



Grandfathered Health Plans Under PPACA (P.L. 111-148)

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The Patient Protection and Affordable Care Act (P.L. 111-148, PPACA, as amended by the Health Care and Education Act, P.L. 111-152) includes provisions for the grandfathering of existing health insurance plans. Given that most Americans had private health insurance coverage on the date of enactment of PPACA, most Americans' health coverage will be affected by the grandfathering provisions.

This report addresses key questions concerning grandfathered plans (e.g., who is covered under such a plan) and insurance reforms affecting such plans, including reporting and consumer information requirements, benefits package, and access to coverage. It also addresses issues regarding the discontinuation of grandfathered plans and interaction with the individual mandate.

What Is a Grandfathered Health Plan?

A grandfathered health plan is an existing group health plan¹ or health insurance coverage (including coverage from the individual health insurance market) in which a person was enrolled on the date of enactment. Therefore, as long as a person was enrolled in a health insurance plan on March 23, 2010, that plan has been grandfathered.

Who Is Allowed Coverage Under a Grandfathered Health Plan?

Current enrollees in grandfathered health plans are allowed to re-enroll in that plan, even if renewal occurs after date of enactment. Family members are allowed to enroll in the grandfathered plan, if such enrollment is permitted under the terms of the plan in effect on the date of enactment. For grandfathered group plans, new employees (and their families) may enroll in such plans.

What Insurance Reforms Are Imposed on Grandfathered Health Plans?

Grandfathered health plans are exempt from the vast majority of the new insurance reforms. However, grandfathered plans are subject to a handful of requirements with different effective dates.²

Grandfathered health plans must comply, for plan years beginning on or after date of enactment (March 23, 2010), with the following reforms:

¹ The definition for "group health plan" includes self-insured plans.

² States have had the primary responsibility for regulating the insurance industry. To the extent that states enacted health insurance standards and requirements prior to PPACA, such state laws would *not* be preempted by the federal health reform law as long as the state laws do not prevent the application of PPACA.

- Development of uniform explanation of coverage documents.³
- Reporting of medical loss ratio⁴ and other financial information to the Secretary of Health and Human Services (the Secretary),⁵ and offering of premium rebates to enrollees if the plan did not meet specified medical loss ratios (rebate offers begin no later than January 1, 2011, and terminate on December 31, 2013).⁶

The insurance reforms to which *grandfathered health plans* must comply for plan years beginning six months on or after date of enactment (September 23, 2010) are the following:⁷

- Prohibition on lifetime limits⁸ on essential health benefits.⁹
- Prohibition on health plan rescissions.¹⁰
- Requirement to extend dependent coverage to children until the individual is 26 years old.¹¹ Prior to 2014, a child may enroll for dependent coverage on a grandfathered plan only if such individual is not eligible for employment-based health benefits.

Grandfathered *group* health plans will be required to comply with the following reforms:¹²

- Restriction on annual limits on essential health benefits provided by group health plans, for plan years beginning six months on or after date of enactment.
- Prohibition on coverage exclusions for pre-existing health conditions.¹³ For most enrollees, this provision will become effective for plan years beginning on or after January 1, 2014. However, for children under age 19, this provision will

³ No later than 12 months from the date of enactment, the Secretary will develop standards, in consultation with the National Association of Insurance Commissioners (NAIC), to implement this reform.

⁴ Medical loss ratio (MLR) typically is considered a measurement of premium value, determined by calculating the percentage of premiums spent on medical claims. Compared with a “low” medical loss ratio, a “high” MLR indicates a greater share of premiums spent on medical care than on administrative expenses or profit.

⁵ No later than December 31, 2010, the NAIC, subject to certification by the Secretary, will establish uniform definitions applicable to this reporting requirement.

⁶ The Secretary will promulgate regulations to enforce these provisions and may provide for penalties.

⁷ PPACA specifically mentioned promulgation of regulations for the dependent coverage provision, but was silent on this issue for the other two provisions. With respect to the requirement to extend dependent coverage, the Secretary will promulgate regulations to define dependents to which coverage will be made available.

⁸ Limits on benefits refers to a cap on the dollar value of benefits that the issuer of the plan will pay out for each enrollee in that plan. Such benefit limits may be imposed on an annual basis or over the lifetime of the enrollee.

⁹ For application to grandfathered plans, section 2301 of the Health Care and Education Act (“Reconciliation”) only specifies the prohibition against lifetime benefit limits included in Section 2711 of PPACA, even though Section 2711 also includes the prohibition against unreasonable annual benefit limits.

¹⁰ Rescission refers to the termination of a health insurance policy on the part of the insurance carrier that issued the policy. Rescission not only leaves the former enrollee without health coverage, but it also treats that person as if he or she were never enrolled in the rescinded plan. Consequently, the former enrollee would be responsible for all health expenses incurred when he or she was previously covered.

¹¹ For additional information, see CRS memorandum, *Health Insurance Coverage of Adult Children Up to Age 26*, by Hinda Chaikind.

¹² PPACA did not specifically mention the promulgation of regulations for these provisions.

¹³ Preexisting health conditions refers to a medical condition that was present prior to the time the person with the condition applied for insurance.

become effective for plan years beginning six months on or after date of enactment.

If Changes Are Made to a Grandfathered Health Plan, Is It Still Grandfathered or Is It a New Plan?

PPACA is silent on the question about whether changes to a plan or coverage would make it a new plan. It is not clear whether changes to covered benefits, cost-sharing requirements, actuarial value, or other plan features would be allowed under a grandfathered plan. Also, PPACA does not address instances when there are changes to the insurance carrier offering the plan (e.g., new corporate owner); it is not clear whether organizational changes would make grandfathered plans into new plans.

Nonetheless, the law gives the Secretary wide latitude with respect to implementation of many insurance reforms and other provisions. In multiple instances, the law specifies that the Secretary will promulgate regulations to implement various provisions affecting private health coverage. In addition, the inclusion of the insurance reforms under Title XXVII of PHSA indicates the intent for the Secretary to exercise broad rulemaking and enforcement authority, which preceded enactment of PPACA. For instance, regulations implementing federal health insurance requirements enacted prior to PPACA may provide insight into this issue.

Regulations implementing the Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191) included rules regarding the renewability and termination of coverage in the group market. To the extent that these regulations address how a health insurance product may continue or discontinue in the private market, such regulations may also indicate when a grandfathered plan continues or discontinues. The HIPAA regulations specify that an issuer offering group coverage “is required to renew or continue in force the coverage at the option of the plan sponsor.” In order to discontinue an insurance product, the issuer must provide “notice in writing to each plan sponsor provided that particular product in that market (and to all participants and beneficiaries covered under such coverage) of the discontinuation at least 90 days before the date the coverage will be discontinued.” Moreover, the issuer must act “uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.”¹⁴ In other words, such requirements place the decision to continue a policy on the plan sponsor. Typically, this is an employer providing health benefits to employees (and their families). And while an issuer may terminate a plan, it may do so only if it does not discriminate based on health factors, and provides advance notice of discontinuation to all enrollees and plan sponsors. Should implementation of grandfathering provisions follow this same construction, changes to a plan’s benefits or costs alone would appear to be insufficient to cause a grandfathered plan to be discontinued.

¹⁴ 45 CFR 146.152, available online at http://edocket.access.gpo.gov/cfr_2009/octqtr/45cfr146.152.htm.

Does Enrollment in a Grandfathered Health §1001 Plan Meet the Individual Mandate Requirement?

Yes. The individual mandate requires most individuals to have health insurance beginning in 2014, or potentially pay a penalty for noncompliance. Individuals will be required to maintain minimum essential coverage for themselves and their dependents. PPACA defines minimum essential coverage to include many different insurance options, including grandfathered plans.¹⁵

On a practical level, the question concerning grandfathered plans and complying with the individual mandate is relevant only to plans in the individual market. A person enrolled in any employer plan, whether the plan has been grandfathered or is new, will have met the individual mandate.

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¹⁵ “Minimum essential coverage” is defined as coverage under Medicare part A, Medicaid, the Children’s Health Insurance Program (CHIP), the TRICARE for Life program, the veteran’s health care program, the Peace Corps program, a government plan (local, state, federal) including the Federal Employees Health Benefits Program (FEHBP) and any plan established by an Indian tribal government, any plan offered in the individual, small group or large group market, a grandfathered health plan, and any other health benefits coverage, such as a state health benefits risk pool, as recognized by the HHS Secretary in coordination with the Treasury Secretary.