



CLOSE-UP: Health Care Reform and Grandfathering

June 24, 2010

The Department of Health and Human Services, the Department of Labor and the Internal Revenue Service (Agencies) have issued the interim final rule on “grandfathered” health plans with a public comment period of 60 days. While the rule has the effect of a final regulation, the federal agencies that issued the rule will review the public comments they receive and possibly make additional changes when the regulation is issued in final form. Federal regulators may also issue clarifications to address certain issues that arise under these regulations in an ongoing manner through administrative guidance.

Definition of Grandfathered

The Patient Protection and Affordable Care Act (PPACA) provides that certain group health plans and health insurance coverage existing as of March 23, 2010 are subject to only certain provisions of PPACA. These plans and health insurance coverage are referred to as grandfathered health plans.

Policies issued in the group market to new entities or individuals after March 23, 2010 are not considered grandfathered, even if the products sold to those new subscribers were offered in the group market before March 23, 2010.

Advantages of being grandfathered

By choosing grandfather status, plans are exempt from several provisions of the recently passed health care reform legislation. Grandfathered plans do not have to:

- Eliminate cost-sharing for certain preventive services as recommended by governmental agencies
- Prohibit discrimination based on salary for coverage or premiums
- Provide choice/direct access requirements allowing members to designate any participating primary care physician or pediatrician they choose
- Eliminate the requirement that female members must obtain a prior authorization to visit a participating obstetrician or gynecologist

- Eliminate the requirement for prior authorization for coverage or additional cost-sharing for emergency hospital services, regardless of whether the provider is in the plan’s network
- Put an internal appeals/external reviews process in place for coverage determinations and claims decisions

Becoming grandfathered

First, employers must decide if they wish to continue to offer the plan or coverage they had in effect on March 23, 2010 with limited changes required to achieve grandfathered status. Then, employers or insurers must inform members of the decision to remain a grandfathered plan. The grandfather regulation provides illustrations to help guide employers’ decisions. When employers tell employees about their health plans, employers who believe their health plans are grandfathered must include information about their status and maintain records needed to verify such status.

Changes grandfathered plans can make

Grandfathered health plans will be able to make routine changes to their policies and still maintain their grandfather status. Generally, insurers and plan sponsors may make certain changes without losing grandfather status, including:

- Raise premiums to reasonably keep pace with health care costs
- Increase deductibles and other out-of-pocket costs “within limits”
- Continue to enroll new employees and new family members
- Make changes to comply with federal or state law
- Increase benefits or voluntarily comply with provisions of PPACA

- Change plan structure, such as switching from a health reimbursement arrangement to major medical coverage or from insured to self-funded coverage
- Make changes to your plan's provider network
- Make changes to a prescription drug formulary
- Make changes to accommodate mergers and acquisitions
- Change your third party administrator

NOTE: These permissible changes are only detailed in the rule's preamble, and do not have the same weight as they would if they were included in the interim final rule itself. In addition, the Agencies are specifically requesting comments on the extent to which plan structure, provider network and drug formulary changes should be permitted.

The preamble does not provide examples of what changes can be made to comply with the rule without loss of grandfather status. Some laws, such as the Mental Health Parity and Addiction Equity Act, provide choices of how to comply, some of which could include more cost sharing and reduced benefits. It is unclear how changes to comply with laws that involve reduced benefits or increased cost sharing, when other compliance choices are available, will be treated under the rule.

Reporting requirements for grandfathered plans

To maintain grandfathered status, a plan or coverage must include a statement in any plan materials provided to participants and beneficiaries describing the benefits provided under the plan or health insurance coverage. The statement must indicate that the plan or coverage believes it is a grandfathered health plan within the meaning of PPACA and must provide contact information for the plan beneficiaries to ask questions or make comments.

In addition to notice, a grandfathered plan must maintain records documenting the terms of the plan or coverage in effect on March 23, 2010, and any other documents necessary to verify, explain or clarify its status as a grandfathered plan. A grandfathered plan must also make such records available for examination for as long as the plan or issuer takes the position that the plan or coverage is a grandfathered plan.

Changes causing loss of grandfather status

Compared to their policies in effect on March 23, 2010, grandfathered plans cannot:

- **Significantly cut or reduce benefits** – For example, a grandfathered plan that decides to no longer cover care for people with diabetes, cystic fibrosis or HIV/AIDS will lose grandfather status. Eliminating one necessary benefit element to diagnose or treat a specific condition is considered the same as eliminating all necessary benefits to diagnose or treat a particular condition.
- **Raise coinsurance charges** – Plans with coinsurance that require a member to pay a fixed percentage of a charge (for example, 20 percent of a hospital bill) cannot increase the coinsurance percentage and remain grandfathered.
- **Significantly raise copayment charges** – Plans that require members to pay co-payments, a fixed-dollar amount for doctor's office visits and other services, can only increase those co-payments above the level in effect on March 23, 2010 by no more than the greater of (a) \$5 (adjusted annually for medical inflation), or (b) to the sum of medical inflation plus 15 percentage points. For example, if a plan raises its copayment from \$30 to \$50 over the next two years, it will lose its grandfathered status.
- **Significantly raise deductibles** – Many plans require members to pay the first bills they receive each year (for example, the first \$500, \$1,000 or \$1,500 a year). Grandfathered plans can only increase these deductibles measured from March 23, 2010 by a percentage equal to medical inflation plus 15 percentage points. In recent years, medical costs have risen an average of four to five percent, so this formula would allow deductibles to go up, for example, by 19 to 20 percent between 2010 and 2011, or by 23 to 25 percent between 2010 and 2012. For example, for a plan with a \$1,000 annual deductible, this would mean if they had a hike of \$190 or \$200 from 2010 to 2011, their plan could then increase the deductible again by another \$50 the following year.
- **Significantly lower employer contributions** – Many employers pay a portion of their employees' premium for insurance and this is usually deducted from their paychecks. Grandfathered plans cannot decrease the percent of premiums the employer

pays by more than five percentage points (for example, decrease their own share and increase the workers' share of premium from 15 percent to 25 percent).

- **Add or tighten an annual limit on what the insurer pays** – Some insurers limit the amount that they will pay for covered services each year. To retain their grandfathered status, plans cannot tighten any annual dollar limit in place as of March 23, 2010. Moreover, plans that do not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit.
- **Change insurance companies** – If an employer decides to buy insurance for its employees from a different insurance company, the new coverage will not be considered a grandfathered plan. This does not apply when employers with self-funded plans switch plan administrators (TPAs) or to employers with collective bargaining agreements during the period of the collective bargaining agreement ratified prior to March 23, 2010.
- **Restructure** – Employers may not engage in a merger, acquisition or similar business restructuring, if the principal purpose of the action is to cover new individuals under the grandfathered plan.

Collective bargaining agreements

Fully-insured health plans maintained in accordance with one or more collective bargaining agreements ratified prior to March 23, 2010 can maintain their grandfathered status at least until the date on which the last agreement in effect on March 23, 2010 terminates. After that point, these plans are subject to the same rules as other health plans. They will lose their grandfathered status if they make any of the substantial changes described above.

Collectively bargained grandfathered plans (insured and self-funded) are subject to the same requirements (including effective date requirements) under PPACA as other grandfathered plans. Retiree-only and "excepted health plans," such as dental plans, long-term care insurance or Medigap, are exempt from the insurance reforms.

Grace period for changes after March 23, 2010

If plans make changes after March 23, 2010, but before the interim regulations were published, a grace period applies. Employers and health insurance issuers can revoke or modify changes made after March 23, 2010 and adopted prior to June 14, 2010, which might otherwise cause the plan to lose grandfathered status. Under this rule, grandfather status is preserved if the changes are revoked, and the plan or coverage is modified, effective the first day of the first plan year beginning on or after September 23, 2010 to bring the terms within the limits for retaining grandfather status.



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