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“Grandfathering” Rules Strike a Balance for Consumers

By Sarah Lueck

The new health reform law includes a number of insurance reforms to aid consumers, several of which will take effect this fall. But plans that existed when the law was enacted on March 23, 2010 — known as “grandfathered” plans — aren’t required to comply with some of these reforms. The law created this exception to avoid disrupting the health insurance market and to generally allow people to keep the plans they have. A key question, then, is how much a grandfathered plan can change before it is considered a new plan that must abide by the new reforms and consumer protections. This issue brief explains which reforms and consumer protections apply to grandfathered plans, what changes in a health insurance plan trigger a loss of grandfathered status, and the expected impact of grandfathering on consumers.

Which immediate reforms in the health reform law apply to grandfathered plans?

All plans, including grandfathered plans, must provide new, standardized coverage information to consumers, eliminate any limits on the amount that a plan will pay out over an enrollee’s lifetime, and make coverage available to dependents up to age 26. Plans also must provide rebates to enrollees when the plans fail to spend at least a specified percentage of premiums collected on the actual provision of health care and efforts to improve health care quality. And the law prohibits plans, including grandfathered plans, from arbitrarily revoking coverage after a beneficiary gets sick.

In addition, grandfathered *employer* plans (those provided by both small and large businesses) must abide by new restrictions on annual benefit limits and must provide coverage for children’s pre-existing medical conditions. These two requirements do *not* apply to grandfathered plans in the individual market.

Which immediate reforms do *not* apply to grandfathered plans?

The near-term reforms that do not apply to grandfathered plans include: a requirement to cover certain preventive services at no charge to enrollees, a process to review insurer rate increases deemed “unreasonable,” the right of plan enrollees to designate their primary care provider, guaranteed access to out-of-network emergency services without prior authorization, and direct access to obstetric and gynecological care without the need for a referral from another provider or prior approval from the insurer.

In 2014, other reforms take effect for new plans in the individual and small-group markets that do not apply to grandfathered plans. These include: a ban on premium variation due to health status or gender, a limit on how much more older people must pay in premiums compared to younger people, requirements that plans cover “essential health benefits” and meet a minimum level of comprehensiveness, and an annual cap on how much people must pay for deductibles, copayments and other cost-sharing charges.

Are grandfathered plans able to sign up new members?

Grandfathered plans generally cannot be sold to new customers, with two exceptions. Employees at a business that offers a grandfathered plan (whether they are new to the firm or newly signing up for coverage)



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are able to enroll. Family members of an enrollee in a grandfathered plan also can be added to the plan.

How would a plan lose grandfathered status?

The health reform law is structured to avoid forcing major changes to existing plans that would disrupt people's current coverage. At the same time, once a health plan is modified significantly compared to when health reform was enacted, it must provide the full consumer protections required under health reform.

The Administration issued an interim final regulation implementing the grandfathering provision on June 17. It allows employers and insurers to modify a plan's coverage to a reasonable degree — for example, to increase cost-sharing charges to keep up with medical-cost growth — without losing grandfathered status. But more significant changes, including those listed below, would trigger a loss of grandfathered status:

- The elimination of all or substantially all benefits to diagnose or treat a medical condition. For example, an insurer could not eliminate coverage of treatments needed for cystic fibrosis.
- An increase in the percentage of a procedure's cost that enrollees must pay, such as charging 25% of the cost of a surgery when the percentage had been 20%.
- A change in a fixed-dollar co-payment that exceeds the rate of medical inflation since enactment of health reform plus 15 percentage points, or \$5 increased by medical inflation, whichever is greater. For example, a health plan would lose grandfathered status if it raised its copayment for a physician visit to \$40 from \$20 and medical inflation since March 2010 was 7.2%. (The \$20 increase exceeds 22.2 percent — the 7.2 percent inflation rate plus 15 percentage points — and also exceeds \$5.36, or \$5 adjusted to reflect 7.2 percent medical inflation.)
- Increases in fixed-dollar cost-sharing amounts *other than* co-payments (i.e., deductibles and the total amount you must pay each year out of pocket) that exceed the rate of medical inflation since enactment of the health reform law plus 15 percentage points.
- A reduction in the share of costs an employer pays toward group health coverage, if the new employer share is more than five percentage points below the one in place when health reform was enacted.

How many plans might lose grandfathered status over time and have to provide the consumer protections contained in the health reform law?

About half of all employer plans (66 percent of small-employer plans and 45 percent of large-employer plans) could lose grandfathered status by 2013, according to mid-range federal estimates. In the individual insurance market, the federal estimate is that 40 percent to 67 percent of individual-market policies could lose grandfathered status by 2013. (Turnover is common in the individual market, which is frequently a source of short-term coverage, for example when people are between jobs.)

Some critics have argued that the grandfathering rules are overly stringent and will prevent people from keeping the coverage they have. This is incorrect. Changes that occur in people's health coverage — particularly in employer-sponsored plans — generally are the result of long-term trends that pre-date the health reform law. Employers facing rising health care costs have already been scaling back benefits and increasing what employees pay for premiums and cost-sharing. If anything, the grandfathering rules are likely to lead some employers to scale back coverage less than they otherwise would in order to avoid losing grandfathered status. When employers and insurers significantly change the plans they offer, those actions themselves prevent enrollees from keeping the coverage they had. It thus is reasonable that in such circumstances, the new plans have to comply with the consumer protections the health reform law provides.