Grandfathered Plans Get a Refresh

New Regulations Went Into Effect on June 15, 2021

The Affordable Care Act (ACA) became law on March 23, 2010, subjecting both group and individual medical coverage to a variety of plan design mandates. Group health plans already in effect as of that date qualified for "grandfathered" status and could avoid meeting some of the mandates required by the new law.

Grandfathered group health plans cannot make certain cost sharing or design changes without losing their grandfathered status. The U.S. Department of Labor, U.S. Department of the Treasury, and U.S. Department of Health & Human Services ("HHS") initially addressed this and grandfathered status in general through a series of frequently asked questions and followed up with two rounds of regulatory guidance.[1] We will refer to these collectively as the "Agencies" in this Alert.

The Agencies revisited grandfathered plan status and issued a new final rule in December 2020 (the "Final Rule"), making it a little easier for plans to maintain grandfathered status. This final rule became effective on **June 15, 2021**.

Brief History

Many employers initially pursued grandfathered status as part of a general "wait and see" ACA strategy, largely due to concerns about the ACA's preventive services mandate and, to a lesser extent, external review for denied claims. While plans can theoretically retain grandfathered status forever, the inability to make significant changes to cost sharing has led to a steep decline in the number of grandfathered plans since 2011. The Kaiser Family Foundation reported 22% of employers maintained at least one grandfathered plan in 2019, down from 58% in 2012 and 72% in 2011.[2]

Grandfathered Plans Can Avoid the Following ACA Provisions

Grandfathered plans are able to avoid some – but not all – of the ACA's plan design mandates. Many of the avoidable provisions are really only relevant to and affect insurance carriers,[3] but the following are the most pertinent avoidable provisions for employers:

- Coverage of ACA-mandated preventive care services in-network without cost sharing;

[1] This includes the 2010 interim final regulations and the 2015 final regulations (finalized with no substantive changes).
[2] Kaiser Family Foundation 2019 Employer Health Benefits Survey (most recent available) and 2014 Survey (including 2012 and 2011 data).
[3] Those include community rating, guaranteed renewability and availability, health factor nondiscrimination for individual coverage.

- External review for denied appeals based on determination of medical necessity, experimental treatment, or similar exclusion based on scientific or clinical judgment;
- Certain patient protections, including the designation of primary care providers, the ability to see an OB/GYN without a referral, and cost sharing for out-of-network emergency services; and
- Coverage of routine costs for individuals participating in clinical trials, such as diagnostic testing. The ACA does not actually require plans to cover the clinical trial's experimental/investigational treatment itself.

Final Rule Expands Ability to Maintain Grandfathered Status

To maintain grandfathered status, plans must generally maintain the same levels of benefits and cost sharing that were in effect prior to March 23, 2010. As a reward to the few plans that have managed to hang on to their grandfathered status for eleven years, the Final Rule offers some relief by allowing them to push fixed-amount cost sharing further than the prior grandfathered rules allowed.

Any of the following changes will cause a loss of grandfathered status for group health plans, as modified by the new June 15, 2021 final rule:

1. Elimination of all or substantially all benefits to diagnose or treat a particular condition.
2. Any increase to participant cost sharing percentage such as coinsurance.
3. An increase in fixed-amount cost sharing other than copayments (e.g., deductible or out-of-pocket maximum) by a total of more than 15% plus medical inflation.[4] From March 2010 to May 2021 (the most recent data available), medical inflation equals 34.71%.[5]

    a) **NEW as of June 15, 2021:** A grandfathered High Deductible Health Plan (HDHP) will not lose grandfathered status for increases to fixed-amount cost-sharing requirements (such as deductibles) required for the plan to maintain its status as a qualified HDHP. Although this has yet to occur, this allows an HDHP to maintain grandfathered status if an increase to the annual statutory minimum deductible is greater than 15% plus medical inflation.

    b) **NEW as of June 15, 2021:** Grandfathered plans may use traditional medical CPI inflation or the most recently published "premium adjustment percentage" by HHS in its annual notice of benefit and payment parameters for medical inflation, whichever is greater. Under HHS's current methodology, the premium adjustment percentage (35.42%) is higher than the corresponding CPI medical inflation (34.71%).

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[4] Medical inflation is determined by reference to the overall medical care component of the Consumer Price Index (CPI).
[5] Bureau of Labor & Statistics Data as viewed on June 27, 2021 and based on the following calculation: (521.50 – 387.142) ÷ 387.142 = 34.71%. Note: The Agencies use values of 475 and 485 for the trailing 12-month average to determine medical inflation for examples in the Final Rule, but the real value is closer to 520 for any 12-month period beginning with January 2020. The 521.50 value used in our example is the average from May 2020 – May 2021.

- **Note:** The premium adjustment percentage increases to 44.09% for 2022, which will likely be three or more percentage points higher than the corresponding Medical CPI inflation.

Example

A grandfathered plan's deductible as of March 23, 2010 was $1,000. As of June 15, 2021, the plan's deductible can be up to $1,504.20 without affecting grandfathered status.

- Using Medical CPI Inflation: $1,000 × (100% + (15% + 34.71%)) = $1,497.10
- Using Premium Adjustment Percentage: $1,000 × (100% + (15% + 35.42%)) = **$1,504.20**

4. Any increase in a fixed amount copayment equal to the greater of: (1) 15% plus medical inflation; or (2) $5 increased by medical inflation.

a) **NEW as of June 15, 2021:** Grandfathered plans may use traditional medical CPI inflation or the most recently published "premium adjustment percentage" by HHS in its annual notice of benefit and payment parameters for medical inflation, whichever is greater.

- Example
- A grandfathered plan's copayment for brand drugs as of March 23, 2010 was $30. As of June 15, 2021, the copayment can be up to $45.13 without affecting grandfathered status.
  - Using Medical CPI Inflation: $30 × (100% + 49.71%) = $44.91, which is greater than $30 + ($5 × (100% + 34.71%)) = $36.74
  - Using Premium Adjustment Percentage: $30 × (100% + 50.42%)) = **$45.13,** which is greater than $30 + ($5 × (100% + 35.42%)) = $36.77

5. Decrease in employer contribution rate of more than 5% toward any tier of coverage.

- Example
- As of March 21, 2010, ABC Company contributed 80% toward the cost of employee-only coverage and 70% toward the cost of employee + spouse and family coverage. The employer cannot reduce its contribution below 75% for employee-only or 65% for either of the other tiers without the plan losing its grandfathered status.

Additionally, grandfathered plans must provide notice of that status along with plan contact information to plan participants in all significant plan materials, including benefits enrollment guides.[6]

[6] The DOL has a model disclosure notice available.

Note: Grandfathered status must be continuous. Once it is lost, there is no way to reclaim it.

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