paragraph g changes" which will cause cessation of grandfathered status:<br>• Elimination of all or substantially all benefits to diagnose or treat a particular condition;<br>• Any increase in a percentage cost-sharing requirement (such as co-insurance) measured from March 23, 2010;<br>• Any increase in a fixed-amount cost-sharing requirement other than a copayment (e.g., a deductible or out-of-pocket limit) if the total increase in the cost-sharing requirement measured from March 23, 2010, exceeds the maximum percentage increase (see notes for the definition of "maximum percentage increase");<br>• An increase in a fixed-amount copayment, measured from March 23, 2010, to the date of the increase that exceeds the greater of:<br>o $5, adjusted for medical inflation (see notes for definition).<br>o The maximum percentage increase (see notes for definition), determined by expressing the total increase in copayment as a percentage. | "Contribution rate based on cost of coverage" and "contribution rate based on formula" are defined in 45 C.F.R. § 147.140(g)(3)(iii).<br><br>If a plan is maintained pursuant to one or more collective bargaining agreements (CBAs) that were ratified before March 23, 2010, the coverage is grandfathered health plan coverage at least until the last of the CBAs relating to the coverage in effect on March 23, 2010, terminates. If an amendment is made to a CBA to bring it into conformity with the ACA, it should not be treated as a termination of the CBA(s). Effectively, this delays the application of a number of ACA provisions to health plans maintained under CBAs.<br><br>Provisions that do not apply to grandfathered health plans:<br>PHS Act sections 2701, 2702, 2703, 2705, 2706, 2707, 2709 (concerning clinical trials), 2713, 2715A, 2716, 2717, 2719, and 2719A.<br><br>Provisions that do not apply to grandfathered coverage in the individual market (but do apply to group coverage): | IFR:<br>https://www.federalregister.gov/articles/2010/06/17/2010-14488/interim-final-rules-for-group-health-plans-and-health-insurance-coverage-relating-to-status-as-a<br><br>Amendment to IFR:<br>https://www.federalregister.gov/articles/2010/11/17/2010-28861/amendment-to-the-interim-final-rules-for-group-health-plans-and-health-insurance-coverage-relating<br><br>FAQs and Factsheets:<br>https://www.cms.gov/CCIIO/Resources/Files/factsheet_grandfather_amendment.html<br><br>https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs4.html<br>(See all questions) | |

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| | • Decrease in contribution rate by employers and employee organizations:<br>o If the plan decreases its contribution rate based on cost of coverage by more than 5 percentage points below the contribution rate for the coverage period including March 23, 2010.<br>o If the plan decreases its contribution rate based on a formula (for example, hours worked or tons of coal mined) toward the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percent below the contribution rate for the coverage period including March 23, 2010.<br>• Changes in annual limits: addition of a new annual limit after March 23, 2010, reduction in an annual limit after March 23, 2010, or addition of an overall annual limit to a plan that had an overall lifetime limit as of March 23, 2010.<br><br>The plan must also maintain documentation of plan or policy terms on March 23, 2010, and any other records necessary to verify, explain, or clarify the plan's status as a grandfathered health plan and must make this documentation available upon request. And the plan must comply with the | PHS Act sections 2704 and 2711 as it concerns annual limits.<br><br>PHS Act section 2714 is applicable to grandfathered plans. | | |

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| | grandfathering provision's notice requirement to maintain grandfathered status. | | | |
| Notice Requirement<br><br>45 C.F.R. § 147.140 | Disclosure of grandfathered status—to maintain grandfathered status, a plan must include a statement:<br>• In any summary of benefits provided under the plan;<br>• That the plan believes it is a grandfathered health plan within the meaning of section 1251 of the Affordable Care Act;<br>• And must provide contact information for questions and complaints. | The regulation includes model notice language at 45 C.F.R. § 147.140(a)(2)(ii).<br><br>Generally, if the plan does not provide notice to participants and beneficiaries, grandfathered status is lost as of the plan year the notice was not provided.<br><br>In the case of plans with CBAs, until all CBAs expire, notice is not required to maintain such status (see above). | DOL grandfathered status website, model notice language (link on this page):<br>http://www.dol.gov/ebsa/healthreform/regulations/grandfatheredhealthplans.html | |
| **Preexisting Condition Exclusions:** PHS Act § 2704 (42 U.S.C. § 300gg-3) | | | | |
| 45 C.F.R. § 147.108<br><br>**Effective Date:**<br>For individuals under 19: Plan years beginning on or after September 23, 2010.<br><br>For all individuals: Plan years beginning on or after January 1, 2014. | A self-funded, non-Federal governmental plan may not impose any preexisting condition exclusion (as defined in 45 C.F.R. § 144.103).<br><br>Plans may not apply pre-existing condition exclusions:<br>• To enrollees under age 19, for plan years beginning on or after 9/23/2010;<br>• To all enrollees for plan years beginning on or after 01/01/2014. | Note: this includes initially denying coverage of a child under age 19 due to a pre-existing condition. | Regulations and Guidance:<br>Final Rule:<br>https://www.federalregister.gov/articles/2015/11/18/2015-29294/final-rules-for-grandfathered-plans-preexisting-condition-exclusions-lifetime-and-annual-limits<br><br>http://webapps.dol.gov/FederalRegister/PdfDisplay.aspx?DocId=23983 | ☐ YES<br>☐ NO |
| **Prohibition on Excessive Waiting Periods:** PHS Act § 2708 (42 U.S.C. § 300gg-7) | | | | |

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| 45 C.F.R. § 147.116<br><br>**Effective Date:**<br>Plan years beginning on or after January 1, 2014. | A self-funded, non-Federal, governmental group health plan shall not apply any waiting period that exceeds 90 days ("Waiting period" is defined in PHS Act section 2704(b)(4) and interpreted in 45 C.F.R. § 147.116). | A waiting period is the period that must pass with respect to an individual who is otherwise eligible to be covered for benefits under the terms of the plan before coverage for that individual can be effective.<br><br>Restrictions on benefit-specific waiting periods do not apply to self-funded, non-Federal, governmental group health plans. | Final Rule:<br>http://www.gpo.gov/fdsys/pkg/FR-2014-02-24/pdf/2014-03809.pdf | ☐ YES<br>☐ NO |
| **Lifetime Limits:** PHS Act § 2711 (42 U.S.C. § 300gg-11) | | | | |
| 45 C.F.R. § 147.126<br><br>**Effective Date:**<br>Plan years beginning on or after September 23, 2010. | Lifetime limits on the dollar value of EHBs are prohibited (see non-grandfathered ACA HIPAA checklist for list of EHB categories under PHS Act § 2707 and ACA § 1302). | Self-funded, non-Federal governmental plans are not required to provide EHBs. However, if they do provide such benefits, they are prohibited from placing lifetime dollar limits on them.<br><br>Specific covered services that are not EHBs are not subject to the prohibition on lifetime dollar limits.<br><br>If the limit is not a dollar limit (i.e., a visit limit), the lifetime limit prohibition would not be triggered, unless the visit limit incorporates a specific dollar amount per visit. | Regulation:<br>Final Rule:<br>https://www.federalregister.gov/articles/2015/11/18/2015-29294/final-rules-for-grandfathered-plans-preexisting-condition-exclusions-lifetime-and-annual-limits<br><br>45 C.F.R. § 147.126 -<br>http://www.gpo.gov/fdsys/pkg/CFR-2010-title45-vol1/xml/CFR-2010-title45-vol1-sec147-126.xml<br><br>CCIIO webpage:<br>http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Annual-Limits.html | ☐ YES<br>☐ NO |
| **Annual Limits:** PHS Act § 2711 (42 U.S.C. § 300gg-11) | | | | |

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| 45 C.F.R. § 147.126<br><br>**Effective Date:**<br>Plan years beginning on or after September 23, 2010. | Restricted annual limits on the dollar value of EHBs were permitted for plan years beginning before 1/1/2014.<br>Annual limits on the dollar value of EHBs are prohibited for plan years beginning on or after January 1, 2014. | As with lifetime limits, self-funded, non-Federal governmental plans are not required to provide EHBs. However, if these benefits are provided, plans may not place annual limits on the dollar value of the benefit.<br><br>Plans may impose annual limits on specific covered benefits that are not EHBs.<br><br>If the limit is not a dollar limit (i.e., an annual visit limit), the annual limit prohibition would not be triggered, unless the visit limit incorporates a specific dollar amount per visit. | Regulation:<br>Final Rule:<br>https://www.federalregister.gov/articles/2015/11/18/2015-29294/final-rules-for-grandfathered-plans-preexisting-condition-exclusions-lifetime-and-annual-limits<br><br>45 C.F.R. § 147.126 -<br>http://www.gpo.gov/fdsys/pkg/CFR-2010-title45-vol1/xml/CFR-2010-title45-vol1-sec147-126.xml<br><br>CCIIO webpage:<br>http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Annual-Limits.html | ☐ YES<br>☐ NO |
| **Rescissions:** PHS Act § 2712 (42 U.S.C. § 300gg-12) | | | | |
| 45 C.F.R. § 147.128<br><br>**Effective Date:**<br>Plan years beginning on or after September 23, 2010. | Coverage may only be rescinded in the event of an act or omission that constitutes fraud or intentional misrepresentation of a material fact.<br><br>A discontinuation or cancellation with retroactive effect due to non-payment of premiums is not a rescission.<br><br>A self-funded, non-Federal governmental plan is required to provide thirty (30) days' advance written notice prior to rescinding coverage. The | An inadvertent misstatement of fact does not constitute fraud (e.g., forgetting to mention psychologist visits when completing a medical history on enrollment). | Regulation:<br>Regulations and Guidance:<br><br>Final Rule:<br>https://www.federalregister.gov/articles/2015/11/18/2015-29294/final-rules-for-grandfathered-plans-preexisting-condition-exclusions-lifetime-and-annual-limits<br><br>45 C.F.R. § 147.128 - | ☐ YES<br>☐ NO |

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| | enrollee may appeal this decision under 45 C.F.R. § 147.136 (Appeals provision). | | http://www.gpo.gov/fdsys/pkg/CFR-2010-title45-vol1/xml/CFR-2010-title45-vol1-sec147-128.xml<br><br>Fact Sheets and FAQs: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs2.html | |
| **Dependent Coverage until 26 Years of Age:** PHS Act § 2714 (42 U.S.C. § 300gg-14) | | | | |
| 45 C.F.R. § 147.120<br><br>**Effective Date:**<br>Plan years beginning on or after September 23, 2010. | Extension of dependent coverage until 26 years of age<br><br>Self-funded, non-Federal governmental plans that provide for dependent coverage for children must continue to make such coverage available until age 26. | The plan need not extend coverage to such dependents' spouses or children.<br><br>Dependent eligibility can only be defined in terms of the relationship between the child and the subscriber. Requirements for eligibility cannot include:<br>• Financial dependency;<br>• Residency (including living or working in the plan service area)<br>• Eligibility for other coverage;<br>• Student status;<br>• Employment; and<br>• Marital status<br><br>Terms of dependent coverage cannot vary based on age for children under age 26. For example: plans cannot impose a premium | CCIIO webpage: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Coverage-for-Young-Adults.html<br><br>Regulations and Guidance:<br>Final Rule:<br>https://www.federalregister.gov/articles/2015/11/18/2015-29294/final-rules-for-grandfathered-plans-preexisting-condition-exclusions-lifetime-and-annual-limits<br><br>Fact Sheets and FAQs: http://www.cms.gov/CCIIO/Resources/Files/adult_child_fact_sheet.html | ☐ YES<br>☐ NO |

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| | | surcharge for dependents over 18. Note that this does not prohibit plans from imposing age rating. | http://www.cms.gov/CCIIO/Resources/Files/adult_child_faq.html<br><br>http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html (see Q14)<br><br>http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html# (see Q5) | |
| **Summary of Benefits and Coverage (SBC):** PHS Act § 2715 (42 U.S.C. § 300gg-15) | | | | |
| 45 C.F.R. § 147.200<br><br>**Effective Date:**<br>Plan years beginning on or after September 23, 2012. | Uniform explanation of coverage documents and standardized definitions. | Please see separate checklist for handling SBC reviews. | CCIIO webpage:<br>http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html | ☐ YES<br>☐ NO |
| **Additional Public Health Service Act Protections** | | | | |
| **Newborns and Mothers Health Protection Act (1996)**<br>PHS Act § 2725<br>PHS Act § 2751<br>42 USC § 300gg-25 | NMHPA: Standards relating to benefits for newborns and mothers | | CCIIO webpage:<br>https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/NMHPA.html | Opted Out?<br>☐ YES<br>☐ NO<br><br>If NO, is contract compliant? |

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| 42 USC 300gg-51<br>45 CFR § 146.130<br>45 CFR § 148.170 | | | Fact Sheets & FAQs:<br>https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html | ☐ YES<br>☐ NO |
| **Mental Health Parity and Addiction Equity Act (2008)**<br>PHS Act § 2726<br>42 USC § 300gg-26 (cross-references 29 USC § 1185(a))<br>45 CFR § 146.136 | MHPAEA: Parity in the application of certain limits to mental health and substance use disorder benefits. Non-Federal governmental health plans with 50 or fewer employees (100 or fewer in some states) are exempt from MHPAEA requirements.<br><br>MHPAEA does not require a plan offer mental health or substance use disorder (MH/SUD) benefits; only that if it does offer such benefits, it comply with MHPAEA's parity provisions. | Parity requirements must be met in the way MH/SUD and medical/surgical benefits are treated with respect to:<br>• Annual and lifetime dollar limits;<br>• Financial requirements;<br>• Out of network benefits;<br>• Treatment limitations:<br>o Quantitative, e.g.: visit limits, days of coverage;<br>o Non-quantitative, e.g.: medical management standards, formulary design, or methods for determining reasonable and customary amounts).<br><br>The law's requirements apply only to those self-funded, non-Federal, governmental health plans that choose to include MH/SUD benefits in their benefit packages. | Regulation & Guidance:<br>http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf<br><br>Fact Sheets & FAQs:<br>https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html<br>DOL Fact Sheet:<br>http://www.dol.gov/ebsa/newsroom/fsmhpaea.html | Opted Out?<br>☐ YES<br>☐ NO<br><br>If NO, is contract compliant?<br>☐ YES<br>☐ NO |
| **Women's Health and Cancer Rights Act (1998)**<br>PHS Act § 2727<br>PHSA § 2752<br>42 USC § 300gg-52 (cross-references 29 USC § 1185(b)) | WHCRA: Required coverage for reconstructive surgery following mastectomies | WHCRA is a self-implementing statute, so no regulations have been drafted. | CCIIO webpage:<br>https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/WHCRA.html<br><br>Fact Sheets & FAQs: | Opted Out?<br>☐ YES<br>☐ NO<br><br>If NO, is contract compliant?<br>☐ YES |

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| 42 USC § 300gg-27 | | | https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html | ☐ NO |
| **Michelle's Law (2008)**<br>PHS Act § 2728<br>PHS Act § 2753<br>42 USC § 300gg-28<br>42 USC § 300gg-54 | Coverage of students on a medically necessary leave of absence.<br><br>Law is limited in applicability based on the application of other regulations that provide overlapping protections. See limited example in Notes section. | Michelle's Law is applicable in the following limited example: a plan offers dependent coverage to individuals up to age 29, but conditions the coverage for those 27 years and older on having full-time student status. If such a student takes a medically necessary leave of absence, they are protected from loss of coverage. | No guidance on CCIIO website. | Opted Out?<br>☐ YES<br>☐ NO<br><br>If NO, is contract compliant?<br>☐ YES<br>☐ NO |