



CLOSE-UP: Update on Grandfathering

Revised August 31, 2010

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 grandfathered for purposes of the coverage mandates under PPACA. Plans that remain grandfathered 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.*

How does a plan become grandfathered?

Employers must decide if they wish to continue to offer the plan or coverage they had in effect on March 23, 2010 with only limited changes, and they must meet various other requirements to maintain grandfathered status. The grandfather regulation provides illustrations to help guide employers' decisions. Employers who believe their health plans are grandfathered must provide notice of the plan's grandfathered status and maintain records needed to verify that status. A model notice provided in the grandfather regulations can be used to satisfy the notice requirement.

What are the changes grandfathered plans do *not* need to make?

A plan that maintains grandfather status is *exempt* from several provisions of the health care reform legislation. Following is a list of the current exemptions. As we receive information about additional exemptions that will become effective in the future, we will update this Close-Up.

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 a new internal appeals/external reviews process in place for coverage determinations and claims decisions

What changes *must* grandfathered plans make?

A plan that maintains grandfather status is still required to comply with a number of the PPACA provisions. Effective for the first plan year beginning on or after September 23, 2010, grandfathered plans must:

- Prohibit pre-existing condition exclusions for individuals under age 19 (and all individuals for plan years beginning on or after January 1, 2014)
- Prohibit lifetime limits on coverage
- Restrict annual limits before plan years beginning on or after January 1, 2014, and prohibit all annual limits for plan years beginning on or after January 1, 2014
- Prohibit rescissions other than for fraud or intentional misrepresentation of material fact
- Extend dependent child coverage to age 26, unless the dependent has other eligible employer-sponsored health coverage available
- Report medical loss ratio with rebates to enrollees where required ratios are not met
- Provide uniform explanation of coverage documents (implementation date to be determined)

What changes *can* grandfathered plans make?

Grandfathered plans are able to make routine changes and still maintain grandfather status, including:

- Raise premiums to reasonably keep pace with health care costs provided the change does not cause the plan to exceed applicable limits
- Increase deductibles and other out-of-pocket costs "within limits"

- Continue to enroll new employees and new family members, subject to an anti-abuse rule
- Make changes to comply with Federal or state law, provided such change does not cause the plan to exceed applicable limits
- Increase benefits or voluntarily comply with provisions of PPACA, provided such change does not cause the plan to exceed applicable limits
- 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
- Changing a third party administrator (for self-insured plans)

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 regulation 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. If a plan makes changes to comply with other laws that involve reduced benefits or increased cost sharing, when other compliance choices are available, it may cause the plan to lose grandfather status.

What are the notice and 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 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.

Although the grandfather regulation does not state when this notice must be provided, issuers are presuming that it must be provided in plan materials upon renewal for plan years beginning on or after September 23, 2010.

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.

What changes cause 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 or substantially 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 beyond the amount in effect on March 23, 2010 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) the sum of medical inflation plus 15 percentage points (see explanation below). 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 (see explanation below).

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 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 that determine employer contribution rate based on cost of coverage cannot decrease the employer contribution rate below the rate in effect on March 23, 2010 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). Grandfathered plans that determine employer contribution rate based on a formula (such as hours worked or tons of coal mined) cannot decrease the employer contribution rate below the rate in effect on March 23, 2010 by more than five 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 decrease 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 and meets the following thresholds established for annual limits:
 - \$750,000 for plan years beginning on or after September, 23, 2010
 - \$1,250,000 for plan years beginning on or after September 23, 2011
 - \$2,000,000 for plan years beginning on or after September 23, 2012
 - For plan years beginning on or after January 1, 2014, an annual limit on the dollar amount of benefits for any individual is prohibited.
- **Change insurance companies –** If an employer decides to buy insurance for its employees from a different insurance company after March 23, 2010, 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 –** If the principal purpose of a merger, acquisition, or similar business restructuring is to cover new individuals under the grandfathered health plan, the plan ceases to be a grandfathered health plan. The goal of this rule, as stated in the preamble to the grandfather regulations is to prevent grandfather status from being bought and sold as a commodity in commercial transactions.

What is medical inflation?

Medical inflation, for purposes of the grandfather regulations, is defined as the increase since March 2010 in the Overall Medical Care Component (OMCC) of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by the Department of Labor using the 1982–1984 base of 100. In March 2010, the OMCC was 387.142.

How is medical inflation calculated?

The increase in the OMCC is computed by subtracting 387.142 from the OMCC for any month in the 12 months before the new change is to take effect and then dividing that amount by 387.142. The example below helps to illustrate how this works.

On March 23, 2010, a grandfathered health plan has a copayment requirement of \$30 per office visit for specialists. The plan is subsequently amended to increase the copayment requirement to \$40. Within the 12-month period before the \$40 copayment takes effect, the greatest value of the OMCC is 475.

- The increase in the copayment from \$30 to \$40, expressed as a percentage, is 33.33 percent ($40 - 30 = 10$; $10 \div 30 = 0.3333$; $0.3333 = 33.33$ percent). Medical inflation from March 2010 is 0.2269 ($475 - 387.142 = 87.858$; $87.858 \div 387.142 = 0.2269$).
- The maximum percentage increase permitted is 37.69 percent ($0.2269 = 22.69$ percent; 22.69 percent + 15 percent = 37.69 percent). Because 33.33% does not exceed 37.69 percent, the change in the co-payment requirement at that time allows the plan to maintain grandfathered status.

Although the regulations indicate that the increase must be determined as of the effective date of the increase, the OMCC is computed on a monthly basis by using the relevant CPI-U figure for any of the 12 months preceding the month in which the coverage change is to take effect.

Presumably, the month in which the CPI-U figure was the highest during the relevant 12-month look-back period will be used for this purpose, resulting in the highest possible medical inflation (and maximum percentage increase) number.

Can employers with multiple plan designs change one and stay grandfathered?

If an employer offers several plan options and only makes changes to one or some of the plan options, the plan options that have not been amended (or are amended within limits allowed under the grandfather regulations) will retain grandfather status. Grandfathering determination is made

separately with respect to each benefit package available under a group health plan or health coverage.

Can employers eliminate one of several plans and stay grandfathered?

An employer could lose grandfathered status by eliminating one of several plans. Although employees may voluntarily switch plan options as permitted under the plans, an anti-abuse rule under the grandfather regulation applies to situations where an employer eliminates a plan option. Under the anti-abuse rule, the remaining plan option will lose grandfather status if:

- Employees are transferred into the remaining option, and
- An employer compares the terms of the remaining option with the terms of the eliminated option (in effect on March 23, 2010) and, hypothetically, amends the eliminated option to match the remaining option, and
- There is no bona fide employment-based reason to transfer the employees into the remaining option (changing the terms or cost of coverage is not a bona fide employment-based reason.)

What about HRAs and changing deductibles?

Plans may lose grandfathered status if they increase the plan's deductible, even though the employee's share of the deductible does not change from the amount on March 23, 2010.

The grandfather regulation does not distinguish between a plan sponsor that passes the increase in deductible to plan participants or a plan sponsor that absorbs (or self-funds) the increase. Therefore, there is a risk that the regulating departments (Treasury, Labor and Health and Human Services) would look to the terms of the plan or policy as revised (i.e., the increased deductible) and view the employer's decision to fund the deductible as a non-enforceable, voluntary decision that an employer may make year to year. Groups in this situation that wish to retain grandfather status should seek legal advice before making this change.

If I lose grandfather status, can I regain it?

Generally, once a plan loses grandfather status, it must implement all applicable PPACA requirements and cannot regain grandfather status. A plan must determine for itself whether any requirement has positive, negative or neutral consequences based upon its own unique circumstances and business objectives.

There is a very narrow grace period that allows plans to reverse changes that were adopted after March 23, 2010 and prior to June 14, 2010, provided that the revocation or modification is effective no later than the

first plan year beginning on or after September 23, 2010. There appears to be no allowance for plans to revoke or modify changes that are effective after June 14, 2010. It seems that plans that renewed after June 14, 2010 must comply with the terms of the regulation in its entirety, without the benefit of any grace period, or lose grandfather status.

How does grandfathering apply to 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 collective bargaining 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 have made or 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. This means that collectively bargained health plans do not have the benefit of a delayed effective date for purposes of implementing applicable provisions. Retiree-only and "excepted health plans," such as dental plans, long-term care insurance or Medigap, are exempt from the insurance reforms.

NOTE: Please see the attached chart for a summary of provisions that apply to grandfathered versus non-grandfathered plans.

This document provides updated information originally posted on June 24, 2010 and August 10, 2010

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Please note that information contained in this Close-Up is based on our understanding of the Patient Protection and Affordable Care Act of 2010, as amended, and guidance as of the date of this publication.

How Grandfathering Impacts Health Insurance Plans

As of August 31, 2010

Health Care Reform Provision	Effective Date <i>(first plan year beginning on or after date provided unless otherwise noted)</i>	Grandfathered Plans			Non-Grandfathered Plans		
		Individual	Fully-Insured Group	Self-Insured Group	Individual	Fully-Insured Group	Self-Insured Group
Elimination of Lifetime Dollar Limits	9/23/10	Yes	Yes	Yes	Yes	Yes	Yes
Restrictions on Annual Dollar Limits ¹	9/23/10	No	Yes	Yes	Yes	Yes	Yes
Prohibition on Pre-Existing Condition Exclusions for Children Under Age 19	9/23/10	No	Yes	Yes	Yes	Yes	Yes
Internal Appeals/External Reviews Process	9/23/10	No	No	No	Yes	Yes	Yes
Ban on Rescissions	9/23/10	Yes	Yes	Yes	Yes	Yes	Yes
Extension of Dependent Coverage to Age 26	9/23/10	Yes	Yes ²	Yes ²	Yes	Yes	Yes
Coverage for Preventive Services	9/23/10	No	No	No	Yes	Yes	Yes
Choice/Direct Access Requirements	9/23/10	No	No	No	Yes	Yes	Yes
Coverage for Emergency Services	9/23/10	No	No	No	Yes	Yes	Yes
Medical Loss Ratio (MLR) Reporting Requirement	9/23/10	Yes	Yes	No	Yes	Yes	No
Medical Loss Ratio Rebates	1/1/2011	Yes	Yes	No	Yes	Yes	No
Ban on Discrimination Based on Salary	9/23/10	No	No	No <i>(applicable prior to PPACA)</i>	No	Yes	No <i>(applicable prior to PPACA)</i>
Uniform Explanation of Coverage Documents	By 3/23/2012	Yes	Yes	Yes	Yes	Yes	Yes
Provision of Additional Information Reporting Requirement	By 3/23/2012	Yes	Yes	Yes	Yes	Yes	Yes

¹ For plan years beginning on 1/1/14 and after, annual limits are prohibited.

² For plan years prior to 1/1/14, not applicable if dependent is eligible for other employer-sponsored coverage.

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How Grandfathering Impacts Health Insurance Plans (continued)

As of August 31, 2010

Health Care Reform Provision	Effective Date <i>(first plan year beginning on or after date provided unless otherwise noted)</i>	Grandfathered Plans			Non-Grandfathered Plans		
		Individual	Fully-Insured Group	Self-Insured Group	Individual	Fully-Insured Group	Self-Insured Group
Requirement							
Quality Reporting	By 3/23/2012	No	No	No	Yes	Yes	Yes
Auto Enrollment Provision ³	By 3/23/2012 <i>(awaiting regulations)</i>	No	Yes	Yes	No	Yes	Yes
Prohibition on Excessive Waiting Periods	2014	No	Yes	Yes	No	Yes	Yes
Coverage for Approved Clinical Trials	2014	No	No	No	Yes	Yes	Yes
Rating Limitations ⁴	2014	No	No	No	Yes	Yes	No
Guaranteed Issue	2014	No	No	No	Yes	Yes	No
Guaranteed Renewability	2014	No	No	No	Yes	Yes	No
Prohibited Discrimination Based on Health Status	2014	No	No	No	Yes	Yes	Yes
Prohibited Discrimination on Providers Acting Within Scope of License	2014	No	No	No	Yes	Yes	Yes
Must Cover Essential Health Benefits ⁵	2014	No	No	No	Yes	Yes	No
Must Follow Cost-Sharing Limits	2014	No	No	No	Yes	Yes	Yes
Prohibition on Pre-Existing Condition Exclusions for All Members	2014	No	Yes	Yes	Yes	Yes	Yes
“Cadillac Tax”	2018	Yes	Yes	Yes	Yes	Yes	Yes

³ Applies to employers with 200+ employees.

⁴ Applies only to individual and small group insurance coverage unless large group insurance coverage is offered through an exchange.

⁵ Applies to individual and small group insurance coverage.

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