Grandfathering

The Patient Protection and Affordable Care Act (PPACA) allows group and individual health plans that were effective on March 23, 2010 to choose to be "grandfathered." Grandfathered status would exempt these plans from certain (but not all) requirements of PPACA.

By choosing "grandfathered" status, plans would be allowed to make routine changes to their benefits and plan policies, such as:

- Modest cost increases to keep pace with medical inflation
- Changes to comply with state and federal regulations
- Adding plan benefits or slightly modifying existing plan benefits
- Voluntarily adding new consumer protections to comply with federal law

A "grandfathered" plan would lose this special status if:

- Benefits are significantly reduced
- Members' costs are significantly increased

Blue Cross & Blue Shield of Rhode Island (BCBSRI) will NOT implement "grandfathering" for individual plans and fully insured groups.

Self-insured groups

Self-insured groups may choose to "grandfather," but these groups must communicate this decision to us in writing. We will help them by creating a sign-off sheet, which will allow BCBSRI to document and keep track of each group's decision.

- BCBSRI will not monitor plan changes made by self-insured groups that choose to be "grandfathered," and BCBSRI cannot provide legal advice to groups.
- A self-insured group that elects to be "grandfathered" must monitor its plan design and contributions to ensure that it can retain this status. If a self-insured group loses its status, the group must inform us.

Note: The federal agencies that issued the regulations estimate that almost 70 percent of groups would lose "grandfathered" status by 2014.

"Grandfathered" status limitations

When groups choose the "grandfather" status, they must still comply with the following PPACA requirements:

- For the first plan year* beginning on or after September 23, 2010, groups:
    1. May not impose lifetime dollar limits on "essential health benefits."
    2. May not rescind coverage except for fraud or misreprentation.
    3. Must extend coverage to dependent children up to age 26 if the child is not eligible to enroll in employer-sponsored coverage.
    4. May not impose pre-existing condition exclusions for children under age 19.
    5. May only apply "restricted" annual dollar limits for essential health benefits.

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- Waiting periods may not exceed 90 days in plan years beginning on or after January 1, 2014.
- Groups may not impose pre-existing condition exclusions for any enrollee after the plan year beginning on or after January 1, 2014.
- Beginning with plan years that start on or after January 1, 2014, the dependent mandate applies to all children up to age 26, regardless of whether the child is eligible for employer-sponsored coverage.

Grandfathered coverage must also comply with the following provisions of the PPACA:

- Uniform coverage document requirements, subject to regulations to be issued by the Secretary of Health & Human Services (HHS) within 12 months.

The following changes would result in loss of “grandfathered” status:

- Reduction or elimination of benefits for a particular condition, including elimination of benefits for any necessary element to diagnose or treat a condition.
- Any change in percentage coinsurance from what was in effect on March 23, 2010.
- A change in flat dollar copayments, from what was in effect on March 23, 2010, in excess of the greater of (i) $5 (adjusted for medical inflation); or (ii) medical inflation plus 15 percent.
- A change in deductible or out-of-pocket maximums from what was in effect March 23, 2010, greater than medical inflation plus 15 percent.
- Certain changes to, or adoption of, overall annual benefit limits.
- A decrease of employer contribution level by more than 5 percent (for any tier of coverage) from the contribution level in effect March 23, 2010.

“Plan year” means the date specified in the group health plan’s plan document or, if no plan year is specified, the deductible or limit year, or if there is no deductible or limit year, the policy year. Because BCBSRI does not collect plan year information, we assume that each group health plan’s plan year coincides with the BCBSRI renewal date.

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