

# Is Retaining Grandfathered Status Still Worth It?

by | **Stacie M. Kalmer** and **Gregory A. Storm**

**E**leven years after the passage of the Patient Protection and Affordable Care Act (ACA), a surprising number of Taft-Hartley multiemployer plans remain *grandfathered*, or exempt from some ACA requirements, because they have not made certain benefit changes in those 11 years. A recent survey by the International Foundation of Employee Benefit Plans found that overall, nearly 29% of responding organizations had grandfathered health plans. Just over half (51%) of responding multiemployer plans reported retention of grandfathered status.<sup>1</sup> After more than a decade of limiting benefit changes, some plan sponsors are now asking whether retaining grandfathered status is still beneficial.

This article will provide a history of the grandfathered plan rules under ACA, including what changes can be made without jeopardizing grandfathered status, based on guidance issued by federal agencies including the Departments of Labor (DOL) and Health and Human Services (HHS). It also will discuss whether remaining grandfathered continues to make sense.

## Background

Group health plans in existence on March 23, 2010 are subject to only specified ACA provisions for as long as they remain grandfathered.<sup>2</sup> This relatively straightforward rule leads to two more involved questions: What does it take for a plan to remain grandfathered, and which ACA provisions apply to grandfathered plans?

Multiple sets of regulations and numerous pieces of informal guidance explaining grandfathered status have been issued. In short, as long as a plan (1) was in existence on March 23, 2010 and (2) does not make one of six specified benefit changes, the plan remains grandfathered. In addition, grandfathered plans must provide a notice advising participants of the plan's grandfathered status with any summary of benefits

(e.g., summary plan descriptions, summary of material modifications, open enrollment materials, benefit guides).<sup>3</sup> Grandfathered plans also must maintain records documenting the terms of the plan in effect on March 23, 2010 and any other documentation that can be used to verify grandfathered status.<sup>4</sup> Failure to provide the required notice or documentation could result in the plan losing its grandfathered status.

## Changes a Grandfathered Plan Cannot Make

Following is a list of six changes grandfathered plans cannot make in order to remain grandfathered.<sup>5</sup> All of these changes are measured against the plan rules in effect on March 23, 2010.<sup>6</sup> A plan that makes one of these changes ceases to be grandfathered on the date that the amendment is effective.<sup>7</sup> Once grandfathered status is lost, plans may not “correct” the action and regain grandfathered status.<sup>8</sup>

The federal agencies have confirmed that temporarily changing benefits for COVID-19 treatment or diagnosis during the COVID-19 public health emergency or national emergency will not cause a loss of grandfathered status when benefits revert to the usual plan rules.<sup>9</sup>

### ***1. Eliminating All or Substantially All Benefits to Diagnose or Treat a Particular Condition***

Although it is a facts-and-circumstances determination,<sup>10</sup> eliminating any necessary element to diagnose or treat a condition is considered eliminating all or substantially all benefits.<sup>11</sup> For example, a plan would cease to be grandfathered if it eliminated all coverage for cystic fibrosis, even though very few participants may be affected, because the plan now provides no coverage for the particular condition.<sup>12</sup> If a plan instead eliminated benefits for mental health counseling, and counseling was considered a “necessary element” for treatment of a mental health condition, the plan would also cease to be grandfathered.<sup>13</sup>

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Many multiemployer health plans have elected to maintain grandfathered status and are therefore exempt from some Patient Protection and Affordable Care Act (ACA) requirements. The authors discuss the factors that plan sponsors should consider when evaluating whether to retain grandfathered status.



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## **2. Increasing the Coinsurance Amount**

Because coinsurance, as a percentage cost share of any given medical service, automatically incorporates medical inflation, any increase in the coinsurance paid by the participant—either in or out of network—will cause a plan to lose grandfathered status.<sup>14</sup> Prohibited cost-sharing increases apply across the benefit package. In other words, if a plan increases the coinsurance on one service, the plan will cease to be grandfathered even if the plan maintains all other cost sharing.<sup>15</sup>

## **3. Increasing the Deductible or Out-of-Pocket Maximum in Excess of the Maximum Percentage Increase**

In contrast to coinsurance, so-called “fixed dollar” cost sharing (i.e., deductibles, out-of-pocket maximum, copayments) does not automatically incorporate medical inflation. To remedy this, grandfathered plans are allowed to increase deductibles and out-of-pocket maximums—again, either in or out of network—by the “maximum percentage increase” (more on this below). Like coinsurance increases, prohibited increases to fixed dollar cost sharing apply across the benefit package.

Recent regulations<sup>16</sup> provide a special rule for high-deductible health plans (HDHPs) which, by rule, must have a deductible no less than a statutorily defined amount.<sup>17</sup> For 2021, the minimum deductible is \$1,400 for self-only coverage and \$2,800 for family coverage.<sup>18</sup> To avoid a scenario where a grandfathered plan must choose between remaining grandfathered or remaining an HDHP, plans may now increase their deductible by an amount necessary to maintain status as an HDHP without losing their grandfathered status.<sup>19</sup>

## **4. Increasing the Copayment in Excess of the Maximum Percentage Increase or, if Greater, \$5 Plus Medical Inflation**

Similar to the rules for deductibles and out-of-pocket maximums, in-network and out-of-network copayments can also be increased by the maximum percentage increase or \$5 plus medical inflation, if greater.<sup>20</sup>

The definition of *maximum percentage increase* was recently updated to provide plans with more flexibility to increase fixed dollar cost sharing. For changes effective before June 15, 2021, the maximum percentage increase is medical inflation plus 15%.<sup>21</sup> After June 15, 2021, the maximum percentage increase is the greater of medical inflation plus 15%, or the premium adjustment percentage minus one plus 15%.<sup>22</sup>

## **5. Decreasing the Employer’s Contribution Rate by More Than 5%**

Plans that base employer contribution rates on a formula (e.g., 80% of the cost of coverage) will lose grandfathered status if the employer contribution rate decreases by more than 5% from the rate in effect on March 23, 2010 (e.g., a reduction to 70% of the cost of coverage).<sup>23</sup> Even if a participant is paying more for coverage, as long as the participant is not paying a higher percentage of the cost of coverage, the plan will retain grandfathered status.

Plans that have fixed dollar employee contributions (e.g., \$250 per month) or no employee contributions will not lose grandfathered status even if the employer contribution rate decreases, provided there is no increase in the employee contribution rate.<sup>24</sup>

Recognizing that some multiemployer plans may not actually know when an employer decreases its contribution rate (assuming the employee’s contribution rate is not bargained), the federal agencies note that nothing prohibits a multiemployer plan from requiring contributing employers to notify the plan in advance of any contribution rate change.<sup>25</sup> Further, the guidance provides a special rule whereby a multiemployer plan will not lose its grandfathered status based on a change in an employer’s contribution rate unless the plan knows, or should know, of the change and the plan (1) requires contributing employers to make a representation regarding the contribution rates in advance of the plan year and (2) includes in “relevant” plan documents a statement that the employer must notify the plan of any midyear contribution rate changes.<sup>26</sup> Participation agreements would seem like an appropriate “relevant” plan document for such a statement.

## **6. Adding or Decreasing an Overall Annual or Lifetime Dollar Limit**

As a general matter, ACA prohibits plans from imposing annual or dollar limits on essential health benefits.<sup>27</sup> Consequently, a plan may no longer maintain an annual or lifetime dollar limit on all benefits.

## **Changes That a Grandfathered Plan Can Make**

The federal agencies have been fairly clear that unless a change falls within one of the above six categories, it will not cause a loss of grandfathered status.<sup>28</sup> Beyond this broad statement, guidance also provides some specific examples

of changes a plan may make without losing grandfathered status. For example, movement of drugs between tiers of a prescription drug formulary will not cause a loss of grandfathered status.<sup>29</sup> Provided that any benefit change does not exceed the thresholds described above, plans may also make changes to comply with federal legal requirements or to voluntarily comply with ACA mandates.<sup>30</sup> A plan could add new benefit packages and, while the new packages would be non-grandfathered,<sup>31</sup> the existing packages would remain grandfathered. Other changes that do not appear to trigger a loss of grandfathered status include changes to prescription drug formularies or provider networks as well as changes to eligibility terms—even those that eliminate coverage for a class of employees (or dependents).<sup>32</sup>

A plan also can make structural changes such as purchasing a new insurance policy, changing insurance carriers or administrators, and even changing from insured to self-funded (or vice versa) and still be grandfathered as long as the benefits covered under the plan remain the same.<sup>33, 34</sup>

### ***New Employers and Employees***

New contributing employers can join a grandfathered plan, as can new employees and new employee groups from existing employers.<sup>35</sup> However, an employer cannot move a group of employees from a nongrandfathered plan into a grandfathered plan for the sole purpose of covering the employees under a grandfathered plan or for cost savings.<sup>36</sup> Such employee transfers must be reviewed carefully to ensure that the employer has a “bona fide employment-based reason” to transfer the employees,<sup>37</sup> including the following:

- A benefit package is eliminated because the issuer is leaving the market or no longer offers the product
- Low or declining participation by plan participants in a benefit package makes it impractical to continue offering the package
- A benefit package is eliminated from a multiemployer plan as part of the collective bargaining process
- A benefit package is eliminated for any reason as long as multiple benefit packages covering a significant portion of other employees remain available to the transferring employees.

Without a bona fide employment-based reason to transfer the employees, the plan will lose its grandfathered status

## takeaways

- A group health plan is *grandfathered*, which means it is exempt from certain provisions of the Patient Protection and Affordable Care Act (ACA), if it was in existence on March 23, 2010 and did not make one of six specified benefit changes.
- A sizable portion of multiemployer benefit plans remain grandfathered, but some plan sponsors may wonder whether retaining the status remains beneficial.
- Guidance from federal agencies has been fairly clear that unless a change falls within the six specified categories, it will not cause a loss of grandfathered status. Examples of changes that do not appear to affect grandfathered status include changes to prescription drug formularies or provider networks.
- When analyzing the value of maintaining grandfathered status, plans should evaluate whether savings resulting from benefit changes offset any increased costs of having to comply with ACA requirements.
- Requirements to provide full coverage of preventive services and limits on out-of-pocket maximums for nongrandfathered plans are often identified as items that could add cost.

if amending the plan to match the terms of the nongrandfathered plan would have caused a loss.<sup>38</sup>

### ***Changes to Dental and Vision Benefits***

Whether a grandfathered plan can add, eliminate or modify dental and vision benefits without jeopardizing the plan’s overall grandfathered status seems to depend on whether those benefits are integral to the benefit package. The grandfathered plan analysis applies to each benefit package separately.<sup>39</sup> If an election to enroll in a grandfathered plan’s medical benefits automatically enrolled the participant in dental and/or vision benefits as well, the dental and/or vision benefits would likely be considered integral to the benefit package. As such, changes to dental and vision would be analyzed for the six changes that cause a loss of grandfathered status.

In contrast, if a participant was required to make a separate election to enroll in the dental and/or vision benefits, the benefits would likely be considered separate benefit packages. Further, they would appear to qualify as excepted benefits, which are not subject to ACA.<sup>40, 41</sup> Therefore, any changes solely to the dental or vision program would not cause a plan overall to lose its grandfathered status.

## ACA Provisions Not Applicable to Grandfathered Plans

Under current guidance, grandfathered plans are subject to all ACA requirements except for the following:

- Nondiscrimination requirements applicable to wellness programs
- Prohibition of discriminating against providers acting within the scope of their licenses
- Coverage for routine patient costs as part of clinical trials
- Coverage of designated preventive care services
- Transparency in coverage requirements<sup>42</sup>
- Enhanced internal claims-and-appeals procedures
- External review
- Patient protections, including designation of primary care providers and coverage of out-of-network emergency room services at in-network rates<sup>43</sup>
- Limits on out-of-pocket maximums.<sup>44</sup>

## Is Maintaining Grandfathered Status Still Worth It?

The benefit changes that cause a plan to lose grandfathered status all involve reducing benefits offered or provided to participants. Changes that improve benefits do not affect grandfathering. Similarly, changes that do not reduce benefits below levels in effect on March 23, 2010 do not cause a loss of grandfathering. For example, if a grandfathered plan decreased participant coinsurance in 2016 and then increased participant coinsurance in 2020 back to the 2010 level, neither change would cause that plan to lose its grandfathered status.

It's important to remember this when analyzing the value of maintaining grandfathered status. The question often can be rephrased in the context of cost savings. If savings resulting from benefit changes offset any increased costs of having to comply with ACA requirements for nongrandfathered plans, plan sponsors may be more willing to adopt those benefit reductions.

Plan consultants typically identify the requirement to provide full coverage of preventive services and limits on out-of-pocket maximums as the nongrandfathered compliance items that could potentially add costs. However, many plans already cover most, if not all, ACA-designated preventive services at 100% because plan sponsors want to encourage participants to use preventive care to promote a healthier population and reduce overall health care costs. Accordingly, depending on the plan design, becoming subject to ACA preventive care rules may not cause much additional cost.

In contrast, out-of-pocket limits have the potential to be a large cost driver. Many plans have out-of-pocket limits below the ACA maximums for nongrandfathered plans, which are \$8,550 for individual coverage and \$17,100 for family coverage in 2021. Losing grandfathered status would not, therefore, seem to impact a plan that, even after benefit changes, uses an out-of-pocket limit of \$6,000 for individual coverage and \$12,000 for family coverage, for example. However, under ACA out-of-pocket maximum rules, copays must count toward the out-of-pocket maximum, and many plans have historically excluded copays from the out-of-pocket maximum. Adding in copays, particularly prescription drug copays, to the out-of-pocket maximum has the potential to significantly impact cost if a plan were to become nongrandfathered.

Nongrandfathered plans have structured their out-of-pocket maximums in a number of ways to help offset some of the increase in cost. Under ACA guidance, the out-of-pocket limit applies only to in-network benefits. Accordingly, some nongrandfathered plans apply higher out-of-pocket limits on non-network benefits and still comply with ACA. Another common nongrandfathered plan design is to apply a separate out-of-pocket maximum on prescription drugs—When added to the out-of-pocket maximum that applies to all other medical benefits, the overall out-of-pocket maximum will equal the ACA maximum amount.

Complying with all of the ACA requirements listed above may increase a plan's operational activities and corresponding costs. Nongrandfathered plans would need to add en-

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**Stacie M. Kalmer** is a shareholder with the law firm of Reinhart Boerner Van Deuren s.c. in Milwaukee, Wisconsin. She primarily works with multiemployer health plans in the retail industry and building and construction trades and also advises multiemployer retirement plans, corporate plans and governmental plans. She holds a J.D. degree from Marquette University.



**Gregory A. Storm** is a shareholder in the Reinhart Boerner Van Deuren s.c. employee benefits practice and a member of the firm's executive compensation team. He advises a wide range of corporate, governmental, nonprofit and multiemployer plan clients on a variety of employee benefit plan issues. Storm is a frequent speaker on employee benefits topics, including the challenges of health care reform and planning opportunities in recent legislative developments. He holds a J.D. degree from the University of Notre Dame Law School and a B.A. degree from St. Mary's University of Minnesota.

hanced claims-and-appeals procedures and external review requirements, with external review typically adding costs when elected by a participant. External review is available only for denied appeals for claims involving medical determinations or rescissions. Correspondingly, depending on the plan, adding the external review step may not significantly increase annual costs.

## Conclusion

All told, plan sponsors may decide that savings associated with the difficult decisions to change benefits outweigh the added compliance requirements of losing grandfathered status. Considering the impact of operational changes and increased compliance costs are the critical components of any such review. 

## Endnotes

1. *Employee Benefits Survey: 2020 Results*, International Foundation of Employee Benefit Plans.

2. 42 USC 18011.

3. 29 CFR 2590.715-1251(a)(2). (Mirror regulations are available from the Department of the Treasury and Department of Health and Human Services; this article will cite to the Department of Labor guidance for ease of reference.)

4. 29 CFR 2590.715-1251(a)(3).

5. 29 CFR 2590.715-1251(g).

6. The Patient Protection and Affordable Care Act (ACA) and regulations provided a special extension of grandfathered status for insured plans maintained pursuant to a collective bargaining agreement (CBA) ratified before March 23, 2010. 42 USC 18011(d); 29 CFR 2590.715-1251(f). Such plans would remain grandfathered, regardless of changes, until the date on which the last CBA expired. 75 Fed. Reg. 34538, 34542. Once the last CBA ratified before March 23, 2010 expired, the plan would have to analyze the changes made since March 23, 2010 to determine whether it remained grandfathered. *Id.* This special rule was not a delayed effective date like some other laws have provided for. 75 Fed. Reg. 34543. Such plans were required to comply with all ACA provisions applicable to grandfathered plans during the grandfathering extension. *Id.* No similar rule was provided for self-funded plans maintained pursuant to a CBA. 75 Fed. Reg. 34542.

7. 29 CFR 2590.715-1251(g)(1).

8. *Id.*

9. "FAQs about Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 43," June 23, 2020, Q15.

10. The federal agencies specifically refused to provide a bright-line test establishing what constitutes "substantially all." See 80 Fed. Reg. 72192, 72195.

11. 29 CFR 2590.715-1251(g)(1)(i).

12. 75 Fed. Reg. 34543.

13. 29 CFR 2590.715-1251(g)(5) Example 2.

14. See 75 Fed. Reg. 34543.

15. 80 Fed. Reg. 72195.

16. The final regulations were effective January 14, 2021 and available for use June 15, 2021. However, like all regulations issued in the waning days of the Trump administration, the Biden administration is likely reviewing the regulation. As of the date of writing, the final regulations are still effective.

17. Internal Revenue Code §223(c)(2).

18. Rev. Proc. 2020-32.

19. 29 CFR 2590.715-1251(g)(3).

20. 29 CFR 2590.715-1251(g)(1)(iv).

21. 29 CFR 2590.715-1251(g)(4)(ii).

22. *Id.*

23. 29 CFR 2590.715-1251(g)(1)(v)(B).

24. 29 CFR 2590.715-1251(g)(1)(v)(E).

25. 80 Fed. Reg. 72196.

26. 29 CFR 2590.715-1251(g)(1)(v)(C).

27. ACA does not clearly define *essential health benefits*. Rather, ACA provides broad, general categories of types of benefits that would qualify as essential (e.g., hospitalization, maternity care, prescription drugs). Self-funded plans have flexibility to define essential health benefits by reference to any state's ACA benchmark plan.

28. See Preamble to Interim Final Regulations, 75 Fed. Reg. 34544 ("[C]hanges other than the changes [described in the regulations] will not cause a plan or coverage to cease to be a grandfathered health plan."); FAQs about the Affordable Care Act Implementation (hereinafter referred to as "ACA FAQs")—Part II, October 8, 2010, Q1 ("[T]hese six changes are the only changes that would cause a cessation of grandfathered status." (Emphasis in original.))

29. 80 Fed. Reg. 72197.

30. 75 Fed. Reg. 34544.

31. The grandfathered analysis applies separately to each benefit package (29 CFR 2590.715-1251(a)(1)(i)), and since the new packages would not have been in existence since March 23, 2010, the new packages would be nongrandfathered.

32. *Id.*

33. See 29 CFR 2590.715-1251(a)(1)(i).

34. 75 Fed. Reg. 34544.

35. 29 CFR 2590.715-1251(b)(1).

36. 29 CFR 2590.715-1251(b)(2).

37. *Id.*

38. *Id.*

39. 29 CFR 2590.715-1251(a)(1)(i).

40. See Employee Retirement Income Security Act §732(a).

41. See 29 CFR 732(c)(3)(ii).

42. Effective for plan years beginning on and after January 1, 2022, grandfathered plans will be subject to the patient protection requirements, as modified by the Consolidated Appropriations Act, 2021 (CAA), and to the CAA's price comparison requirements, which are similar to those found in the transparency in coverage rules under ACA.

43. *Ibid.*

44. See 42 USC 18011(a).