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

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Summary

The Patient Protection and Affordable Care Act (P.L. 111-148, PPACA), 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 was affected by the grandfathering provisions.

A grandfathered health plan is an existing group health plan 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.

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.

Grandfathered health plans are exempt from the majority of new insurance reforms under PPACA. However, grandfathered plans are subject to a handful of requirements: (1) uniform explanation of coverage documents; (2) medical loss ratio reporting and premium rebates; (3) prohibition on lifetime limits; (4) restriction on rescissions; (5) dependent coverage for children under 26 years of age; (6) prohibition on excessive waiting periods; (7) restricted annual limits; and (8) coverage for preexisting health conditions.

Enrollment in a grandfathered plan meets the individual mandate requirements that are effective in 2014.

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. The regulation 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: for a plan that 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, the regulation included transitional rules that provide some flexibility in allowing changes to be made to the terms of a plan or coverage after enactment that do not cause loss of grandfathered status, and analysis of the potential impact of grandfathering rules on group and individual health plans. Comments on the interim final rules were due by August 16, 2010. Among the issues that generated comments from different stakeholder groups (health plans, employers, consumers, and state regulators) are prescription drug formularies, provider networks, cost-sharing, plan design and funding, and plan disclose requirements.

On November 17, 2010, the Departments published an amendment to the interim final rules on grandfathered health plans. The amendment permits group health plans to change insurance carriers and still maintain grandfathered status.

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Introduction

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 was 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. In addition, the report describes analysis of the potential impact of the grandfathering regulations on existing health plans, and describes a sampling of comments submitted during the public comment period.

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:

[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, Bernadette Fernandez, and Mark Newsom.

[2] The definitions for "group health plan" and "health insurance coverage" refer to prior definitions in the Public Health Service Act (PHSA). Under the 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.

- 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 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 grandfathered group plan is not required to make available dependent coverage to a child who is 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] that are greater than 90 days.[14]

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[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 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 Departments of Health and Human Services, Labor, and Treasury published interim final rules with comment period (*Federal Register*, Vol. 75, No. 92, May 13, 2010).

[9] Limits on benefits refers to a cap on the dollar value of benefits that the issuer of the coverage 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 health benefits, which, at a minimum, must include 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 s/he 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 applicable to group coverage only because a waiting period applies when the individual becomes *eligible* for health benefits through a plan sponsor.

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

- Prohibition on annual limits on essential health benefits,[16] effective for plan years beginning on or after 2014. Prior to 2014, only "restricted" annual limits on essential health benefits are allowed, effective for plan years beginning on or after six months from date of enactment (September 23, 2010).[17]
- 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 on or after six months from date of enactment (September 23, 2010).

Grandfathered Health Plans and the Individual Mandate Requirement

The individual mandate requires most individuals to have health insurance coverage 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

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

[16] Same as footnote 10.

[17] PPACA does not preclude a plan from imposing annual (or lifetime) limits on benefits that are not "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* (footnote 12).

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

[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.

requirements, actuarial value, or other plan features would be allowed under a grandfathered plan (some, but not all, of these plan features are addressed in the regulation on grandfathered plans, as discussed below). 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 statutory language whether organizational changes would make grandfathered plans into new plans (a change in issuer is addressed in the regulation, and later in an amendment to the regulation).

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 (CBA). Health insurance provided under CBAs, 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 Grandfathered Health Plans

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] The Departments identified certain changes to benefits, cost-sharing, employer contributions, and access to coverage that would cause the loss of grandfathered status.[22] The rules also clarified the loss of grandfathered status in either of the following instances: a plan did not have continuous enrollment since enactment (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, the rules include transitional rules, a statement regarding federal enforcement, and an estimate of the potential impact of grandfathering rules on group and individual health plans. Comments on the interim final rules were due August 16, 2010.

Overall, the Departments have existing authority (under three relevant federal statutes[23]) to promulgate regulations with respect to health insurance market reforms, and issue amendments to such regulations. Moreover, the Departments reserved the right to issue administrative guidance (not in the form of regulation) to "clarify or interpret the rules contained in these interim final regulations for maintaining grandfathered health plan status."[24] Nevertheless, the Departments did not specify an exact timeline for either amendments to the interim final rules or administrative guidance.

Changes Related to Benefits, Spending, and Coverage Access

The interim final rules 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:

[21] *Federal Register*, Vol. 75, No. 116, June 17, 2010.

[22] The interim final rules are silent on the impact of some changes, such as eligibility (e.g., part-time workers were offered health benefits pre-PPACA, but are no longer offered benefits), on grandfathered status.

[23] The Public Health Service Act, the Employee Retirement and Income Security Act of 1974, and the Internal Revenue Code.

[24] *Federal Register*, Vol. 75, No. 116, June 17, 2010, p. 34545.

- "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";
- Any of the following changes regarding an employer's contribution towards premiums:

  (A) "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" or

  (B) "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"; and
- Any of the following changes regarding annual dollar limits:

  (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 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 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...."

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. Moreover, in the preamble to the interim final rules, HHS stated that it will not enforce PPACA insurance reforms with respect to retiree-only coverage (for additional information about the treatment of retiree health plans under PPACA, see the **Appendix**).

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.[25] These calculations formed the mid-range estimates.

As indicated in **Table 1**, the Departments estimated that half of all employer health plans would lose grandfathered status by 2013, if employers did not change their behavior. There is a notable

[25] 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. This particular change was addressed in an amendment to the interim final rules, which are discussed in a later section ("Amendment to Interim Final Rules").

difference among plans by firm size. For large employer (100 or more employees) plans, nearly half (45%) would lose grandfathered status by 2013, based on these estimates. For small employer (3-99 employees) plans, about two-thirds (66%) 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[26] or having other priorities that outweigh the desire to keep grandfathered status.[27] With these different scenarios in mind, the Departments also calculated low-range and high-range estimates for plans losing grandfathered status.[28]

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.[29]

Submitted Comments

As mentioned previously, the issuance of the interim final rules included a public comment period that ended on August 16, 2010. To date, well over 2,000 submissions have been posted on http://www.regulations.gov in response to this regulation. While it is beyond the scope of this report to review and summarize all submissions, CRS analyzed selected comments that reflect a range of perspectives: health plan, employer, consumer, and regulator.[30] Issues that generated

[26] 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. One reason may include the desire to maintain current coverage rules given the uncertainty of the future impact of reform on the private market.

[27] 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, increasing co-insurance requirements.

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

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

[30] The comments described in this document were selected to present a range of comments submitted in response to the interim final rules on grandfathered health plans. They are not meant to be all-inclusive, nor is the CRS description meant to be fully representative of all the perspectives reflected by the individuals and organizations that submitted (continued...)

comments across the various perspectives include prescription drug formularies, provider networks, cost-sharing, plan design and funding, and the requirement to disclose certain information to plan participants and beneficiaries.

Overall, the comments from health plans and employers argued for more flexibility in plan changes that would still allow the maintenance of grandfathered status. In contrast, consumers generally supported the rules, but in some instances argued for restricting even further the changes that a grandfathered plan could make. State regulators expressed views and made recommendations that spanned the different perspectives. Notably, across the comments, the assumption was that maintaining grandfathered status is desirable, so the commenter either wanted to be able to make more changes and still be grandfathered, or use the loss of grandfathered status to discourage changes.

Plans and employers recommended that changes to prescription drug formularies and provider networks be allowed, in order for coverage to adopt innovation, promote high-quality care, and keep current with a dynamic health care marketplace. Consumers, however, supported the loss of grandfathered status with changes in formularies and networks that negatively affected access to care. Regulators expressed views on both sides of this issue. For example, one state regulator said that a significant change in the provider network should lead to loss of grandfathered status, while another stated that allowance should be given to a dynamic market where providers enter and exit regularly.

Plans and employers recommended more flexibility with changes to cost-sharing that would be allowed. Some suggested that medical inflation was not an appropriate measure, and suggested a standard based on actuarial value. Plans and employers also argued for greater flexibility in general, whether it was plan options, funding of coverage, issuer of coverage, employer contributions, or other features. Consumers supported the grandfathering rules with respect to cost-sharing and plan structure. In specific instances, consumers identified other cost-sharing changes (e.g., visit limits) that should lead to loss of grandfathering status, as well as recommended further clarification of the cost-sharing rules. In keeping with this perspective, consumers generally supported the regulations regarding changes to issuer, employer contributions, and overall plan design. State regulators, again, expressed different views on these issues; for instance, one state recommended more flexibility in the cost-sharing rules, while another state recommended that prescription drug copayments be added to the rules.

The same range of concerns and recommendations applied to the requirement to provide enrollees with health plan information, including whether their plan has been grandfathered. Health plans and employers uniformly argued that the notice be issued less frequently and the information streamlined, to minimize the burden and cost. Consumers argued for more information to be included in the notice, specifically which insurance reforms do and do not apply to grandfathered plans. Regulators expressed both of these views.

(...continued)

comments.

Amendment to Interim Final Rules

On November 17, 2010, the Departments published an amendment to the interim final rules on grandfathered health plans.[31] After review of the comments concerning the link between a change in health insurance coverage to loss of grandfathered status, the Departments amended the rules to allow group health plans to "enter into a new policy, certificate, or contract of insurance"[32] and maintain grandfathered status. This amendment would allow, for example, an employer plan that currently provides health coverage through insurance carrier A to get coverage through insurance carrier B, and still be considered a grandfathered plan (provided that there is no other change to the plan that would cause loss of grandfathered status). This amendment included a comment period that ended on December 17, 2010.

[31] *Federal Register*, Vol. 75, No. 221, Nov. 17, 2010.

[32] Ibid., p. 70116.

Appendix. Retiree Health Plans and PPACA

Whether retiree health benefits are subject to PPACA depends, in part, on the population that is eligible for the health benefits. Generally, retiree health benefits may be offered under a plan that is separate from health benefits offered to current employees (retiree-only plans). Or retiree health benefits may be offered through the same plan offered to current employees; an example of this is what is offered through the Federal Employees Health Benefits Plans (FEHBP), which covers both retirees and workers under the same plans.

Plans that cover workers must comply with the relevant PPACA provisions that impact employer-provided insurance (such as the dependent coverage requirements). Therefore, if the retiree coverage is offered through the same plan offered to current employees, then those plans, by default, must comply with the same provisions Alternatively, if the retiree coverage is offered through retiree-only plans, then such plans may (or may not) be subject to PPACA's insurance reforms.

Retiree-only plans may not have to comply with PPACA's insurance provisions:

- The authority to regulate employer-provided health benefits, including retiree health benefits, rests with the federal government. PPACA's insurance reforms are examples of the federal regulation of employer-provided health benefits.
- However, states are the primary enforcers of health insurance requirements, even post-PPACA. Therefore, the states have the authority to enforce PPACA's insurance reforms on retiree health plans offered through state-licensed insurance companies. (Note: self-insured plans are not offered through state-licensed insurers, so they generally are not subject to state law or regulations. Self-insured plans are subject to federal standards.[33]) Each state will decide whether it will actively enforce the PPACA insurance reforms on retiree plans.
- For states that do not adequately enforce applicable health insurance requirements, the enforcement responsibility typically falls back to the federal government. However, HHS has stated that it will not enforce PPACA insurance reforms with respect to retiree-only coverage. This statement was made in the preamble to the interim final rules regarding grandfathered plans. In other words, at this time, there is no federal role in enforcing the PPACA insurance reforms on retiree-only plans. However, given the Administration's aforementioned authority to promulgate regulations and issue administrative guidance relating to federal health insurance standards, it is possible that the Administration may reconsider its position on enforcement.

The federal exemption for retiree-only health plans is not a new exemption. Retiree-only health plans have been exempt from federal health insurance requirements since enactment of the Health Insurance Portability and Accountability Act of 1996. In the preamble to the interim final rules regarding grandfathered plans, HHS indicates that this exemption still applies.

[33] For additional information about self-insured plans, see CRS Report R41069, *Self-Insured Health Insurance Coverage*, by Bernadette Fernandez.

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