Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (PPACA)

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The Patient Protection and Affordable Care Act (P.L. 111-148, PPACA),[1] as amended, 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 describes grandfathered plans and summarizes the PPACA insurance reforms that will affect such plans, including the requirements concerning medical loss ratios, dependent coverage, and preexisting health condition coverage. It also discusses issues addressed during the regulation promulgation process, including the possible loss of grandfathering status.

Grandfathered Health Plans

A grandfathered health plan is an existing group health plan or health insurance coverage (including coverage from the individual health insurance market)[2] in which a person was enrolled on the date of PPACA's enactment. Therefore, as long as a person was enrolled in a health insurance plan on March 23, 2010, that plan has been grandfathered.

Current enrollees in grandfathered health plans are allowed to re-enroll in that plan, even if renewal occurs after the 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.

Insurance Reforms Applicable to Grandfathered Health Plans

Grandfathered health plans are exempt from the majority of new insurance reforms under PPACA. However, grandfathered plans are subject to a handful of requirements with different effective dates.[3]

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

- Development of uniform explanation of coverage documents.[4]
- Reporting of medical loss ratio[5] and other financial information to the Secretary of Health and Human Services (the Secretary),[6] and offering of premium rebates

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[1] For information regarding the private health insurance provisions in PPACA, see CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by Hinda Chaikind et al.

[2] The definitions for "group health plan" and "health insurance coverage" refer to prior definitions in the Public Health Service Act (PHSA). Under PHSA, "group health plans" include self-insured plans. For additional information about self-insured plans, see CRS Report R41069, *Self-Insured Health Insurance Coverage*, by Bernadette Fernandez.

[3] 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, or enact standards and requirements after PPACA, such state laws would *not* necessarily be preempted by the federal health reform law as long as the state laws do not prevent the application of PPACA.

[4] 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.

[5] Medical loss ratio (MLR) typically is considered a measurement of premium value, determined by calculating the (continued...)

to enrollees if the plan did not meet specified medical loss ratios (rebate offers begin no later than January 1, 2011).[7]

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:[8]

- Prohibition on lifetime limits[9] on essential health benefits.[10]
- Prohibition on health plan rescissions,[11] except in cases of fraud or intentional misrepresentation of material fact.
- Requirement to extend dependent coverage to children until the individual is 26 years old.[12] Prior to 2014, a child may enroll for dependent coverage under a grandfathered group plan only if such individual is not otherwise eligible for employment-based health benefits (e.g., through his or her own employer).

Grandfathered health plans must comply, *for plan years beginning on or after January 1, 2014*, with the prohibition on waiting periods[13] greater than 90 days.[14]

Grandfathered plans providing *group* coverage will be required to comply with the following reforms:[15]

- Prohibition on "restricted" annual limits on essential health benefits[16] provided by group health plans, for plan years beginning six months on or after date of enactment.[17]

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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.

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

[7] The Secretary will promulgate regulations to enforce these provisions and may provide for penalties.

[8] 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.

[9] 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.

[10] While grandfathered plans are not required to offer "essential health benefits," the PPACA provision relating to both lifetime and annual limits explicitly links these limits to essential benefits: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness and chronic disease management, and pediatric services, including oral and vision care.

[11] Rescission refers to the retroactive 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 covered under the rescinded policy. Consequently, the former enrollee would be responsible for all health expenses incurred when s/he was previously covered.

[12] For additional information, see CRS Report R41220, *Preexisting Exclusion Provisions for Children and Dependent Coverage under the Patient Protection and Affordable Care Act (PPACA)*, by Hinda Chaikind and Bernadette Fernandez (hereafter cited as *Preexisting Exclusion*).

[13] A waiting period refers to the time period that must pass before an individual is eligible to enroll in health benefits.

[14] While the statutory language applies the excessive waiting period provision to grandfathered health plans (which technically includes both group and individual coverage), the prohibition itself is applied only to group coverage.

[15] PPACA did not specifically mention the promulgation of regulations for these provisions.

- Prohibition on coverage exclusions for preexisting health conditions.[18] 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 become effective for plan years beginning six months on or after date of enactment.

Grandfathered Health Plans and the Individual Mandate Requirement

The individual mandate requires most individuals to have health insurance beginning in 2014, or potentially pay a penalty for noncompliance.[19] 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.[20]

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.

Loss and Continuation of Grandfathered Status

PPACA is silent on the question about which plan changes would lead to loss of grandfathered status. The statutory language does not specify 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 related to the insurance carrier offering the plan (e.g., new corporate owner), so it is not clear from the language whether organizational changes would make grandfathered plans into new plans.

The only scenario that the statute specifies loss of grandfathered status is in the case of coverage provided under one or more collective bargaining agreements. Coverage provided under such

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[16] Same as footnote 10.

[17] In 2014, this provision expands to a prohibition against any annual limit on essential health benefits. PPACA does not preclude a plan from imposing annual (or lifetime) limits on benefits that are not included in essential health benefits.

[18] A preexisting health condition refers to a medical condition that was present prior to the time the person with the condition applied for insurance. For additional information about this provision, see *Preexisting Exclusion.*

[19] For additional information, see CRS Report R41331, *Individual Mandate and Related Information Requirements under PPACA*, by Hinda Chaikind and Chris L. Peterson.

[20] "Minimum essential coverage" is defined as coverage under Medicare part A, Medicaid, the Children's Health Insurance Program (CHIP), Tricare, the TRICARE for Life program, veteran's health care as determined by the Secretary of Veterans Affairs, 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 (this would not apply to the temporary high risk health insurance pool program created under PPACA (§1101), which ends on January 1, 2014), as recognized by the HHS Secretary in coordination with the Treasury Secretary.

agreements that were in effect on the date of enactment is grandfathered until the termination date of the last agreement. Any amendment made to such coverage, solely for the purpose of conforming with PPACA requirements, will cause neither termination of an agreement nor loss of grandfathered status.

Interim Final Rules

On June 17, 2010, the Departments of Health and Human Services, Labor, and Treasury ("Departments") issued interim final rules with request for comments regarding grandfathered plans.[21] In the proposed regulation, the Departments identified certain changes to benefits, cost-sharing, employer contributions, and access to coverage that would cause the loss of grandfathered status. It also clarified the loss of grandfathered status in either of the following instances: a plan did not have continuous enrollment (does not need to be the same enrollee), and termination of an existing collective bargaining agreement under which grandfathered health coverage was provided. In addition, it included transitional rules and a statement regarding federal enforcement, and estimated the potential impact of grandfathering rules on group and individual health plans. Comments on the interim final rules are due August 16, 2010.

Changes Related to Benefits, Spending, and Coverage Access

The proposed regulation identified certain changes that would cause a plan to lose grandfathered status. Some of the changes that would cause loss of grandfathered status relate to covered benefits, cost-sharing requirements, and employer contribution rates:

- "Elimination of all or substantially all benefits to diagnose or treat a particular condition";
- "Any increase … in a percentage cost-sharing requirement (such as an individual's coinsurance requirement)";
- "Any increase in a fixed-amount cost-sharing requirement other than a copayment (for example, deductible) … [that] exceeds the maximum percentage increase" (defined as medical inflation + 15%);
- "Any increase in a fixed-amount copayment … [that] exceeds the greater of:

  (A) An amount equal to $5 increased by medical inflation … (that is, $5 times medical inflation, plus $5), or,

  (B) The maximum percentage increase";
- "Employer or employee organization decreases its contribution rate based on cost of coverage … by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010";
- "Employer or employee organization decreases its contribution rate based on a formula … by more than 5 percent below the contribution rate for the coverage period that includes March 23, 2010";
- Any of the following changes regarding annual dollar limits:

[21] *Federal Register*, vol. 75, no. 116, June 17, 2010.

(A) "A group health plan, or group health insurance coverage, that, on March 23, 2010, did not impose an overall annual or lifetime limit … [later] imposes an overall annual limit";

(B) "A group health plan, or group health insurance coverage, that, on March 23, 2010, imposed an overall lifetime limit … but no overall annual limit … [later] adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010"; or

(C) "A group health plan, or group health insurance coverage, that, on March 23, 2010, imposed an overall annual limit … [later] decreases the dollar value of the annual limit…."

The proposed regulation also included "anti-abuse" rules that specified instances in which changes to employee access to coverage would cause loss of grandfathered status. The rules specified that plans or coverage would cease to be grandfathered:

- "If the principal purpose of a merger, acquisition, or similar business restructuring is to cover new individuals under a grandfathered health plan"; or
- If the following changes to the eligibility criteria were made:

  (A) "Employees are transferred into the plan or health insurance coverage (the transferee plan) from a plan under which employees were covered on March 23, 2010 (the transferor plan)";

  (B) "Treating the transferee plan as if it were an amendment of the transferor plan"; and

  C) "There was no bona fide employment-based reason to transfer the employees…." (Changing the cost or terms of coverage does not constitute a bona fide employment-based reason.)

Transitional Rules and Enforcement

The proposed regulation provides some flexibility in allowing changes to be made to the terms of a plan or coverage after enactment which do *not* cause loss of grandfathered status. Such changes include the following:

- "Changes effective after March 23, 2010 pursuant to a legally binding contract entered into on or before March 23, 2010";
- "Changes effective after March 23, 2010 pursuant to a filing on or before March 23, 2010 with a State insurance department";
- "Changes effective after March 23, 2010 pursuant to written amendments to a plan that were adopted on or before March 23, 2010"; and
- "After March 23, 2010, a group health plan or health insurance issuer makes changes to the terms of the plan or health insurance coverage and the changes are adopted prior to June 14, 2010, … [but later] the changes are revoked or modified effective as of the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010, and the terms of the plan or health insurance coverage on that date, as modified, would not cause the plan or coverage to cease to be a grandfathered health plan…."

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With respect to enforcement of the grandfathering rules, the Departments will consider "good-faith efforts to comply with a reasonable interpretation of the statutory requirements." As part of this consideration process, the Departments may disregard plan and policy changes that only moderately exceed the changes that would lead to loss of grandfathered status, and are adopted before June 14, 2010.

Potential Impact of Grandfathering Rules on Group and Individual Plans

The interim final rules include analysis of the potential impact of grandfathering rules on group health plans and coverage provided through the group and individual health insurance markets.

Using data from an annual employer survey, the Departments analyzed changes to employer-sponsored health insurance from 2008 to 2009. They then calculated the proportion of health plans that would lose grandfathered status if the same changes were made under grandfathering rules.[22] These calculations formed the mid-range estimates.

As indicated in **Table 1**, half of all employer health plans would lose grandfathered status by 2013, if employers did not change their behavior. There is a notable difference among plans by firm size. For large employer (100 or more employees) plans, nearly half would lose grandfathered status by 2013. For small employer (3-99 employees) plans, about two-thirds would do so.

Table 1. Mid-Range Estimates of the Cumulative Percentage of Employer Health Plans Losing Grandfathered Status, 2011-2013

	2011	2012	2013
Mid-range Estimates			
Small Employer Plans	30%	51%	66%
Large Employer Plans	18%	33%	45%
All Employer Plans	22%	38%	51%

Source: Departments' analysis of Kaiser/HRET Employer Survey, 2008-2009. See *Federal Register*, vol. 75, no. 116, June 17, 2010.

Notes: Small employers: 3-99 employees. Large employers: 100 and more employees. Assumes no behavioral change by employers.

However, the Departments acknowledged that employers may behave differently under grandfathering rules, either wanting to maintain grandfathered status[23] or having other priorities that outweigh the desire to keep grandfathered status.[24] With these different scenarios in mind, the

[22] These changes include not only the health plan changes listed above, but also the employer switching the issuer (i.e., insurance carrier) that is providing the coverage.

[23] Some employers may not want the health benefits they offer to incorporate the PPACA insurance reforms for whatever reason, and may be motivated to retain grandfathered status.

[24] Some employers may believe the health benefits they offer already meet the PPACA requirements, so retaining grandfathered status may not be a priority compared with, say, changing health insurance issuers.

Departments also calculated low-range and high-range estimates for plans losing grandfathered status.[25]

For the individual health insurance market, the Departments relied on existing studies that estimated 40%-67% of individual policies are in effect for less than a year. Applying these same turnover rates under grandfathering rules, and assuming that some policies maintained for a longer period of time would eventually also lose grandfathered status, the Departments estimated that the proportion of individual health plans losing grandfathered status would exceed the 40%-67% range in a given year.[26]

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[25] For low-range and high-range data, see Table 3 in the preamble section of the interim final rules (page 34553).

[26] *Federal Register*, vol. 75, no. 116, June 17, 2010.